DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

DEC 3 1 2014

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-0558

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Department of Veterans Affairs (VA) Medical Center in Northport, New York. The whistleblower alleged that staff in the Primary Care, Agent Orange, and Rural Health Clinics, were being directed to manipulate scheduling and data, thereby potentially placing patients at risk; that the Rural Health Clinic was being utilized as a funding mechanism, and was not being used to treat patients; and that the facility Director improperly barred the whistleblower from entering onto the Northport VA Medical Center campus without a police escort.

The Former Acting Secretary delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Former Acting Secretary asked the Interim Under Secretary for Health to review this matter and to take any actions deemed necessary under the above code. She, in turn, directed the Interdisciplinary Crisis Response Team (now the Office of Accountability Review [OAR]) to conduct an investigation. In its investigation, OAR made the following determinations; OAR found no evidence that the Northport VA Medical Center's policy of not ordering a consult in the Veterans Integrated System Technology Architecture was being used to manipulate wait times; OAR concluded that the staff in the Primary Care, Agent Orange and Rural Health Clinics were not being directed to manipulate scheduling and data; OAR concluded that the Rural Health Clinic was not being used solely as a funding mechanism and that patients are being seen by the Mobile Medical Units; and that the Northport Director did not improperly restrict the whistleblower's access to the medical center.

The Honorable Carolyn N. Lerner

Findings from the investigation are contained in the report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations listed in the report. We may also send your office a follow-up response describing actions which have been and will be taken in response to this report.

Thank you for the opportunity to respond.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the

Office of Special Counsel

OSC File Number DI-14-0558

Department of Veterans Affairs
Northport Medical Center
Northport, NY

Report Date: December 18, 2014

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

The former Acting Secretary of the Department of Veterans Affairs (VA) authorized the Interdisciplinary Crisis Response Team (now the Office of Accountability Review [OAR]) to investigate a complaint lodged with the Office of Special Counsel (OSC) by (b)(6) (hereafter, the whistleblower), a current employee at the Northport VA Medical Center (hereafter, the Medical Center) in Northport, New York. OSC sent a letter dated May 29, 2014, to the Secretary of VA in which the whistleblower alleged the following:

- Staff in the Primary Care, Agent Orange, and Rural Health Clinics are directed to manipulate scheduling and data, placing patients at risk;
- The Rural Health Clinic is used as a funding mechanism and is not used to see or treat patients; and
- The facility Director improperly barred the whistleblower from entering onto the Northport VA Medical Center campus without a police escort.

Summary of OAR's Conclusions

OAR conducted an investigation of the whistleblower's allegations. This investigation included a site visit to the VA medical center in Northport, New York, as well as an interview of the whistleblower. A summary of the team's investigative findings is as follows:

- VA found no evidence that the Medical Center's policy of not ordering a consult in Veterans Integrated System Technology Architecture (VistA) was being used to manipulate wait times. The Chief of Staff and Primary Care Management at the facility indicated that Primary Care is not a consult service, and therefore, the consult package in VistA is not used at the Medical Center for Primary Care. This scheduling practice was verified as appropriate by the Veterans Health Administration's (VHA) Office of Primary Care Operations. However, this practice did result in six patients out of 242 that were referred to Primary Care who were not contacted to set up an appointment. Northport attempted to contact all six missed patients, and conducted a medical record review of these patients. Only one patient was unable to be reached despite repeated attempts. Negative medical outcomes were not identified for any of these patients. **Recommendations – see below**.

- VA concluded that the staff in the Primary Care, Agent Orange and Rural Health Clinics are not being directed to manipulate scheduling and data or placing patients at risk. **No recommendations are made for this item**.

- VA concluded that the Rural Health Clinic is not being used as a funding mechanism, and patients are being seen on the Mobile Health Units. **No recommendations are made for this item.**

- VA concluded that the facility Director did not improperly restrict the whistleblower's access to the medical center due to his alleged conduct. **No recommendations are made for this item.**

Summary of Recommendations

In regards to the facility referring new patients to Primary Care or conducting patient referrals from other clinics to Primary Care, OAR makes the following recommendations:

1. We recommend that the local facility comply with recommendations from the Office of Inspector General (OIG) report #VAOIG-14-02603- 267; "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (originally published on August 26, 2014). Specifically, items #:
   15) We recommend the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition.
   20) We recommend the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.

2. We recommend that the local facility comply with recommendations from the Government Accountability Office (GAO) report #13-130; "VA HEALTH CARE: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement" (originally published on January 18, 2013). Specifically, items #:
   1) To ensure reliable measurement of veterans' wait times for medical appointments, the Secretary of VA should direct the Under Secretary for Health to take actions to improve the reliability of wait time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error; and
   2) To better facilitate timely medical appointment scheduling and improve the efficiency and oversight of the scheduling process, the Secretary of VA should direct the Under Secretary for Health to take actions to ensure that VAMCs consistently and accurately implement VHA's scheduling policy, including use of the electronic wait list, as well as ensuring that all staff with access to the VistA scheduling system complete the required training.

Summary of Actions Accomplished

The Medical Center contacted the six missed patients identified in the course of this investigation, and conducted a medical record review of these patients. Of the six patients, five were successfully contacted. These patients advised the facility that they are not interested in utilizing the VA for primary care, as they obtain their primary care in the community setting. Only one patient was unable to be reached despite five telephone calls and a New Enrollee Appointment Request (NEAR) letter. Negative medical outcomes were not identified for any of these patients.

Summary Statement

The OAR investigation and review of its findings did not identify any violations of statutory laws, as codified in the United States Code, agency regulations, as found in the Code of Federal Regulations, or rules, such as Executive Orders. In summary, based on this investigation, no violation of law, rule, regulation, or relevant policy (and identified herein) was identified.

Table of Contents

Executive Summary 2

I. Introduction 6

II. Facility Profile 6

III. Summary of Specific Allegations of the Whistleblower 6

IV. Summary of Whistleblower's Allegations and Investigative Team's findings, conclusions and recommendations:

Allegation #1a: Manipulation of scheduling and data in Primary Care 7

Allegation #1b: Manipulation of scheduling and data in Agent Orange Clinic. 10

Allegation #1c: Manipulation of scheduling and data in Rural Health Clinic... 12

Allegation #2: The Rural Health Clinic is used as a funding mechanism and is not used to see or treat patients 12

Allegation #3: The Northport VAMC Director improperly barred the whistleblower from entering the Northport VA Medical Center campus without a police escort 14

Attachments 15

Report to the Office of Special Counsel

I. Introduction

The former Acting Secretary of VA authorized the Interdisciplinary Crisis Response Team (now the Office of Accountability Review [OAR]) to investigate a complaint lodged with OSC by a whistleblower at the Medical Center, Northport, New York. The whistleblower alleged the following:

- Staff in the Primary Care, Agent Orange, and Rural Health Clinics are directed to manipulate scheduling and data, placing patients at risk;
- The Rural Health Clinic is used as a funding mechanism and is not used to see or treat patients; and
- The facility Director improperly barred the whistleblower from entering onto the Northport VA Medical Center campus without a police escort.

II. Facility Profile

The Medical Center is a tertiary care, level 1 facility located on Long Island, New York, and has five clinics located in East Meadow, Patchogue, Riverhead, Bay Shore, and Valley Stream. Veterans in Long Island, New York, can be seen at the Health Screening Clinic (HSC) or on the Mobile Medical Units (MMU) to determine eligibility for VA care through the Medical Center or its community-based outpatient clinics (CBOC). Comprehensive health services are provided through primary care, specialty care, and long-term care and in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

III. Summary of the Review

Two individuals detailed to OAR, (b)(6) [redacted] Human Resources Specialist, Office of Human Resources, VA Central Office, and (b)(6) [redacted] Human Resources Consultant, Workforce Management and Consulting, Veterans Health Administration, conducted a site visit on July 29 and 30, 2014. The team interviewed several witnesses and reviewed policies, procedures, and reports related to patient wait times, scheduling, the Rural Health program, and the restriction of the whistleblower's access to patient care. A full list of the documents reviewed is in the Attachment.

VA's Office of General Counsel reviewed OAR's findings and was unable to identify any violations of statutory laws, as codified in the United States Code, agency regulations, as found in the Code of Federal Regulations, or rules, such as Executive Orders.

During the site visit, the following individuals were interviewed in person:

(b)(6) Whistleblower
(b)(6) Supervisory Program Specialist, Business Office
Primary Care Coordinator, Primary Care Service
(b)(6) Associate Director
(b)(6) Assistant Associate Chief of Staff, Primary Care and the Emergency Room
(b)(6) Executive Assistant to the Director (also Rural Health Coordinator)
(b)(6) Community Outreach Supervisor
(b)(6) Nurse Practitioner, Rural Health Program
(b)(6) MD, Chief of Staff
(b)(6) Medical Center Director
(b)(6) Patient Advocate

On July 25, 2014, the investigative team conducted a telephonic interview with (b)(6) (b)(6) Associate Chief of Staff, Primary Care and the Emergency Room, due to his unavailability during the week of the face-to-face investigation.

The team reviewed all allegations reported by OSC in its letter dated May 29, 2014.

IV. Summary of Whistleblower's Allegations and Investigative Team's Responses

Allegation #1 Staff in the a) Primary Care, b) Agent Orange, and c) Rural Health Clinics are directed to manipulate scheduling and data, placing patients at risk.

Allegation #1a. Manipulation of scheduling and data in Primary Care:

VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures" (June 9, 2010) (the "Directive"), establishes VA's policy and procedures for scheduling clinic appointments and "ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process." VA's policy recognizes the regulatory mandate, but consistent with the standards of medical practice, makes clear that priority based on the regulation may not impact the medical care of any other previously scheduled Veteran. Nor can it take priority over other Veterans' more acute health care needs. Emergent or urgent care is to be provided on an expedient basis and emergent and urgent care needs invariably take precedence over a scheduling priority based on the regulation.

Paragraph 2(e)(7) of the Directive states; "**New Enrollee Appointment Request (NEAR) Call List**. The NEAR Call List is a tool to be used by enrollment staff to communicate to Primary Care Management Module (PCMM) Coordinators or schedulers, at the Veteran's designated preferred location, that a newly enrolled Veteran has requested an appointment during the enrollment process."

New Patients: Veterans in Long Island, New York, can be seen at the HSC or on the MMU to determine eligibility for VA care through the Medical Center or its CBOCs. The investigative team's visit in July 2014, identified that the practice at the Medical Center was to enter a progress note for newly enrolled Veterans interested in being referred to Primary Care. Specifically, if a newly enrolled Veteran was interested in receiving care by a physician in a Primary Care Clinic, the provider working in the HSC or MMU would enter a Primary Care Referral Progress Note into the computer system. This note was a special template created by the Medical Center for Primary Care referrals in its computerized health system called VistA. The progress note was supposed to be written electronically to include the Primary Care Coordinator, as a co-signer in VistA. Therefore, she was always made aware of a Primary Care referral. According to the Primary Care Coordinator, she was usually able to contact prospective patient within 24 hours of the referral to Primary Care, but that she technically had up to 5 days after receipt of the progress note in which to contact the patient and ask the patient when he/she desires to be seen in the Primary Care Clinic. Those patients who needed immediate care would have immediately been taken to the Primary Care Clinic or the Emergency Room instead of making a referral using a progress note.

Referrals to Primary Care: Not all patients at the Medical Center receive primary care services through the VA health care system. Some patients request only specialty care such as mental health services, audiology, etc... If a patient's specialty care provider identifies a medical issue for which primary care services may be warranted, the provider may refer his/her patient to the Primary Care Clinic. For those patients that do not already have an established Primary Care provider, the Medical Center's process for making this kind of referral is the same as the one identified above for new patient referrals – a Primary Care Referral Progress Note is input into VISTA and the scheduling clerk contacts the patient to arrange for an appointment. The Chief of Staff and Primary Care management indicated that Primary Care is not a consult service and therefore the consult package in VistA is not used at the Medical Center for Primary Care. All new patients requesting to utilize the Medical Center for Primary Care are entered onto the NEAR listing upon registration and eligibility verification. The Medical Center is currently utilizing the Primary Care new referral note for those patients who are not assigned to a Primary Care provider, and who are identified by non-Primary Care providers as having potential for assignment to Primary Care. The Medical Center monitors these referrals through system-generated reporting.

The OAR investigation verified that, from January 2014 through June 2014, six patients out of 242 that were referred to Primary Care were not contacted to set up an appointment.

The Primary Care Coordinator was asked about desired wait times and understood the process of asking the patient when he/she desired to be seen. Appointments at the Northport campus can frequently be made within 14 days of the patient's requested date, but wait times at some of the CBOCs are currently as long as 6 weeks. Therefore, while the start date of the wait time may have been a day or two different, a review of

data and testimony produced no evidence which substantiated that management was using this process to make the wait times appear shorter than they were. Significant patient wait times were appropriately annotated after the patient was initially contacted and asked for his/her desired appointment date.

The whistleblower is aware that patient referrals to Primary Care cannot be processed with the Consult function within the VistA computer system. The Whistleblower was dissatisfied with the referral process to Primary Care being scheduled by the Primary Care Coordinator, but he could not identify any law, rule, regulation or policy that this process violates.

Conclusion: There is no evidence that the Medical Center's policy of not ordering a consult in VistA was being used to manipulate wait times. The Chief of Staff and Primary Care management at the facility indicated that Primary Care is not a consult service, and therefore, the consult package in VistA is not used at the Medical Center for Primary Care. This scheduling practice was verified as appropriate by VHA's Office of Primary Care Operations.

Recommendations:

1. We recommend that the local facility comply with recommendations from OIG report #VAOIG-14-02603- 267; "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (originally published on August 26, 2014). Specifically, items #:
   15) We recommend the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition.
   20) We recommend the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.

2. We recommend that the local facility comply with recommendations from GAO report #13-130; "VA HEALTH CARE: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement" (originally published on January 18, 2013). Specifically, items #:
   1) To ensure reliable measurement of veterans' wait times for medical appointments, the Secretary of VA should direct the Under Secretary for Health to take actions to improve the reliability of wait time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error; and
   2) To better facilitate timely medical appointment scheduling and improve the efficiency and oversight of the scheduling process, the Secretary of VA should direct the Under Secretary for Health to take actions to ensure that VAMCs consistently and accurately implement VHA's scheduling policy,

including use of the electronic wait list, as well as ensuring that all staff with access to the VISTA scheduling system complete the required training.

Actions Accomplished:

1) The Medical Center contacted the six missed patients identified in the course of this investigation, and conducted a medical record review of these patients. Of the six patients, five were successfully contacted. These patients advised the facility that they are not interested in utilizing the VA for primary care, as they obtain their primary care in the community setting. Only one patient was unable to be reached despite five telephone calls and a NEAR letter. Negative medical outcomes were not identified for any of these patients.

Allegation #1b. Manipulation of scheduling and data in Agent Orange Clinic:

Northport Center Memorandum 11-121, dated June 17, 2009, entitled "Evaluation of Veterans Reporting Exposure to Agent Orange – Herbicide Clinic," describes the process for Veterans who claim exposure to Agent Orange to receive evaluation and treatment. New patients or current patients who believe that they have been exposed to Agent Orange or other herbicides are instructed to report to the Emergency Room to meet with a scheduling/eligibility clerk to assess their eligibility for enrollment into the Agent Orange registry . No appointment is necessary, and the patient can report at any time. Although clinicians may encourage Veterans to seek assistance or advice from the scheduling/eligibility clerk regarding their eligibility to be enrolled in the Agent Orange registry, clinicians do not make the administrative decision to enroll the Veteran in the registry. However, clinicians refer Veterans to other clinics in the Medical Center based on their medical conditions which may be subsequent to herbicide exposure.

According to the Primary Care Coordinator, a scheduling/eligibility clerk assigned to the Emergency Room meets with the patient, has him/her complete an application, and completes paperwork to have blood work, a urinalysis, an x-ray and an EKG performed. Nursing staff will also interview the patient regarding symptoms and complaints. Only if it is determined that the patient meets the eligibility criteria, a follow-up appointment is made with a provider in Primary Care who is designated as the Environmental Health Provider. Appointment slots for herbicide evaluations are referred to as the Herbicide Clinic. During the appointment, the patient will be provided the results of the laboratory results, data available on Agent Orange exposure and conditions, and instructions about the Compensation and Pension process if the Veteran wants to file a claim. Patients are not seen again by the Environmental Provider unless he/she "has a specific new condition, which he/she feels is related to the exposure," or if he/she is a new patient being assigned to the Environmental Provider.

The whistleblower disagreed with the process of having patients go to the Emergency Room to meet with an eligibility clerk prior to a determination being made that they were

eligible for an Agent Orange exposure evaluation. He stated that his clinical decision that the patient was eligible for registry in Agent Orange was all that was necessary for a patient to have an appointment scheduled with the Environmental Health Provider. However, the local medical center policy outlines the process for an initial eligibility determination to be made prior to being scheduled for an appointment with the Environmental Health Provider. The whistleblower was not assigned to any position that determined eligibility or provided care to patients wanting to register as having been exposed to Agent Orange or other herbicides. He was therefore not authorized to make an eligibility determination. It is not a violation of regulation or policy, and does not have a negative impact upon patient health or safety as no appointment was necessary for the patient to report to the Emergency Room.

The whistleblower also opined that patients should be referred to the Agent Orange Clinic in the same method as consults/referrals in VistA. However, in order to receive an examination by the Environmental Health Provider in the Herbicide Clinic, VA must first determine the patient's eligibility for an examination based on his/her potential exposure to herbicides. Once the patient's eligibility is determined by the eligibility clerk, the patient is immediately scheduled for an appointment by the eligibility clerk because he/she also performs this function.

The whistleblower did not provide any information about patients who were erroneously denied services. Data manipulation could not be substantiated as there was no evidence indicating that patients were being turned away or not being registered.

Conclusion: The process used by the Medical Center for evaluating patients who may have been exposed to Agent Orange does not violate policy. Any provider can refer a patient for follow-up care within the medical center regardless of whether he/she has indicated that he/she has been exposed to an herbicide. A Veteran's application for benefits due to exposure to Agent Orange or other herbicides does not impact the whistleblower's responsibility as a nurse practitioner to refer the patient for care he deems appropriate based on his clinical assessment of the patient. If a patient has medical issues, whether related to exposure to herbicides or not, or whether on the registry or not, he would still receive care from the Medical Center.

There is no evidence to substantiate these allegations.

Recommendation: No recommendation is made.

Allegation #1c. Manipulation of scheduling and data in Rural Health Clinic:

The Medical Center does not have a Rural Health Clinic but rather a Rural Health Initiative. This initiative has many components which will be further discussed in Allegation #2.

Conclusion: Since there is no Rural Health Clinic, there is no evidence to substantiate the allegations.

Recommendation: No recommendation is made.

NOTE: The whistleblower provided no information to form a basis for investigating his other allegations mentioned in the referral letter that he was prevented from making referrals.

Allegation #2 The Rural Health Clinic is used as a funding mechanism and is not used to see or treat patients.

Findings and Recommendations

Findings: There is no clinic at the Medical Center that is referred to as a Rural Health Clinic. Rural Health is an initiative that provides VA funding to VHA facilities that have Veteran patients within their catchment areas who have difficulty accessing care at a main campus, as explained below. The whistleblower is thus correct in part because this initiative is a funding mechanism. In fact, the Medical Center has used these funds to increase access to medical care for its patients.

The Medical Center has four CBOCs that were strategically placed on Long Island, in an effort to make access to health care easier for those Veterans residing there. The Eastern area of Long Island presents unique challenges in that seasonal travel can double or triple normal travel times, especially on the eastern end of the island in which there is only one road. Veteran population projections were used to determine where a CBOC should be located on the island in order to ensure that access to care is optimal. Two CBOCs have recently opened, and two others have been relocated since the current facility Director was appointed approximately 6 years ago.

The Medical Center has submitted several funding requests to the VHA Office of Rural Health since approximately 2008, as part of the Rural Health initiative, in order to obtain funding for personnel and equipment to provide care to patients in areas that are deemed rural. This care is not limited to those patients living in what are considered to be rural areas, but also includes those patients for which access to a CBOC is more conveniently located near their residence.

Funding for the staff and equipment used on the MMUs assigned to the Medical Center was supplied by rural health monies. They are currently used to deliver audiology and podiatry care to patients on the CBOC grounds or at alternate sites such as libraries, grocery stores, etc., which are closer to the areas in which the patients live. This enables multiple patients to drive a shorter distance to receive care instead of going to the Northport campus.

The Medical Center also uses its MMUs to provide outreach to Veterans with staff, who can determine patient eligibility for benefits and perform physical examinations. The patient population in the Northeast is diminishing for a number of reasons and as such, Northport strives though its Outreach Program to enroll all eligible Veterans who are interested in receiving care in the VA health care system.

The whistleblower also alleges that the rural health clinic at the Medical Center does not see or treat patients. We believe that the whistleblower is referring to the rural health initiative. However, patients throughout Long Island, whether in areas deemed rural or non-rural, are being seen at the Medical Center, the CBOCs, and the MMU. In fact, the CBOCs often have long appointment wait times due to their popularity. Testimony confirms that MMUs are dispatched approximately 3 or 4 days a week depending on the needs identified by the Outreach Coordinator and the Nurse Practitioner assigned to the Rural Health Initiative. The Nurse Practitioner assists with the mobile podiatry clinic, performs eligibility examinations, and is responsible for ensuring the upkeep of both mobile units.

The whistleblower alleges that the Nurse Practitioner is not assigned a panel of patients. However, the Nurse Practitioner assigned to the Rural Health Initiative does not have a panel of patients because she sees patients on the MMU for the purpose of routine blood pressure checks or eligibility examinations or assists with podiatry care. She also serves as a back up to the Health Screen Clinic and works with the Outreach Coordinator to ensure Veterans in the Long Island area are aware of the services provided by VA.

The whistleblower also opined that the MMUs should be used for Primary Care services for continuity of care. This type of care occurs at the main campus in Northport and the CBOCs and not on the MMUs. The funding from VHA's Office of Rural Health was not requested nor approved for the purposes of providing Primary Care services, but to provide podiatry and audiology services on the MMUs.

Conclusion: There is no basis to conclude that these are improper uses of MMUs or that money from the rural health initiative is being used for the purposes other than for which it was given to the facility. There is no evidence to substantiate this allegation.

Recommendation: No recommendation is made.

Allegation #3: The facility Director improperly barred the whistleblower from entering the Northport VA Medical Center campus without a police escort.

VA Findings and Recommendations

Finding: The whistleblower stated that he was not a Medical Center patient at the time of the incident that led to the facility Director restricting his access to the Medical

Center, and he confirmed this finding during his interview. He is and was a full-time, permanent Title 38 employee of the Medical Center.

(b)(6) (b)(6)
(b)(6)
(b)(6) while an Administrative Investigation Board (AIB) was being conducted and until a resolution could be reached. In order to ensure the safety of the employees who made the allegations against the whistleblower, as well as ensure the whistleblower's safety, the Director required the whistleblower to have a police escort if he entered VA property.

The whistleblower testified that he was raising the issue of the restrictions placed upon his access to patient care, as a violation of his patient rights, rather than as an employee. He said that the employment issues involving his (b)(6) had been resolved. On December 18, 2013, the whistleblower reached a settlement with the Medical Center in which all issues involving the AIB were considered resolved. The facility Director indicated that he believed the settlement agreement included resolution of the allegation that the whistleblower's right as a patient was violated because as cited above, he would be required to have a police escort should he decide to begin receiving treatment at the facility.

Conclusion: The whistleblower's complaint is based on the assumption that he was a patient, not an employee. The whistleblower has never been a patient at the Medical Center. There is no indication in the record that VA violated law or policy by requiring the whistleblower to obtain a police escort on the Northport campus. Title 38 of the Code of Federal Regulations 17.107 outlines the procedures by which VA will address access to VA care by disruptive patients. The whistleblower alleged VA failed to follow these procedures when it required him to obtain a VA police escort to appear on the Northport campus. However, the regulation is not applicable. Although the whistleblower was ***eligible*** to be a patient, he was not a VA patient when he was placed (b)(6) therefore this regulation does not apply to his situation.

Recommendation: No recommendation is made.

Attachments

Documents reviewed by VA:

- VHA Directive 2010-027, entitled *VHA Outpatient Scheduling Processes and Procedures*, dated June 9, 2010
- VHA Directive 2008-056, entitled *VHA Consult Policy*, dated September 16, 2008
- Percentage of Patients Seen in Primary Care within 14 days – June 2011 through June 2014
- Training certificate to confirm staff trained about use of NEAR list
- Primary Care New Referral Tracking – January 2014 through June 2014
- Consult Management Business Rule – May 2014

ISSUE I – Primary Care, Agent Orange and Rural Health Clinics – Manipulation of Scheduling and Data

1. Medical Center Policy Memorandum (MCPM) 11-121 – Evaluation of Veterans Reporting Exposure to Agent Orange – Herbicide Clinic (dated 6/17/09)
2. MCPM 05-23 – Occupational Health Services (Employees) (dated 1/4/2011)
3. Northport VAMC Outpatient Scheduling Processes and Procedures (dated 6/9/10)
4. Standard Operating Procedure (SOP): New Patients into Primary Care (Issued 1/13, Revised 5/2013)
5. SOP: Request Provider Change (Revised 10/31/05 and 10/8/13)
6. Veterans Integrated Service Network 3 Consultation/Specialty Care Referral Policy Interfacility Consult Management (Issued 5/1/09, Updated 7/27/12)
7. MCPM 11 ACHA-01 – Cancellation and Rescheduling Policy (dated 9/2/05)
8. MCPM 11-206 – No-Show Policy (dated 9/29/11)
9. Non-VA Care Policies – http://nonvacare.hac.med.va.gov/policy-programs/handbooks-directives.asp
10. VHA Handbook 1101.10 Patient Aligned Care Team (PACT) Handbook - http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=2977
11. Northport SOP for Agent Orange Registration (dated 6/23/2014)

ISSUE II – Rural Health Clinic – Funding Mechanism – Patients Not Treated

PART I - Program Assessment, Coordination Duties, Initiatives, Annual Reports

1. Veterans Rural Health Needs Assessment, VISN 3 New York and New Jersey Network, prepared by (b)(6) (dated 6/30/11)
2. Rural Health Coordinator, Nurse III, Functional Statement
3. Northport VAMC East End Health Care Program FY 2010 – Flow Diagram
4. Specific Duties for Rural Health Point of Contact
5. Rural Health/East End Health Care Program, prepared by (b)(6) RN, MSN
6. Rural Health Initiative Overview, prepared by (b)(6) (dated 04/06/11)

7. Mobile Unit Program Overview
8. Rural Health Initiative Update – FY 2012
9. Northport VAMC: Expansion of Rural Health Program 2012 Annual Report
10. Northport VAMC Rural Health Report, prepared by (b)(6) [redacted] (dated 10/01/12)
11. Rural Health Fall Meeting Minutes – September 12, 2012

PART II – Funding, Expenses, Staffing, Clinic Allocation, Usage

1. Office of Rural Health Management and Analysis Tool – FY 2012
2. Office of Rural Health Proposal Funding Request Form – FY 2011 – Riverhead CBOC – Telehealth
3. Office of Rural Health Proposal Funding Request Form – FY 2011 – Riverhead CBOC – New CBOC
4. Office of Rural Health Proposal Funding Request Form – FY 2012 – Riverhead CBOC – FINAL (dated 07/20/11)
5. Office of Rural Health Proposal Funding Request Form – FY 2011 – Riverhead CBOC – Integrating Mental Health Care
6. Rural Health TDA's and Expenses for FY 10-12
7. Rural Health Update (dated 08/08/2013)
8. Mobile Unit Maintenance – Old Unit and New Unit for FY 12 and 13
9. Production Unit M1 and MM – Primary Care
10. Rural Health Funding for FY 10
11. Office of Rural Health (ORH) Report – Northport VAMC Milestones/Key Events FY 11 and Explanation of Information from (b)(6) [redacted]
12. Northport VAMC Mobile Medical Unit Report – Operational Costs FY 12 and FY 13 (dated 09/12/13)
13. Rural Health Mobile Unit Staffing Explanation provided by (b)(6) [redacted] (dated 06/19/14)
14. Unique Trend Report 1 and 5 Year Comparison
15. Mobile Unit Podiatry Program FY 12
16. Mobile Unit Request Form FY 2012 and Explanation of Information from (b)(6) [redacted] (b)(6) [redacted]

ISSUE III – Placement on AA Pending Investigation

1. Timeline
2. Non-duty with pay status memo
3. AIB Report

Attachments & Exhibits for

OSC Case #DI-14-0558

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2010-027

June 9, 2010

VHA OUTPATIENT SCHEDULING PROCESSES AND PROCEDURES

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for implementing processes and procedures for the scheduling of outpatient clinic appointments and for ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process.

2. BACKGROUND

a. It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays. Wait times for patients to be seen through scheduled appointments in primary care and specialty care clinics are monitored. In addition, patients (both new and established) are surveyed to determine if they received an appointment when they wanted one.

b. VHA is mandated to provide priority care for non-emergent outpatient medical services for any condition of a service-connected (SC) Veteran rated 50 percent or greater or for a Veteran's SC disability. Priority scheduling of any SC Veteran must not impact the medical care of any other previously scheduled Veteran. Veterans with SC disabilities are not to be prioritized over other Veterans with more acute health care needs. Emergent or urgent care is provided on an expedient basis. Emergent and urgent care needs take precedence over a priority of service connection.

c. The assurance of timely access to care requires consistent and efficient use of Veterans Health Information Systems and Technology Architecture (VistA) in the scheduling of outpatient clinic appointments.

d. Tracking and assessing the utilization and resource needs for specialty care also require use of the Computerized Patient Record System (CPRS) electronic consult request package.

e. **Definitions**

(1) **Desired Date.** The desired appointment date is the date on which the patient or provider wants the patient to be seen. Schedulers are responsible for recording the desired date correctly.

(2) **Emergent and Urgent Care**

(a) Urgent Care is care for an acute medical or psychiatric illness or for minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a condition where delay might impair recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a Department of Veterans Affairs (VA) medical facility if the discharging physician directs the patient to return on a specified day for the appointment.

THIS VHA DIRECTIVE EXPIRES JUNE 30, 2015

(b) Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(3) **Provider.** A provider is an individual licensed to deliver health care and services to patients.

(4) **Service-Connected (SC).** Service connection or "service-connected" means that VA has determined that a condition or disability was incurred in, or has been aggravated by, military service.

(5) **Non-Service Connected (NSC).** NSC refers to a condition or disability VA has not determined was incurred in, or has been aggravated by, military service.

(6) **New Enrollee.** A new enrollee is a previously non-enrolled Veteran who applies for VA health care benefits and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits, is determined to be eligible, and is enrolled.

(7) **New Enrollee Appointment Request (NEAR) Call List.** The NEAR Call List is a tool to be used by enrollment staff to communicate to Primary Care Management Module (PCMM) Coordinators or schedulers, at the Veteran's designated preferred location, that a newly enrolled Veteran has requested an appointment during the enrollment process.

(8) **Appointment Type.** Using VistA, an outpatient appointment requires the selection of at least one appointment type, which combined with the "Purpose of Visit" code creates one of 40 unique appointment types. Appointment types can be critical when scheduling different types of appointments. Examples of appointment types include: regular, employee, collateral of Veteran, sharing agreement, etc. For a complete list of appointment types, see the Patient Appointment Information Transmission (PAIT) Release Notes and Installation Guide Patch SD*5.3*333 at http://www.va.gov/vdl/documents/Clinical/Patient_Appointment_Info_Transmission/sd_53_p333_rn.doc .

(9) **Newly registered Patient to the Facility.** A newly registered patient to the facility is a Veteran who is enrolled with VHA, but who has not been registered at a specific facility.

(10) **New Patient as Defined for VHA Wait Time Measurement Purposes.** For VHA Wait Time Measurement purposes, a "new patient" is any patient not seen by a qualifying provider type within a defined stop code or stop code group at that facility, within the past 24 months. ***NOTE:*** *See data definitions at http://vssc.med.va.gov/WaitTime/New_Patient_Monitor.asp# . This is an internal VA Web site not available to the public. In order to access this site, VA staff may need to go first to http://vssc.med.va.gov and accept the VHA Support Service Center Data Use Agreement.*

(11) **Electronic Wait List (EWL).** The EWL is the official VHA wait list. The EWL is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic).

(12) **Service Agreement.** A service agreement is a written agreement defining the work flow rules between any two or more services that send work to one another. Ideally, this document is developed based on discussion and consensus between the two or more involved services. The document is signed by service chiefs from involved services. If the agreement is between services at separate facilities, as with inter-facility consult service agreements, it needs to be signed by the Chiefs of Staff of each involved facility.

(13) **Encounter.** An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

(a) Contact can include face-to-face interactions or those accomplished using telecommunications technology.

(b) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc.

(c) Use of e-mail is limited and does not constitute an encounter. E-mail communications are not secure and e-mails must not contain patient specific information. ***NOTE:*** *Secure messaging communication is available through the My HealtheVet (MHV) personal health record (PHR). These communications may meet the definition of an encounter, based on type of message and content.*

(d) A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely, history and clinical decision-making. Telephone encounters must be associated with a clinic that is assigned one of the Decision Support System (DSS) Identifier telephone codes and are designated as count clinics.

(14) **Occasion of Service.** Formerly known as ancillary service, an "occasion of service" is a specified identifiable instance of an act of technical and administrative service involved in the care of a patient or consumer, which is not an encounter and does not require independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).

(a) Occasions of service are the result of an encounter. Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(b) Some occasions of service, such as clinical laboratory and radiology studies and tests, are automatically loaded to the Patient Care Encounter (PCE) database from other VistA packages.

(15) **Count.** The term "count" refers to workload that meets the definition of an encounter or occasion of service.

(16) **Count versus Non-Count Clinics**. In the creation of Clinic Profiles, clinics are designated as either Count Clinics or Non-Count Clinics. Count Clinics are transmitted to PCE as encounters. Non-Count Clinics are not transmitted to PCE. There are generally two reasons why a clinic might be designated as non-count: if the clinic is administrative in nature and therefore not providing patient care; and if the workload associated with the clinic is transmitted to PCE automatically through another means (a VistA package other than Scheduling) then the clinic is setup as non-count to avoid sending duplicate workload to PCE (for example, occasions of service.)

(17) **DSS Identifiers.** DSS Identifiers are used to measure workload for all outpatient encounters. They are the single designation by which VHA defines clinical work units for costing purposes. In some, but not all cases, DSS Identifiers are defined to be used only for specific Non-Count Clinics assigned to a clinic profile. In these cases, DSS rules must be followed. As a specific example: when a clinic's Primary Stop Code is 674, that clinic is explicitly defined to be a Non-Count Clinic and that is the only way it should be used.

(a) Primary Stop Code. The first three numbers of the DSS Identifier represent the primary stop code. The primary stop code designates the main clinical group responsible for the care. Three numbers must always be in the first three characters of a DSS Identifier for it to be valid.

(b) Secondary Stop Code. The last three numbers of the DSS Identifier contain the secondary or credit stop code, which the VA medical center may use as a modifier to further define the primary work group. For example, a flu vaccination given in Primary Care is designated by 323710. The secondary stop code modifier may also represent the type of provider or team. For example, a Mental Health Clinic run by a social worker can be designated 502125.

(c) Credit Pair. A DSS Identifier Credit Pair is the common term used when two DSS Identifiers, a primary code and a secondary code, are utilized when establishing a clinic in the VistA software. Some specific credit pairs are listed in the DSS Identifier References.

3. POLICY. It is VHA policy that all outpatient clinic appointments, meeting the definition of an encounter, are made in Count Clinics using the VistA Scheduling software in a fashion that best suits patients' clinical needs and preferences; this includes, but is not limited to: appointments made for clinic visits; VA provided home care; consultations; and medical, surgical, dental, rehabilitation, dietetic, nursing, social work, and mental health services and procedures.

NOTE: *The Count Clinic requirement does not include: non-VA care paid through VistA Fee; procedures performed in the operating room and recorded in the VistA Surgery Software; instances where encounters are generated based on unscheduled telecommunication; and occasions of service, such as clinical laboratory, radiology studies, and tests that are automatically loaded to the PCE database. An exception from the requirement of using VistA*

Scheduling software is also extended to providers and programs such as Care Coordination Home Telehealth when encounters are generated based on unscheduled communication.

4. ACTION

a. **Director of Systems Redesign.** The Director, VHA Systems Redesign, within the Office of the Deputy Under Secretary for Health for Operations and Management (10N), is responsible for oversight of implementation of requirements of this Directive, to include measurement and monitoring of ongoing performance.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director, or designee, is responsible for the oversight of enrollment, scheduling, processing, consult management, and wait lists for eligible Veterans.

c. **Facility Director.** The facility Director, or designee, is responsible for:

(1) Ensuring that when outpatients are seen for what constitutes an encounter on a "walk-in" basis without an already scheduled appointment, an appointment is recorded in a Count Clinic with the "Purpose of Visit" entered in the VistA Scheduling Software as "unscheduled." ***NOTE:*** *Since unscheduled visits include no entry of "desired date" for wait time measurement, desired date is equated to appointment creation date. In addition, applicable profiles need to be designed to ensure sufficient capacity to accommodate unscheduled "walk-in" patients. Unscheduled encounters that occur via telephone will not be used in the VistA Scheduling Software.*

(2) Ensuring outpatient appointments for diagnostic laboratory and imaging services are not made using count clinics. Non-Count clinics may be used to schedule laboratory and imaging appointments. Requests for laboratory and imaging services must be made by provider orders (not consult requests). Orders transmit directly to the laboratory or radiology software applications. Work performed in response to such orders triggers transmission of encounter data via the VHA PCE software application. ***NOTE:*** *The use of Count Clinics for diagnostic services is inappropriate in part because it would generate duplicate workload reports.*

(3) Defining "standard work" for the clinic teams to most efficiently operate the clinic. This work includes:

(a) Ensuring clinic flow occurs in a standardized manner including patient check-in with scheduling staff, nurse interview, provider visit, and check-out.

(b) Ensuring providers document orders in CPRS and explain rationale and timeframes for medications, diagnostic tests, laboratory studies, return appointments, consultations, and procedures before the patient leaves the examination room.

(c) Ensuring a check out process occurs following each clinic visit. The check-out process may consist of: nurse-administered patient education; clinical pharmacist education and review of prescription orders; collection of patient feedback; scheduling of diagnostic studies; consultations; and follow-up visits. The check-out process must also include verifying that the

disposition of the appointment in the VistA Appointment Management system has been completed.

(d) Ensuring standardized systems are in place to balance supply and demand for outpatient services including continuous forecasting and contingency planning.

(e) Ensuring each clinic follows these additional business rules for standardizing work.

1. Schedules must be open and available for the patient to make appointments at least three to four months into the future. Permissions may be given to schedulers to make appointments beyond these limits when doing so is appropriate and consistent with patient or provider requests. Blocking the scheduling of future appointments by limiting the maximum days into the future an appointment can be scheduled is inappropriate and is disallowed.

2. Synchronize internal provider leave notification practices with clinic slot availability to minimize patient appointment cancellations.

3. Strive to make follow-up appointments "on the spot" for patients returning within the 3 to 4 month window.

4. Use the Recall/Reminder Software application to manage appointments scheduled beyond the 3 to 4 month scheduling window.

NOTE: *Backlog must be eliminated and demand and supply balanced for the above suggestions to be successful.*

(f) Using the preferred strategy for initiating scheduling which involves:

1. Having the referring providers' team schedule clinical consultation appointments as soon as possible on the day the consult is ordered, before the patient leaves the referring provider team area.

2. Having the treating provider's team either schedule an appointment or, if the timeframe specified by the provider is several months into the future, record in the Recall/Reminder Software application the need for the patient to return to clinic, before the patient leaves the treating provider team area.

a. When a patient needs a follow-up appointment but cannot be immediately scheduled, this need is to be recorded in the Recall/Reminder Software application.

b. The patient must be advised to expect to receive a reminder to contact the clinic to actually schedule an appointment a few weeks prior to the return to clinic timeframe that the provider has specified.

c. The patient needs to be provided information for contacting the clinic at the appropriate time to make the appointment.

3. Having registration or enrollment staff obtain contact information and initiate scheduling action while in direct contact with a newly enrolled or newly registered patient.

(4) Ensuring correct entry of "desired date" for an appointment. The goal is to schedule an appointment on, or as close to the desired date as possible.

(a) For New Patients

1. The scheduler needs to ask the patient: "What is the first day you would like to be seen?" The date the patient provides is the desired date.

2. The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

3. The third step is to offer and schedule an appointment on or as close to the desired date as possible.

(b) For Established Patients' Return Appointments: A specific or a general timeframe is communicated by the provider and the actual desired date is established by the patient.

1. In order for the provider and scheduler to have a clear understanding of the intent for a return appointment, the provider must document the return date in CPRS, preferably through an order. The provider must specify if the return appointment request is for a specific day, or a general timeframe.

2. In order to establish the actual desired date correctly, the scheduler needs to tell the patient that the provider wants to see them again, giving the patient either the provider's specified date or general timeframe, and asking when the patient would like to be seen. The date the patient provides is the desired date.

3. The desired date needs to be defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

4. The scheduler is to offer and schedule an appointment on or as close to the desired date as possible. If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment timeframe.

(c) For Patients Scheduled in Response to Intra and Inter Facility Consults

1. The provider specified timeframe for the appointment needs to be the date of the provider request, unless otherwise specified by the provider.

2. In order to establish the actual desired date correctly, the scheduler informs the patient of the provider's specified date or general timeframe and asks the patient "What day would you like to be seen?" The date the patient provides is the desired date.

3. The desired date needs to be defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

4. The scheduler offers and schedules an appointment on or as close to the desired date as possible. If the provider has specified a desired date (or "soonest appropriate date") and there is a discrepancy between the patient and provider specified desired date, the scheduler must contact the provider for a decision on the appointment timeframe.

5. In creating an appointment in response to a CPRS consult request, the scheduler must use VistA menu options to link the CPRS consult request to the scheduled appointment.

(5) Ensuring that when an appointment is cancelled and rescheduled by the clinic, the scheduler enters as the desired date for the new appointment the desired date for the original appointment.

(6) Ensuring that if the patient must be contacted to create an appointment, policies are in place that outline actions to be taken to make contact, the number of attempts necessary, and documentation required.

(7) Monitoring telephone access and taking action, as needed, to minimize patient problems in accessing providers, teams, and schedulers by phone.

(8) Implementing standardized processes for enrollment, and the scheduling, processing, and management of appointments, consults, and wait lists for eligible Veterans.

(9) The creation and maintenance of a Master List of all staff members that have any of the VistA Scheduling options that may be used for scheduling patients: PCMM menu options for primary care team or for provider assignments, menu options for entries onto the EWL, and the direct supervisors of all such individuals.

(10) Ensuring successful completion of VHA Scheduler Training by all individuals on the Master List. Menu options for creating outpatient appointments are not to be provided to new schedulers without proof of their successful completion of this training. To retain these menu options, all individuals must complete newly released training for schedulers within 120 days of it being announced. ***NOTE:*** *Details regarding the availability of this training will be posted on the Mandatory Training Web page located at: http://vaww.ees.lrn.va.gov/mandatorytraining. This is an internal Web site and is not available to the public.*

(11) Ensuring all individuals on the Master List have their position description or functional statement include specific responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(12) Ensuring all individuals on the Master List have, on file with their supervisor, an annual competency assessment that includes their responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(13) Ensuring completion, using VISN-approved processes and procedures, of a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions, and of the accuracy of desired dates.

(14) Ensuring that identified deficiencies in competency or performance, identified by the annual scheduler audit, are effectively addressed.

(15) Ensuring that all clinic profiles are current at all times and subject to an annual review. This review must include compliance in requirements for use of Count versus Non-Count clinics.

(16) Ensuring full compliance by all involved services with Service Agreements. Service agreements must be reviewed and, if necessary, re-negotiated regularly (at least annually).

(17) Measuring and tracking all unused outpatient appointments in count clinics including those from no shows, patient cancellations, and unscheduled appointment slots.

(18) Ensuring that when appointments become available and the facility has at least 3 days to give patients notice, scheduling personnel offer appointments to patients who are either on the EWL waiting for appointments, or currently have appointments more than 30 days past the desired dates of care. ***NOTE:*** *This applies to management of scheduling in Count Clinics.*

(19) Ensuring that the following Business Rules for Scheduling Outpatient Clinic Appointments are followed.

(a) Patients with emergent or urgent medical needs must be provided care, or be scheduled to receive care, as soon as practicable, independent of SC status and whether care is purchased or provided directly by VA.

(b) Generally, patients with whom the provider does not yet have an established relationship and cannot be scheduled in target timeframes must be put on electronic waiting lists (EWL). VHA's EWL software is used to manage these requests, which usually consist of newly registered, newly enrolled, or new consult requests for patients waiting for their first scheduled appointment. No other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments. When patients are removed from the EWL, except for medical emergencies or urgent medical needs, Veterans who are SC 50 percent or greater, or Veterans less than 50 percent SC requiring care for a SC disability must be given priority over other Veterans.

(c) Facilities are required to provide initial triage evaluations within 24 hours for all Veterans either self-requesting or being referred for mental health or substance abuse treatment. Additionally, when follow-up is needed, it must include a full diagnostic and treatment

evaluation within 14 days. ***NOTE:*** *VHA leadership may mandate specific timeframes for special categories of appointments.*

(d) PCMM Coordinators or Scheduling Coordinators must check the Primary Care EWL daily and act on requests received. Schedulers in all clinics at all locations (substations) must review the EWL daily to determine if newly enrolled or newly registered patients are requesting care in their clinic at their location.

(e) A wait list for hospice or palliative care will not be maintained as VHA must offer to provide or purchase needed hospice or palliative care services without delay.

(f) A patient currently or formerly in treatment for a mental health condition, who requests to be seen outside of the clinician desired date range, needs to be seen or contacted within 1 working day by the treatment team for evaluation of the patient's concern.

(g) The VHA Class I Recall/Reminder Software application is used for patients with whom the service has an established relationship. This software application is typically used when the requested follow-up appointment date is more than 3 to 4 months into the future. These patients include those that have either been seen initially in a given VA clinic and need to return in the future; or those who have been seen initially through purchased non-VA care with a plan to be seen in follow-up at the VA clinic. ***NOTE:*** *Even though a patient seen initially through purchased non-VA care may be new to a facility clinic, the organization has committed to this relationship, so Recall/Reminder scheduling may be appropriate.*

(h) Non-VA care may be utilized in accordance with regulatory authority when service is not available in a timely manner within VHA due to capability, capacity, or accessibility. Availability of non-VA care and access to VA care must be taken into account before non-VA care is authorized. An analysis of costs of care needs to be undertaken at appropriate intervals to determine if services could be more efficiently provided within VA facilities. Use of purchased care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality. Purchased care must only be considered when the request for care can be resolved efficiently, including having results available to the referring facility in a timely manner.

(i) Patients provided authorization for continued non-VA care need to be tracked and brought back within VHA as capacity becomes available. This needs to be from the oldest authorization moving forward, as clinically indicated.

(j) Clinic cancellations, particularly when done on short notice, are to be avoided whenever possible. If a clinic must be canceled or a patient fails to appear for a scheduled appointment, the medical records need to be reviewed to ensure that urgent medical problems are addressed in a timely fashion. Provisions need to be made for necessary medication renewals and patients need to be rescheduled as soon as possible, if clinically appropriate.

(k) When a patient does not report ("no-show") for a scheduled appointment, the responsible provider, surrogate, or designated team representative needs to review the patient's

medical record, including any consult or procedure request received or associated with the appointment and then determine and initiate appropriate follow-up action. ***NOTE:*** *It may be useful for the facility to assign a case manager to the patient with multiple "no-shows" to determine the best method to manage the patient's pattern of repetitive "no-shows."*

(l) Facility leadership must be vigilant in the identification and avoidance of inappropriate scheduling activities. ***NOTE:*** *For further guidance, please see the Systems Redesign Consultation Team Guidebook available on the Systems Redesign Web site at Systems Redesign Consultation Team Guide 2008 (https://srd.vssc.med.va.gov/Pages/default.aspx). This is an internal VA Web site not available to the public.*

(20) Providing annual certification through the VISN Director to the Director, Systems Redesign, in the Office of the Deputy Under Secretary for Health for Operations and Management, of full compliance with the content of this Directive. Initial certifications are due 6 months following issuance of this Directive and then annually thereafter.

5. REFERENCES

a. Public Law 104-262.

b. Title 38 United States Code (U.S.C.) Sections 1710, and 1703, 1705.

c. Code of Federal Regulations, § 17.52, 17.100, 17.36, 17.37, 17.38, and 17.49.

6. FOLLOW-UP RESPONSIBILITY: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to the Director, Systems Redesign Program at 605-720-7174.

7. RESCISSIONS: VHA Directive 2009-070 is rescinded. This VHA Directive expires June 30, 2015.

Robert A. Petzel, M.D.
Under Secretary for Health

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Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2008-056

September 16, 2008

VHA CONSULT POLICY

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines policy for management of the clinical consultation process and describes processes of care related to those consults associated with clinical consultation. ***NOTE:*** *This Directive is not relevant for other uses of the consult functionality, such as requesting prosthetic items.*

2. BACKGROUND

a. A clear and solid consultation process is vital to patient care. The consultation process works best when there is a relationship between the sending and receiving services (in addition to those between sending and receiving facilities), where defined work flow rules exist. Effective use of service agreements improves the relationship, establishes clear processes, and reduces the need for inspection and rework. Creation of consult templates in the Computerized Patient Record System (CPRS) can operationalize service agreements, enhancing the effectiveness of referrals. CPRS has a consultation functionality that is widely used for communication of patient issues beyond strict clinical consultation.

b. **Definitions**

(1) **Consult Tracking.** Consult tracking is a CPRS functionality that facilitates documented communication of patient specific activities, which can be either clinical or administrative in nature.

(2) **Consult.** A consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests and subsequent activities.

(3) **Clinical Consultation.** A clinical consultation is provided by a physician or other health care provider in response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem (e.g., consult to Dermatology for rash). A clinical consultation request is initiated by a physician or appropriate source with the clear expectation that a reply will be provided in a timely fashion.

(4) **Non-consultative Service Request.** A non-consultative service request is sent using the CPRS consult functionality for a purpose other than a clinical consultation, i.e., a request to Dermatology for a non-formulary approval or request to reschedule a no-show.

(5) **Service Agreement.** A service agreement is an agreement or understanding between any two or more services, one of which sends work to the other(s), defining the work flow rules. The agreements may exist within one facility or between two or more facilities. Typically this is a written document that is developed based on discussion and consensus between the involved

services and facilities. The document is signed by service chiefs from the involved services. ***NOTE:*** *See Attachment A for recommended content for service agreements.*

3. **POLICY:** It is VHA policy that all requests for clinical consultation be clinically completed with results consistent with VHA timeliness standards and resolved efficiently taking into account individual health care needs.

4. **ACTIONS:** In order to provide timely and clinically appropriate care to all veterans, all requests for clinical consultative services must be resolved efficiently taking into account individual health care needs.

a. **Director of VHA Systems Redesign.** The Director, VHA Systems Redesign (10NSR), is responsible for overall oversight of implementation of requirements of this Directive, to include measurement and monitoring of ongoing performance.

b. **Veterans Integrated Service Network (VISN) Director.** Each VISN Director, or designee, is responsible for the oversight of the consultation process.

c. **Facility Director.** Each facility Director, or designee, is responsible for ensuring:

(1) The CPRS consult functionality is the mechanism used to initiate, manage, and communicate clinical consultations.

(a) Clinical consultations that can be resolved without a face-to-face encounter need to be answered electronically and the consult completed without scheduling an appointment. All other clinical consultations must be acted on by scheduling an appointment within VA's established timeframe or documenting the reason why an appointment is not scheduled within the timeframe. Facility staff must ensure outpatient appointments created in response to CPRS intra-facility and inter-facility consult requests are effectively linked in VistA to the specific CPRS consult request.

(b) Facility staff must understand the recommendation that urgent or emergent requests for a clinical consultation are verbally communicated in addition to sending an electronic clinical consultation.

(2) The preferred strategy for scheduling is used, i.e., having the referring providers' teams schedule as many clinical consultation appointments as possible on the day the consult is ordered before the patient leaves the referring provider team area.

(3) Effective use of service agreements, well-designed communication processes, and effective electronic templates are in place in order to obviate the need for review of consults before scheduling. The ideal process is direct scheduling of consult appointments without clinical review by the receiving service. If review is necessary, however, it needs to be performed on a regular, timely basis to ensure adherence with timeliness standards.

(4) Procedures are established to track and process clinical consultation requests that are without action within 7 days of the request.

(5) Needs of patients who fail to keep an appointment are addressed. When a patient fails to keep a scheduled consultative appointment, the receiving service must reassess the need for service and either reschedule the appointment or cancel the consult request, as appropriate.

(6) When the receiving service or provider cancels a scheduled consultative appointment, the receiving service or provider reassesses the patient's clinical need and reschedules the appointment as expeditiously as possible.

(7) Reports of consult requests are attached to the consult request in the CPRS consult package. This enables the requestor to be alerted to the report's availability and ensures that the results are available and easily identifiable.

(8) Non-VA care is utilized in accordance with regulatory authority when service is not available in a timely manner within VHA due to capability, capacity, or accessibility.

(a) Availability of non-VA care and access to VA care must be taken into account before non-VA care is authorized. Analysis of costs of care needs to be undertaken at appropriate intervals to determine if services could be more efficiently provided within VA facilities.

(b) Use of Purchased Care is to be considered only when:

1. The patient can be treated sooner with purchased care than at VA and the service is clinically appropriate and of high quality.

2. The request for consultative care can be resolved efficiently including having results available to the referring provider in a timely manner.

(9) That when VHA obtains care outside VA, the results are made available to the referring provider within CPRS in a timely manner.

(10) Appropriate checks and balances are in place before the consult request for non-VA care is closed out, to ensure the clinical documentation from the non-VA provider is obtained and scanned into CPRS and attached in the consult package in the patient's medical record. This information is not required before payment is made.

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to the Director, Systems Redesign Program at (605) 720-7174.

7. RESCISSIONS: None. This VHA Directive expires on September 30, 2013.

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Under Secretary for Health

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ATTACHMENT A

RECOMMENDED CONTENT FOR SERVICE AGREEMENTS

1. The service agreement is a written agreement made between any two or more parties, where one party sends work to the other, outlining the work flow rules. The agreements may exist within or between facilities. They are developed by consensus; signed by service chiefs from involved services; reviewed or updated as changes are needed, at a minimum annually; and audited.

2. The service agreement is available for reference by posting on the facility or Veterans Integrated Service Network (VISN) website, as appropriate.

3. The service agreement must contain, at a minimum, the following elements:

a. The services covered by the agreement are listed and defined in order to clarify which topics are selected to be covered by the service agreement.

b. The timeframe expected for response from the consultant is established.

c. Judicious and appropriate history, physical, and diagnostic information from the sending provider are provided in order to put the consultant in a position to be able to make a patient care decision on the initial visit.

d. Criteria for discharge from specialty care. It is the expectation that patients are discharged from the specialty clinic once consultation and any needed procedure and follow-up is completed. If ongoing care is co-managed by both the sender and consultant, responsibilities must be clarified.

e. The method for communicating recommendations and treatment plan back to the referring clinician is delineated in order to simplify, standardize, and clarify communication.

f. The agreement has a review and renewal date. ***NOTE:*** *An annual timeframe is recommended.*

4. Additional valuable elements may include:

a. Concurrence signatures of the written agreement by the involved service chiefs, as well as the Chief of Staff (or the Chiefs of Staff and VISN Chief Medical Office in the event the request is for an Inter-facility Consult (IFC)).

b. Definition of a method for accessing consultants outside of the formal consultation process, so questions may be asked or advice given, potentially avoiding the need for formal consultation.

c. Definition of a method for immediate access to the consulting service for clinical issues that need urgent or emergent attention.

d. A description of how primary care and specialty care evaluate and monitor the service agreement, including identification of data sources.

(1) Adherence to agreements is monitored by measuring the sender responsibilities of sending the right work (right requests) (see Att. A, subpar. 3a) packaged the right way (correct pre-work is included) (see Att. A, subpar. 3c).

(2) The receiver responsibilities are measured by auditing adherence to agreed upon timeliness response standards (see Att. A, subpar. 3b).

e. CPRS Consultation referral templates.

CONSULT MANAGEMENT BUSINESS RULES

Purpose: Each individual request within the consult package must be classified within only one of the consult request types below (with the exception of Clinical Procedures which may also be designated as Future Care and Non VA Care which should contain the na administrative flag). This classification will be determined by the purpose of the request. To best manage the consult process, facilities should establish a local committee to monitor compliance with rules outlined below.

Note: For prosthetic requests, follow the issues and guidance issued by prosthetics.

Consult Request Type	Clinical Consultations			Administrative Uses of the Consult Package		Non-VA Care Coordination (NVCC)	Clinical Procedures with Vendor Interface
				Clinical Request	Order		
	Outpatient Consultation	Inpatient Consultation	Inter-facility	Outpatient Clinical Request / Transfer of Care	Scheduling Order / Administrative		
Requirement	Mandatory Use of the Consult Package - Requestor receives clinical information in response to sending the consult for **two way communication**			Optional Use of the Consult Package - Can be used for inpatients or outpatients for **one way communication**		Mandatory use of the Consult Package	Mandatory use of the Consult Package
Definitions	A request for clinical evaluation performed by a provider within their scope, either face to face or virtual (e.g. E-Consult) within a site where the requesting provider expects to receive the results as a reply. This is traditional consultation.	A request for consultative services to be completed during an inpatient admission. All requests should be addressed prior to discharge and completed. This is not for follow up outpatient visits or for initial visits as an outpatient. At the time of discharge, incomplete inpatient clinical consultation requests must be discontinued and the need assessed and addressed by creating an outpatient request or communicating with the PCP in the medical record.	A request for service between sites. They must either be Outpatient Clinical Consultation or Administrative Communications. The results of the request must be returned to the requesting site through the inter-facility consult request and is completed when the result is available.	A request is for transfer of care between providers where the only necessary response is acceptance or acknowledgement of the referral. Functionally, this is using the consult package as an order or notification. For example: a referral to Primary Care or Mental Health by the Emergency Department (ED/UC). Clinical consultation and administrative requests are not included in this category.	A request for scheduling within the service from the provider that does not meet the criteria for Clinical Consultation. This includes requests to schedule a clinical procedure (i.e. screening colonoscopy) when physician review is not required prior to scheduling. An example is a Cardiologist consulting for a Cardiac Catheterization they will perform. Another example is a request for laboratory or radiology services that are reported via another mechanism with separate view alerts. This also includes administrative orders such as travel or escort.	Refer to NVCC Standard Operating Procedure on Non-VA Care Referral Review http://nonvacare.hac.med.va.gov/nvcc/sop-and-guides.asp	A request for a clinical service when interface with a vendor is necessary. Sites may consider these clinical or administrative depending on the consult service request.
Facility Oversight for Consult Management	Facilities will designate a committee responsible for overseeing consult management. Guidance is provided in the 'Consult Management Committee Charter'			Facilities will designate a committee responsible for overseeing consult management. Guidance is provided in the 'Fact Sheet for Administrative Documentation'			Facilities will designate a committee responsible for overseeing consult management. Guidance is provided in the 'Consult Management Committee Charter'

Consult Request Type			Clinical Consultations			Administrative Uses of the Consult Package		Non-VA Care Coordination (NVCC)	Clinical Procedures with Vendor Interface
			Outpatient Consultation	Inpatient Consultation	Inter-facility	Clinical Request Outpatient Clinical Request / Transfer of Care	Order Scheduling Order / Administrative		
	Consult Service Titles that cannot be used in combination		One naming convention or flag must be used for each consult service. Outpatient Consult Services should not include these names in the title: 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care'. The name should not begin with 'NON VA CARE' Do not place characters directly adjacent to the words 'Outpatient' or 'Outpt' without a space, such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services	One naming convention or flag must be used for each consult service. Inpatient Consult Services should not include these names in the title: 'Outpatient', 'Outpt','Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care'. The name should not begin with 'NON VA CARE' Do not place characters directly adjacent to the words 'Inpatient' or 'Inpt' such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services	One naming convention or flag must be used for each consult service. Inter-Facility Consult Services should not include these names in the title: 'Outpatient', 'Outpt','Inpatient', 'Inpt', 'CP', 'FC' or 'Future Care'. The name should not begin with 'NON VA CARE' Do not place characters directly adjacent to the words 'Inter-Faciility', 'Inter Facility', or 'IFC' without a space, such as placing a dash before or after or placing them in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services	One naming convention or flag must be used for each consult service. Administrative Consult Services should have an Administrative Flag set. They should not include these names in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', 'IFC', 'CP', 'FC' or 'Future Care'.			One naming convention or flag must be used for each consult service. Clinical Procedure Services should not include these names in the title: 'Outpatient', 'Outpt', 'Inpatient', 'Inpt', 'Inter-Facility', 'Inter Facility', or 'IFC'. The name should not begin with 'NON VA CARE' Do not place characters directly adjacent to the name 'CP' such as placing a dash immediately after or placing it in parenthesis. The administrative flag and prosthetics flag should not be set as 'Y' for these services
	Document Class for Note Titles		Note titles used to respond to consults must be built in the 'CONSULTS' document class within the TIU package (except for procedures)			No note is specifically required prior to completing consult.			No note is specifically required prior to completing consult.
	Urgency Field		For those urgency fields that are not clearly defined, local facility policy must define parameters for both inpatient and outpatient. Maximum thresholds are included below and should not be exceeded in facility policies.			For those urgency fields that are not clearly defined, local facility policy must define parameters for both inpatient and outpatient. Maximum thresholds are included below and should not be exceeded in facility policies.			For those urgency fields that are not clearly defined, local facility policy must define parameters . Maximum thresholds are included below and should not be exceeded in facility policies.
		S = Stat	Within 6 hours			Within 6 hours			Within 6 hours
		R = Routine	TBD			TBD			TBD
		ZE = Emergency	Within 4 hours			Within 4 hours			Within 4 hours
	Notifications		Consult/Request Resolution' notification must be turned on and mandatory			Facility/Service decision			Facility/Service decision

Consult Request Type		**Clinical Consultations**			**Administrative Uses of the Consult Package**		**Non-VA Care Coordination (NVCC)**	**Clinical Procedures with Vendor Interface**
		Outpatient Consultation	Inpatient Consultation	Inter-facility	**Clinical Request** Outpatient Clinical Request / Transfer of Care	**Order** Scheduling Order / Administrative		
		Consult Management Committee Charter			Fact Sheet Administrative Documen			
Build Requirements	Consult Service Titles	Consult service title must include 'Outpatient'. 'Outpatient' can be abbreviated as 'Outpt'.	Consult service title must include 'Inpatient'. 'Inpatient' can be abbreviated as 'Inpt'.	Consult service title must include 'Inter-facility' or 'Inter Facility'. This can be abbreviated as 'IFC'.	Specific note titles are not required since the administrative flag is selected for the specific services in the Vista File 123.		Will contain nationally standardized title naming convention and format	Consult service title must include the prefix 'CP'. CP consult titles may also have the words Future Care or FC in the title.

Percentage of PC Appointments Within 14 days

JUNE 2011 thru FY 2014

* data not yet available

Primary Care(stop code 323, 322, 350)	junFY11	julFY11	augFY11	sepFY11	octFY12	novFY12	decFY12	janFY12	febFY12	marFY12	aprFY12	mayFY12	junFY12
News from Desired Date	94.50%	92.60%	91.00%	85.30%	88.10%	87.40%	85.50%	89.00%	92.20%	93.20%	93.00%	91.10%	88.70%
Established from Desired Date	81.60%	82.10%	85.70%	82.80%	85.60%	85.80%	85.20%	84.30%	83.00%	82.20%	87.20%	89.90%	89.50%
News from Create Date	45.60%	47.40%	43.30%	34.30%	42.10%	33.90%	32.70%	42.30%	45.90%	44.40%	37.70%	38.80%	41.30%

FY2013

Primary Care(stop code 323, 322, 350)	octFY13	novFY13	decFY13	janFY13	febFY13	marFY13	aprFY13	mayFY13	junFY13	julFY13	augFY13	sepFY13
News from Create Date (completed appts)	34.95%	44.64%	51.23%	56.42%	57.48%	43.84%	48.34%	37.71%	27.21%	35.07%	38.24%	34.52%

FY2014

Primary Care(stop code 323, 322, 350)	octFY14	novFY14	decFY14	janFY14	febFY14	marFY14	aprFY14	mayFY14	junFY14	julFY14	augFY14	sepFY14
News from Create Date (completed appts)	32.65%	45.95%	47.62%	53.61%	56.80%	59.36%	61.54%	64.71%	54.60%	*	*	*

Percentage of PC Appointmen

JUNE 2011 thru FY 2014

Primary Care(stop code 323, 322, 350)	julFY12	augFY12
News from Desired Date	93.50%	88.30%
Established from Desired Date	88.80%	89.60%
News from Create Date	48.90%	41.80%

FY2013

Primary Care(stop code 323, 322, 350)		
News from Create Date (completed appts)		

FY2014

Primary Care(stop code 323, 322, 350)		
News from Create Date (completed appts)		

In-Service Health Screening
New Enrollee Appointment Request (NEAR LIST)
August 7, 2014 3pm

NAME PRINT	NAME SIGNATURE	TITLE	EXTENSION
Wendy Robertson		Supervisor HSC	7239
Joann DeMarco		Eligibility Officer	7082
Sharon Friedrich		Eligibility Officer	
Scott Diaz		Eligibility Officer	2385
Debbie Marro		Medical Support Assistant	7084
Melinda Gagne		Outreach RN	7591
Linda Tripoli		Outreach NP	
Terri Miller		HSC Nurse Practitioner	7537
Michael Poindexter		Mobile Unit Driver	
Kristin Sievers		Chief HAS	2643
Kuhnel, Susan		Eligibility	2515
Beiner, Wendy			—

August 7, 2014

PC New Referral Listing 1/1/2014 - 6/30/2014 **All

Total Patients	**242**
Assigned Primary Care Provider	167
Other VA	6
Closed - Declined or Failed to Reach	40
Pending Follow-up	29

Missed Follow-up	**6**

DEPARTMENT OF VETERANS AFFAIRS **CENTER MEMORANDUM 11-121**
Northport. NY 11768 **June 17, 2009**

SUBJECT: EVALUATION OF VETERANS REPORTING EXPOSURE TO AGENT ORANGE – HERBICIDE CLINIC

1.PURPOSE AND SCOPE: To describe the process by which veterans claiming exposure to Agent Orange will receive the prescribed evaluation and treatment under the Public Law 97-72.

2.POLICY: All Vietnam Era veterans applying for treatment in the Emergency Room will be asked if they believe that they were exposed to the herbicide, Agent Orange during their time in the service. If the answer is yes, the patient will be referred to the herbicide evaluation process as described below. All referrals of these patients for treatment will be assigned the priority ahead of non-service connected veterans and equal to former prisoners of war who are receiving care for non-service connected conditions. Health care services will be provided without regard to the veteran's age, service connected status or the ability of the veteran to defray the expenses of such care. This policy is not meant to exclude eligible veterans from receiving treatment in other categories of outpatient care.

3. GENERAL:

A. An attending [provider] in the Primary Care Clinic will be designated as Environmental [Provider] by Primary Care Service,

B. [Ambulatory Care] will comply with VA Central Office reporting requirements. An Agent Orange Coordinator will be appointed to monitor related activities.

4. PROCEDURES:

A. Veterans seeking examinations for evaluation of exposure to Agent Orange will be instructed to present themselves for care in the Emergency Room. During this initial visit, the applicant will be requested to complete Part 1 of Form 10-90009, (Agent Orange Registry Code Sheet), with the Agent Orange Coordinator. Nursing staff will then interview the patient regarding symptoms and complaints. Patients will then be given laboratory slips for blood work, urinalysis, x-ray and EKG and instructed to have this work-up completed as soon as possible. There will be no [provider] contact at this visit unless the patient is presenting himself for treatment for a specific condition rather than just for this evaluation.

B. One [provider] in the Primary Care Clinic is designated as Environmental Health [Provider]. Special, [ ] appointment slots will be reserved for herbicide evaluations on the schedule of this individual and will be referred to as the Herbicide Clinic. The

[provider] is responsible for maintaining current knowledge base on Agent Orange/Herbicide exposures as it becomes available through the Institute of Medicine and other sources.

C. The patient will be given an appointment to Herbicide Clinic where he/she will see the Environmental Health [Provider]. During this visit, the results of the basic laboratory tests will be reviewed and discussed with the patient. The [provider] will provide the patient with a written statement, if asked by the patient, of the test results in compliance with VACO recommendation. The patient is advised regarding data available on Agent Orange exposure and the conditions, which are felt to be associated to exposure amongst Vietnam Veterans.

D. The veteran will be given instructions to obtain information regarding application for Compensation and Pension (C&P) process if patient wishes to have claim filed. The veteran is also given informational bulletins and referred to the Vet Center in Babylon as an information counseling source.

E. If continuing medical care is indicated, the examining [provider] will have the patient return to his/her provider. If the patient is new, then the patient will return to the Environmental [Provider] and continue to be followed. Follow-up appointments for Herbicide Clinic will be given only if the patient has a specific new condition, which he/she feels is related to the exposure. In this event, only the second part of the code sheet will be filled out meeting the new complaint.

F. Special inquiries from veterans or their families relating to Agent Orange will be referred to the office of the Agent Orange Coordinator for Ambulatory Care.

G. There is no specific screening test for herbicide exposure. Patients are advised of maintaining regular Primary Care appointments for age appropriate screening and not specific to individual exposure as exact risk is not known. There is a significant lack of information regarding qualification of exposure to individual Vietnam veterans to herbicides (IOM 1994 report).

H. Follow-up letters as outlined in Rescissions M-10, Part I, Chapter 1, Appendix 2A, will be sent to patients.

5. REFERENCES:

A. Agent Orange Brief, January 1997, Environmental Agents Service, VA Central Office, Washington, D.C.

B. DM&S Circular, May 16, 1994: Environmental Medicine, Agent Orange Progress, M-10 Part I & II, VHA Washington, D.C.

6. **RESCISSIONS**: Center Memorandum 11-121, dated [November 22, 2004].

Philip C. Moschitta

PHILIP C. MOSCHITTA
Director

Dist. A
Responsible Service: Chief of Staff Office

DEPARTMENT OF VETERANS AFFAIRS **CENTER MEMORANDUM 05-23**
NORTHPORT, New York 11768 **January 4, 2011**

SUBJ: OCCUPATIONAL HEALTH SERVICES (EMPLOYEES)

1. PURPOSE AND SCOPE: To provide policy and procedures for the efficient operation of the occupational health services program as provided for in VA Handbook 5019 with facility adjustments as referenced. All guidance within the Handbook will be adhered to locally. All use of language or definition shall be consistent with the Handbook. Where latitude or discretionary application is permissible it shall be addressed within this policy if possible. All VA employees, including Canteen Service workers and volunteers are covered.

2. POLICY:

A. Occupational Health Services (OHS) is provided at the facility by the Occupational Health Unit (OHU) located in Bldg. 200[ ]. The OHU provides emergency diagnosis and first aid treatment of an injury or illness that becomes necessary during working hours and that are within the competency of the professional staff and facilities of the OHU. Whether or not such illness was caused by employment, employees will not be billed if evaluated during their work hours. [ ] The OHU conducts physical exams [annual physicals, courtesy physicals, and mandatory physicals] for applicants and fitness for duty exams for specific disciplines as outlined in VA Handbook 5019.

1.) [In accordance with the Memorandum of Understanding between the VA and the AFGE, AFL-CIO, National Veterans Affairs Council #53 dated 10/8/08, bargaining unit police officers have the option of having their annual medical examination performed by the Department's physician or employee's physician at the Department's expense ordered or offered in accordance with applicable laws and regulation.]

B. In an emergency, appropriate care to stabilize an employee will be rendered. [Once employee is stabilized, discharge for follow up care with private physician or coordination of a transfer to an appropriate private hospital should be initiated.] In the event transportation for hospitalization, other than the VA is required, the employee will be responsible for associated costs. If however, VA hospitalization is provided to employees who are not entitled veterans of the armed forces or beneficiaries of the Office of Worker's Compensation Program (OWCP), they will be charged at current Government rates. Such hospital care is authorized as a humanitarian service in emergency cases and a charge will apply. The VA cannot bill the insurance carrier for care provided to a non-veteran, therefore the employee will be responsible for payment to the VA. The billing for these charges shall be explained to the employee or his/her family, as circumstances indicate at the time of [treatment], hospitalization or transfer is being considered or effected.

C. The unit is staffed by a [ ] [nurse practitioner] registered nurse and clerical support.[ ] The Emergency Room [provides back up to (OHU)].

D. The primary goal of the unit is to assure that applicants and employees are both physically and mentally capable of satisfactorily performing their assigned duties for employment and retention. [Evaluations pertaining to mental health are completed by Psychiatry Service.]

E. The unit shall provide examinations and evaluations as referenced in the Handbook with all appropriate considerations identified to specific Title 5 positions, those appointed under 38 U.S.C., Chapter 73 or 74 and personnel identified within the scope of VA Handbook 5019, Part II "Examinations and Evaluation.

F. Medical Surveillance is a significant component of the OHU's operations and may be delegated to appropriate Services with reports to OHU. To that end:

1.) Tuberculin testing is required of all [new] personnel, with the exception of those who have been known to have had infectious tuberculosis prior to entry on duty, or those with a history of manifesting positive tuberculin reactions, and the facility will adhere to current CDC guidelines for compliance on Mantoux skin testing.

2.) Detection and control of potentially hazardous employment condition (i.e., radiation), personal protective equipment compliance and control of surveillance for communicable diseases, monitoring of "Food handlers" risk of exposure to infectious diseases are monitored as needed to provide for a health conscious work environment.

3.) Food handlers who give history of recent gastrointestinal illness, infections disease and infections of exposed surfaces of skin, etc., will be referred to the OHU for appropriate examinations and tests before being permitted to perform further food handling duties.

3. RESPONSIBILITY:

A. The Facility Director has the overall responsibility to assure that an OHS program is in place and operational at the facility and that it complies with the language of VA Handbook 5019 [and consistent with the VHA Center for Engineering and Occupational Safety and Health (CEOSH) Guidebooks.]

B. The Chief, Human Resources is the custodian of the Employee Medical Folder (EMF). To facilitate the practicality of the EMF, records of medical examinations and other miscellaneous medical records will be retained in the OHU. Business rules are in place and apply to the EMF in electronic format to ensure strict employee privacy. This is accomplished by restricted CPRS notes title "Employee Health" which may only be accessed by OHS personnel. The Chief Human Resources Management Service shall be available to the Occupational Health [Provider] for administrative guidance.

C. The Occupation Health [ ] [Provider] is charged with the operation of the program and its multiple components [including OHRS].

4. PROCEDURE:

A. The OHU is located in Building 200. [ ] Employees may report as follows:

1.) Regular scheduled hours are 8[30] a.m. to 4[ ] p.m., Monday through Friday, telephone numbers ext. 2085 or 2086.

2.) All other times, call 2380 (Emergency Room) to be seen.

B. Employees wishing to utilize the OHU will notify their supervisor of their intention to seek medical treatment or review the VA Handbook 5019, available on the web at: http://www1.va.gov/ohrm/Directives-Handbooks/Documents/5019.doc for information about the limitations of the service.

C. Persons seeking employment at the facility will be advised of the examination requirements prior to employment.

D. Employees, identified by OHU personnel, seeking assistance and who may benefit from counseling or other alternative resources not immediately available at the unit level, may be referred to the Employee Assistance Program (EAP). While the EAP falls within the parameters of the VA Handbook 5019, this facility operates the program in a separate fashion. Refer to CM 05-25.

E. OHS provides for voluntary screening / titer tests for many common infectious deceases. Employees are encouraged to have these done as a way to identify personnel who would not be at risk either for themselves or the patients in the event of a breakout of specific diseases.

F. A vaccination program is in place at this facility and participation is encouraged. Certain immunizations are also available based on work assignment. (see Attachment A).

G. For "ON-THE-JOB INJURIES/ILLNESS" refer to CM 05-21"Management of Work Related Injuries" dated [ ] [July 28, 2008].

5. REFERENCES:

A. VA Handbook 5019 "Occupational Health Services"

B. AFGE/VA Master Agreement, Article 28

C. NFFE Master Agreement Part B, Article 12

D. CDC "Guideline for Infection Control in Health Care Personnel"

[E. Memorandum of Understanding between the VA, and the AFGE, AFL-CIO, National Affairs Council #53 dated 10/8/08 concerning VA Directive 0730 and VA Handbook 0730.]

6. RESCISSION: CM # 05-23 Health Services -Employees dated [ ] [July 18, 2007].

7. **ATTACHMENTS:**

A. Appendix A- Statement of Understanding/Vaccine Preventable Diseases

B. Appendix B – CDC website reference

Philip C. Moschitta

[ ] [PHILIP C. MOSCHITTA]
Director

Dist. C

APPENDIX A

STATEMENT OF UNDERSTANDING

VACCINE PREVENTABLE DISEASES

1. The best way to reduce vaccine preventable diseases is to have a highly immune population.

2. Immunization is an important part of good health care. Occupational Health Services Unit provides for:
   A. MMR vaccine to employees susceptible to measles, mumps, or rubella.
   B. Hepatitis B vaccine is available and offered to all employees who have/may have occupational exposure to bloodborne pathogens.
   C. All adults should complete a primary series of tetanus and diphtheria toxoids and receive a booster dose every 10 years. These inoculations are available to all employees.
   D. As part of the pre-employment process, [ ] [applicants are treated for a variety of diseases and can obtain a copy to bring to their private physician.]

   E. Employees, who have concerns regarding their susceptibility to a contagious disease, may contact Occupational Health Services Unit to schedule a screening.

3. I understand that immunization is voluntary; however screening is mandatory in specific instances of highly communicable diseases. If I cannot provide proof of current immunity either through blood screening or other acceptable medical certification and the exposure has occurred IN A NON-WORK RELATED EVENT then I may be required to utilize leave (sick leave, annual leave or leave without pay, as approved)., consistent with CDC recommendations for work restriction. Exposure under working conditions is covered within the compensation program. (refer to CM 05-21)

I have read and understand the statement.

_____ _____

Employee Signature Date signed

APPENDIX B

WEB SITE REFERENCE

(Refer to Table 3, CDC (Centers for Disease Control) Summary of suggested work restrictions for health care personnel exposed to or infected with infectious diseases of importance in health care settings, available in CM Folder in Reproduction Office, [ ] Employee Health Office or on the following website: "www.cdc.gov".)

Shortcut to: http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/InfectControl98.pdf

Northport VA Medical Center
Department of Veterans Affairs VHA DIRECTIVE 2010-027
Veterans Health Administration
Washington, DC 20420 **June 9, 2010**

NORTHPORT VAMC OUTPATIENT SCHEDULING PROCESSES AND PROCEDURES

1. PURPOSE: This Northport VAMC/Veterans Health Administration (VHA) Directive provides policy for implementing processes and procedures for the scheduling of outpatient clinic appointments and for ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process.

2. BACKGROUND

a. It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays. Wait times for patients to be seen through scheduled appointments in primary care and specialty care clinics are monitored. In addition, patients (both new and established) are surveyed to determine if they received an appointment when they wanted one.

b. VHA is mandated to provide priority care for non-emergent outpatient medical services for any condition of a service-connected (SC) Veteran rated 50 percent or greater or for a Veteran's SC disability. Priority scheduling of any SC Veteran must not impact the medical care of any other previously scheduled Veteran. Veterans with SC disabilities are not to be prioritized over other Veterans with more acute health care needs. Emergent or urgent care is provided on an expedient basis. Emergent and urgent care needs take precedence over a priority of service connection.

c. The assurance of timely access to care requires consistent and efficient use of Veterans Health Information Systems and Technology Architecture (VistA) in the scheduling of outpatient clinic appointments.

d. Tracking and assessing the utilization and resource needs for specialty care also require use of the Computerized Patient Record System (CPRS) electronic consult request package.

e. **Definitions**

(1) **Desired Date.** The desired appointment date is the date on which the patient or provider wants the patient to be seen. Schedulers are responsible for recording the desired date correctly.

(2) **Emergent and Urgent Care**

(a) Urgent Care is care for an acute medical or psychiatric illness or for minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a

condition where delay might impair recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a Department of Veterans Affairs (VA) medical facility if the discharging physician directs the patient to return on a specified day for the appointment.

(b) Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(3) **Provider.** A provider is an individual licensed to deliver health care and services to patients.

(4) **Service-Connected (SC).** Service connection or "service-connected" means that VA has determined that a condition or disability was incurred in, or has been aggravated by, military service.

(5) **Non-Service Connected (NSC).** NSC refers to a condition or disability VA has not determined was incurred in, or has been aggravated by, military service.

(6) **New Enrollee.** A new enrollee is a previously non-enrolled Veteran who applies for VA health care benefits and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits, is determined to be eligible, and is enrolled.

(7) **New Enrollee Appointment Request (NEAR) Call List.** The NEAR Call List is a tool to be used by enrollment staff to communicate to Primary Care Management Module (PCMM) Coordinators or schedulers, at the Veteran's designated preferred location, that a newly enrolled Veteran has requested an appointment during the enrollment process.

(8) **Appointment Type.** Using VistA, an outpatient appointment requires the selection of at least one appointment type, which combined with the "Purpose of Visit" code creates one of 40 unique appointment types. Appointment types can be critical when scheduling different types of appointments. Examples of appointment types include: regular, employee, collateral of Veteran, sharing agreement, etc. For a complete list of appointment types, see the Patient Appointment Information Transmission (PAIT) Release Notes and Installation Guide Patch SD*5.3*333 at http://www.va.gov/vdl/documents/Clinical/Patient_Appointment_Info_Transmission/sd_53_p333_rn.doc .

(9) **Newly registered Patient to the Facility.** A newly registered patient to the facility is a Veteran who is enrolled with VHA, but who has not been registered at a specific facility.

(10) **New Patient as Defined for VHA Wait Time Measurement Purposes.** For VHA Wait Time Measurement purposes, a "new patient" is any patient not seen by a qualifying provider type within a defined stop code or stop code group at that facility, within the past 24 months. ***NOTE:*** *See data definitions at http://vssc.med.va.gov/WaitTime/New_Patient_Monitor.asp# . This is an internal VA Web site not available to the public. In order to access this site, VA staff may need to go first to*

http://vssc.med.va.gov and accept the VHA Support Service Center Data Use Agreement.

(11) **Electronic Wait List (EWL).** The EWL is the official VHA wait list. The EWL is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic).

(12) **Service Agreement.** A service agreement is a written agreement defining the work flow rules between any two or more services that send work to one another. Ideally, this document is developed based on discussion and consensus between the two or more involved services. The document is signed by service chiefs from involved services. If the agreement is between services at separate facilities, as with inter-facility consult service agreements, it needs to be signed by the Chiefs of Staff of each involved facility.

(13) **Encounter.** An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

(a) Contact can include face-to-face interactions or those accomplished using telecommunications technology.

(b) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc.

(c) Use of e-mail is limited and does not constitute an encounter. E-mail communications are not secure and e-mails must not contain patient specific information. ***NOTE:*** *Secure messaging communication is available through the My HealtheVet (MHV) personal health record (PHR). These communications may meet the definition of an encounter, based on type of message and content.*

(d) A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely, history and clinical decision-making. Telephone encounters must be associated with a clinic that is assigned one of the Decision Support System (DSS) Identifier telephone codes and are designated as count clinics.

(14) **Occasion of Service.** Formerly known as ancillary service, an "occasion of service" is a specified identifiable instance of an act of technical and administrative service involved in the care of a patient or consumer, which is not an encounter and does not require independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).

(a) Occasions of service are the result of an encounter. Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(b) Some occasions of service, such as clinical laboratory and radiology studies and tests, are automatically loaded to the Patient Care Encounter (PCE) database from other VistA packages.

(15) **Count.** The term "count" refers to workload that meets the definition of an encounter or occasion of service.

(16) **Count versus Non-Count Clinics.** In the creation of Clinic Profiles, clinics are designated as either Count Clinics or Non-Count Clinics. Count Clinics are transmitted to PCE as encounters. Non-Count Clinics are not transmitted to PCE. There are generally two reasons why a clinic might be designated as non-count: if the clinic is administrative in nature and therefore not providing patient care; and if the workload associated with the clinic is transmitted to PCE automatically through another means (a VistA package other than Scheduling) then the clinic is setup as non-count to avoid sending duplicate workload to PCE (for example, occasions of service.)

(17) **DSS Identifiers.** DSS Identifiers are used to measure workload for all outpatient encounters. They are the single designation by which VHA defines clinical work units for costing purposes. In some, but not all cases, DSS Identifiers are defined to be used only for specific Non-Count Clinics assigned to a clinic profile. In these cases, DSS rules must be followed. As a specific example: when a clinic's Primary Stop Code is 674, that clinic is explicitly defined to be a Non-Count Clinic and that is the only way it should be used.

(a) Primary Stop Code. The first three numbers of the DSS Identifier represent the primary stop code. The primary stop code designates the main clinical group responsible for the care. Three numbers must always be in the first three characters of a DSS Identifier for it to be valid.

(b) Secondary Stop Code. The last three numbers of the DSS Identifier contain the secondary or credit stop code, which the VA medical center may use as a modifier to further define the primary work group. For example, a flu vaccination given in Primary Care is designated by 323710. The secondary stop code modifier may also represent the type of provider or team. For example, a Mental Health Clinic run by a social worker can be designated 502125.

(c) Credit Pair. A DSS Identifier Credit Pair is the common term used when two DSS Identifiers, a primary code and a secondary code, are utilized when establishing a clinic in the VistA software. Some specific credit pairs are listed in the DSS Identifier References.

3. POLICY. It is VHA policy that all outpatient clinic appointments, meeting the definition of an encounter, are made in Count Clinics using the VistA Scheduling software in a fashion that best suits patients' clinical needs and preferences; this includes, but is not limited to: appointments made for clinic visits; VA provided home care; consultations; and medical, surgical, dental, rehabilitation, dietetic, nursing, social work, and mental health services and procedures.
NOTE: *The Count Clinic requirement does not include: non-VA care paid through VistA Fee; procedures performed in the operating room and recorded in the VistA Surgery Software; instances where encounters are generated based on unscheduled telecommunication; and*

occasions of service, such as clinical laboratory, radiology studies, and tests that are automatically loaded to the PCE database. An exception from the requirement of using VistA

Scheduling software is also extended to providers and programs such as Care Coordination Home Telehealth when encounters are generated based on unscheduled communication.

4. ACTION

a. **Director of Systems Redesign.** The Director, VHA Systems Redesign, within the Office of the Deputy Under Secretary for Health for Operations and Management (10N), is responsible for oversight of implementation of requirements of this Directive, to include measurement and monitoring of ongoing performance.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director, or designee, is responsible for the oversight of enrollment, scheduling, processing, consult management, and wait lists for eligible Veterans.

c. **Facility Director.** The facility Director, or designee, is responsible for:

(1) Ensuring that when outpatients are seen for what constitutes an encounter on a "walk-in" basis without an already scheduled appointment, an appointment is recorded in a Count Clinic with the "Purpose of Visit" entered in the VistA Scheduling Software as "unscheduled." ***NOTE:*** *Since unscheduled visits include no entry of "desired date" for wait time measurement, desired date is equated to appointment creation date. In addition, applicable profiles need to be designed to ensure sufficient capacity to accommodate unscheduled "walk-in" patients. Unscheduled encounters that occur via telephone will not be used in the VistA Scheduling Software.*

(2) Ensuring outpatient appointments for diagnostic laboratory and imaging services are not made using count clinics. Non-Count clinics may be used to schedule laboratory and imaging appointments. Requests for laboratory and imaging services must be made by provider orders (not consult requests). Orders transmit directly to the laboratory or radiology software applications. Work performed in response to such orders triggers transmission of encounter data via the VHA PCE software application. ***NOTE:*** *The use of Count Clinics for diagnostic services is inappropriate in part because it would generate duplicate workload reports.*

(3) Defining "standard work" for the clinic teams to most efficiently operate the clinic. This work includes:

(a) Ensuring clinic flow occurs in a standardized manner including patient check-in with scheduling staff, nurse interview, provider visit, and check-out.

(b) Ensuring providers document orders in CPRS and explain rationale and timeframes for medications, diagnostic tests, laboratory studies, return appointments, consultations, and procedures before the patient leaves the examination room.

(c) Ensuring a check out process occurs following each clinic visit. The check-out process may consist of: nurse-administered patient education; clinical pharmacist education and review of prescription orders; collection of patient feedback; scheduling of diagnostic studies; consultations; and follow-up visits. The check-out process must also include verifying that the disposition of the appointment in the VistA Appointment Management system has been completed.

(d) Ensuring standardized systems are in place to balance supply and demand for outpatient services including continuous forecasting and contingency planning.

(e) Ensuring each clinic follows these additional business rules for standardizing work.

1. Schedules must be open and available for the patient to make appointments at least three
to four months into the future. Permissions may be given to schedulers to make appointments
beyond these limits when doing so is appropriate and consistent with patient or provider requests. Blocking the scheduling of future appointments by limiting the maximum days into the
future an appointment can be scheduled is inappropriate and is disallowed.

2. Synchronize internal provider leave notification practices with clinic slot availability to minimize patient appointment cancellations.

3. Strive to make follow-up appointments "on the spot" for patients returning within the 3 to 4 month window.

4. Use the Recall/Reminder Software application to manage appointments scheduled beyond the 3 to 4 month scheduling window.
NOTE: *Backlog must be eliminated and demand and supply balanced for the above suggestions*
to be successful.

(f) Using the preferred strategy for initiating scheduling which involves:

1. Having the referring providers' team schedule clinical consultation appointments as soon as possible on the day the consult is ordered, before the patient leaves the referring provider team area.

2. Having the treating provider's team either schedule an appointment or, if the timeframe specified by the provider is several months into the future, record in the Recall/Reminder Software application the need for the patient to return to clinic, before the patient leaves thetreating provider team area.

a. When a patient needs a follow-up appointment but cannot be immediately scheduled, this need is to be recorded in the Recall/Reminder Software application.

b. The patient must be advised to expect to receive a reminder to contact the clinic to actually schedule an appointment a few weeks prior to the return to clinic timeframe that the provider has specified.

c. The patient needs to be provided information for contacting the clinic at the appropriate time to make the appointment.

3. Having registration or enrollment staff obtain contact information and initiate scheduling action while in direct contact with a newly enrolled or newly registered patient.

(4) Ensuring correct entry of "desired date" for an appointment. The goal is to schedule an appointment on, or as close to the desired date as possible.

(a) For New Patients

1. The scheduler needs to ask the patient: "What is the first day you would like to be seen?" The date the patient provides is the desired date.

2. The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

3. The third step is to offer and schedule an appointment on or as close to the desired date as possible.

(b) For Established Patients' Return Appointments: A specific or a general timeframe is communicated by the provider and the actual desired date is established by the patient.

1. In order for the provider and scheduler to have a clear understanding of the intent for a return appointment, the provider must document the return date in CPRS, preferably through an order. The provider must specify if the return appointment request is for a specific day, or a general timeframe.

2. In order to establish the actual desired date correctly, the scheduler needs to tell the patient that the provider wants to see them again, giving the patient either the provider's specified date or general timeframe, and asking when the patient would like to be seen. The date the patient provides is the desired date.

3. The desired date needs to be defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

4. The scheduler is to offer and schedule an appointment on or as close to the desired date as possible. If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment timeframe.

(c) For Patients Scheduled in Response to Intra and Inter Facility Consults

1. The provider specified timeframe for the appointment needs to be the date of the provider request, unless otherwise specified by the provider.

2. In order to establish the actual desired date correctly, the scheduler informs the patient of the provider's specified date or general timeframe and asks the patient "What day would you like to be seen?" The date the patient provides is the desired date.

3. The desired date needs to be defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

4. The scheduler offers and schedules an appointment on or as close to the desired date as possible. If the provider has specified a desired date (or "soonest appropriate date") and there is a discrepancy between the patient and provider specified desired date, the scheduler must contact the provider for a decision on the appointment timeframe.

5. In creating an appointment in response to a CPRS consult request, the scheduler must use VistA menu options to link the CPRS consult request to the scheduled appointment.

(5) Ensuring that when an appointment is cancelled and rescheduled by the clinic, the scheduler enters as the desired date for the new appointment the desired date for the original appointment.

(6) Ensuring that if the patient must be contacted to create an appointment, policies are in place that outline actions to be taken to make contact, the number of attempts necessary, and documentation required.

(7) Monitoring telephone access and taking action, as needed, to minimize patient problems in accessing providers, teams, and schedulers by phone.

(8) Implementing standardized processes for enrollment, and the scheduling, processing, and management of appointments, consults, and wait lists for eligible Veterans.

(9) The creation and maintenance of a Master List of all staff members that have any of the VistA Scheduling options that may be used for scheduling patients: PCMM menu options for primary care team or for provider assignments, menu options for entries onto the EWL, and the direct supervisors of all such individuals.

(10) Ensuring successful completion of VHA Scheduler Training by all individuals on the Master List. Menu options for creating outpatient appointments are not to be provided to new schedulers without proof of their successful completion of this training. To retain these menu options, all individuals must complete newly released training for schedulers within 120 days of

it being announced. ***NOTE:*** *Details regarding the availability of this training will be posted on the Mandatory Training Web page located at: http://vaww.ees.lrn.va.gov/mandatorytraining . This is an internal Web site and is not available to the public.*

(11) Ensuring all individuals on the Master List have their position description or functional statement include specific responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(12) Ensuring all individuals on the Master List have, on file with their supervisor, an annual competency assessment that includes their responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(13) Ensuring completion, using VISN-approved processes and procedures, of a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions, and of the accuracy of desired dates.

(14) Ensuring that identified deficiencies in competency or performance, identified by the annual scheduler audit, are effectively addressed.

(15) Ensuring that all clinic profiles are current at all times and subject to an annual review. This review must include compliance in requirements for use of Count versus Non-Count clinics.

(16) Ensuring full compliance by all involved services with Service Agreements. Service agreements must be reviewed and, if necessary, re-negotiated regularly (at least annually).

(17) Measuring and tracking all unused outpatient appointments in count clinics including those from no shows, patient cancellations, and unscheduled appointment slots.

(18) Ensuring that when appointments become available and the facility has at least 3 days to give patients notice, scheduling personnel offer appointments to patients who are either on the EWL waiting for appointments, or currently have appointments more than 30 days past the desired dates of care. ***NOTE:*** *This applies to management of scheduling in Count Clinics.*

(19) Ensuring that the following Business Rules for Scheduling Outpatient Clinic Appointments are followed.

(a) Patients with emergent or urgent medical needs must be provided care, or be scheduled to receive care, as soon as practicable, independent of SC status and whether care is purchased or provided directly by VA.

(b) Generally, patients with whom the provider does not yet have an established relationship and cannot be scheduled in target timeframes must be put on electronic waiting lists (EWL). VHA's EWL software is used to manage these requests, which usually consist of newly registered, newly enrolled, or new consult requests for patients waiting for their first scheduled appointment. No other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments. When patients are removed from the EWL,

except for medical emergencies or urgent medical needs, Veterans who are SC 50 percent or greater, or Veterans less than 50 percent SC requiring care for a SC disability must be given priority over other Veterans.

(c) Facilities are required to provide initial triage evaluations within 24 hours for all Veterans either self-requesting or being referred for mental health or substance abuse treatment. Additionally, when follow-up is needed, it must include a full diagnostic and treatment evaluation within 14 days. ***NOTE:*** *VHA leadership may mandate specific timeframes for special categories of appointments.*

(d) PCMM Coordinators or Scheduling Coordinators must check the Primary Care EWL daily and act on requests received. Schedulers in all clinics at all locations (substations) must review the EWL daily to determine if newly enrolled or newly registered patients are requesting care in their clinic at their location.

(e) A wait list for hospice or palliative care will not be maintained as VHA must offer to provide or purchase needed hospice or palliative care services without delay.

(f) A patient currently or formerly in treatment for a mental health condition, who requests to be seen outside of the clinician desired date range, needs to be seen or contacted within 1 working day by the treatment team for evaluation of the patient's concern.

(g) The VHA Class I Recall/Reminder Software application is used for patients with whom the service has an established relationship. This software application is typically used when the requested follow-up appointment date is more than 3 to 4 months into the future. These patients include those that have either been seen initially in a given VA clinic and need to return in the future; or those who have been seen initially through purchased non-VA care with a plan to be seen in follow-up at the VA clinic. ***NOTE:*** *Even though a patient seen initially through purchased non-VA care may be new to a facility clinic, the organization has committed to this relationship, so Recall/Reminder scheduling may be appropriate.*

(h) Non-VA care may be utilized in accordance with regulatory authority when service is not available in a timely manner within VHA due to capability, capacity, or accessibility. Availability of non-VA care and access to VA care must be taken into account before non-VA care is authorized. An analysis of costs of care needs to be undertaken at appropriate intervals to determine if services could be more efficiently provided within VA facilities. Use of purchased care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality. Purchased care must only be considered when the request for care can be resolved efficiently, including having results available to the referring facility in a timely manner.

(i) Patients provided authorization for continued non-VA care need to be tracked and brought back within VHA as capacity becomes available. This needs to be from the oldest authorization moving forward, as clinically indicated.

(j) Clinic cancellations, particularly when done on short notice, are to be avoided whenever

possible. If a clinic must be canceled or a patient fails to appear for a scheduled appointment, the medical records need to be reviewed to ensure that urgent medical problems are addressed in a timely fashion. Provisions need to be made for necessary medication renewals and patients need to be rescheduled as soon as possible, if clinically appropriate.

(k) When a patient does not report ("no-show") for a scheduled appointment, the responsible provider, surrogate, or designated team representative needs to review the patient's medical record, including any consult or procedure request received or associated with the appointment and then determine and initiate appropriate follow-up action. ***NOTE:*** *It may be useful for the facility to assign a case manager to the patient with multiple "no-shows" to determine the best method to manage the patient's pattern of repetitive "no-shows."*

(l) Facility leadership must be vigilant in the identification and avoidance of inappropriate scheduling activities. ***NOTE:*** *For further guidance, please see the Systems Redesign Consultation Team Guidebook available on the Systems Redesign Web site at Systems Redesign Consultation Team Guide 2008 (https://srd.vssc.med.va.gov/Pages/default.aspx) . This is an internal VA Web site not available to the public.*

(2) Providing annual certification through the VISN Director to the Director, Systems Redesign, in the Office of the Deputy Under Secretary for Health for Operations and Management, of full compliance with the content of this Directive. Initial certifications are due 6 months following issuance of this Directive and then annually thereafter.

5. REFERENCES

a. Public Law 104-262.

b. Title 38 United States Code (U.S.C.) Sections 1710, and 1703, 1705.

c. Code of Federal Regulations, § 17.52, 17.100, 17.36, 17.37, 17.38, and 17.49.

6. FOLLOW-UP RESPONSIBILITY: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to the Director, Systems Redesign Program at 605-720-7174.

7. RESCISSIONS: VHA Directive 2009-070 is rescinded. This Northport VAMC/VHA Directive expires June 30, 2015.

January 2013
Revised May 2013

SOP: New Patients into Primary Care

- Preferred Facility form is completed in Admissions; patients indicating if active at another VA facility
- Messages are sent thru from call center to New patient scheduling Team for processing
- VA Alerts---Primary Care New Referral Note---referrals are received as VA alert Primary Care Coordinator entered as additional signer
- Search for Progress Notes for Primary Care New referrals is done daily to ensure no patients are missed
- New Enrollee Call Lists prints to Primary Care Coordinators printer daily for any new patients that registered online and requested to see a VA Provider
- Primary Care Coordinator on hospital discharge mail group –processes any discharges without an assigned primary care team

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New Patient Scheduling Team:

- All new patients are contacted to schedule new primary care appointment.
- All new patients are triaged for type of care requested from the VA.
- Eligibility is verified for completeness and eligibility of care prior to contacting veteran.
- VA Dual assignments are verified; veteran is asked if they are transferring care to Northport facility. Veterans are required to have one primary care provider assigned nationwide unless they meet specific criteria as in PCMM Handbook and guidelines.
- Female Veterans are verified for eligibility and VA dual assignments then routed to Women's team Coordinator for scheduling (including if cboc is requested)
- Veterans are checked for OIF OEF status—all active combat OIF OEF Veterans are referred to the OIF OEF Office for scheduling.
- Vietnam Veterans; if are set up for Medical Herbicide appointment then appointment is scheduled one month after unless primary care is needed sooner
- Utilize Health Screening for non vested patients requesting referrals for Audiology or Optometry Service and not primary care services.
- For Home Health Aide referrals or PRI referrals appointments are set up and Chief Outpatient Nursing and PACT Social Worker are notified of date and time of appointment so evaluation may be completed at time of appointment.
- Veterans are screened through Social work service for HPACT placement (homeless pact) for chronically homeless patients.
- Each new patient scheduled is asked to come in earlier than their scheduled appointment time and advised to bring current list of medications and recent lab results with them.
- New Patient Orientation form is sent to all new patients advising the patient of what pertinent medical information to bring with them to their 1st appointment.

***********Cancellation of new patient appointments and no-shows for new patients should be directed back to New Patient Scheduling team and not rebooked by staff.**

a. Assign a new provider based on the following criteria:

- **Panel size**
- **Special request and /or needs , etc. (e.g., male/female, MD vs. NP)**
- **Each new patient will be asked to come in 30 minutes prior to their scheduled appointment for processing and triaging.**

b. New Patients to be scheduled with PG 1 Resident Physicians only not PG 2 or PG 3 residents---One new patient per session for PG 1 Residents

(View profile for Attending vs. PG1 Resident for clinic session –not to schedule new patient with Attending and Resident during same clinic session)

c. New Patient ratio for full clinic day ----2 new patients in the am; 1 new patient in the pm session
d. For Attending Providers --New patients scheduled for a hour slot in morning at 9:30am –double booked 9:30 and 10am slot to obtain an hour with a 2nd new patient being booked at 10:30am. In reality this would give 45 minutes per new patient in morning session.
e. For Nurse Practitioner's and Physician's Assistants----New patient booked at 9:20am double booked for 80 minutes (9:20am slot and 10am slot) with second new patient booked at 10:40am for 40 minute slot which in reality would give the NP or PA 60 minutes for each new.
f. Afternoon new patient 1pm slot will be utilized whenever possible; new patient not to be scheduled after 3pm (evening clinic will be offered)
g. For providers who tour of duty starts earlier (7:30am) new patient will not be scheduled after 2pm.
h. Rotation of new patients: 1 new patient to all under paneled providers first before 2nd new patient is scheduled as access permits.

DRAFT: October 24, 2005 Revised: October 31, 2005, October 8, 2013

SOP: REQUEST PROVIDER CHANGE
Patient requests a PC Provider change

- Form to Request Changing Primary Care Provider is filled out
- Form is routed to PCMM Coordinator (x7367)
- PCMM coordinator designates new provider based on set criteria
- Patient is notified as appropriate via letter/phone
- Form is routed to HSS PC
- Data is track and trended
- Old and new provider are given copy of form
- Final outcome forwarded to patient advocate

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All Staff:

a. Ask patient to fill out Request Provider Change Form

OR

b. Staff member fills out for patient Request Provider Change Form

Note: All staff members who encounters patient can have the patient fill out this form or can fill it out for the patient

e.g., clinic manager, patient advocate, clinic clerk, etc.

PCMM Coordinator:

All Request Provider Change Forms are routed to PCMM coordinator who will,

Addendum: Patients who are requesting a provider change due to Narcotic pain medication will not be processed until a chart review is completed by Primary Care management and approval for change is granted.

a. Assign a new provider based on the following criteria:
- Panel size
- Special request and /or needs , etc. (e.g., male/female, MD vs NP)

b. Contact the patient as appropriate, via letter/phone that his/her request has been received processed and a new provider has been designated, patient will be given the name of his new provider, e.g., Dr. Johnson. Patient will then be instructed that when he/she calls for their next Primary Care appointment they should indicate to the clerk making the appointment that they have been designated a new provider and give that providers name.

Note: *Patient will remain in the care of his/her old provider, e.g., Dr. Kim, until he is physically seen by the new provider Dr. Johnson. After patient has been seen PCMM Coordinator will assign the patient to the new provider who will then take responsibility for this patient Primary Care.*

c. PCMM Coordinator will then give the Request Provider Change Forms to HSS

HSS:

a. Will give copy of the request to the old and new provider so that they may communicate between each other concerning patient needs.

b. Will track and trend both patient and provider problems.

Mandar Tank, MD ACOS Ambulatory Health Care Alliance

VA New York/New Jersey
VETERANS HEALTHCARE SYSTEM
130 West Kingsbridge Road ~ Bldg. 16
Bronx, New York 10468

Network Policy No. 10N3-11-009
Issue Date: May 1, 2009
Update: July 27, 2012 (extended 8/1/14)

VISN 3 Consultation/Specialty Care Referral Policy Interfacility Consult Management

1. PURPOSE:

The purpose of the VISN 3 Clinical Consultation/Specialty Care Referral Policy is to standardize, streamline and optimize timely intra-facility and inter-facility consultation/referral processes. This policy provides guidance on processing of clinical consultations. If the patient's clinical condition warrants consults more quickly than the time frames outlined in this policy, direct clinician-to-clinician communication must take place to assure consult timeliness.

2. BACKGROUND:

Historically, multiple modalities including telephone calls, paper consult requests and electronic consult requests have been used by VHA health care providers to refer patients to other VHA specialty and sub-specialty health care providers for expert services, both within and between VISN 3 facilities. More recently, electronic requests are being utilized consistently to initiate requests for consultation; however electronic completion is not consistently being done by the receiving service at the time of consultation. In addition, VISN 3 has not had consistent timeliness standards, particularly for urgent and emergent consultations, and has not had a unified approach to cancellation of consults. This lack of standardization makes it difficult to track consult completion and assess utilization and resource needs for specialty care. Furthermore, the inconsistencies in consult completion create a potential patient safety hazard, particularly for patients for whom the consult is critical.

3. POLICY:

Effective October 1, 2003, it has been established VISN policy that all consults are initiated and completed using an electronic consult. Effective October 1, 2009, the

provisions within this policy with respect to direct provider communication for stat and emergent, timeliness standards for inpatient and outpatient, electronic completion of consults, and processing of consults in the event of a patient no-show are to be implemented. If the consult is classified as a stat (emergency) or urgent consult, the ordering provider will also call or page the consulting Service to advise/discuss the request. The consultant will document the consult visit on a *consult* title progress note and may not use a non-consult *progress* note to document that the first visit has taken place. (This process allows the consult to be electronically "completed.") A non-consult progress note (or the consult progress note) may be used for subsequent visits to the consulting provider. Facilities will assure policies and procedures are in place to ensure the appropriate and timely disposition of all incomplete/pending consults is monitored.

4. DEFINITIONS:

a. A "clinical consult" is a request from one service to a subspecialty service requesting advice, further evaluation, or management. The procedures and timeliness standards in this policy refer to clinical consultations. The scope of this policy does not pertain to non-invasive procedures or administrative processes that may be currently ordered thru the electronic consultation package.

b. A "stat" consult request, inpatient or outpatient, is one for which the referring provider assesses that the patient needs to be seen immediately by the consultant.

c. An "urgent" inpatient consult request is one whose timing is such that the results of the consult will or may impact the patient's course of therapy or length of stay. An "urgent" outpatient consult is one whose timing is such that the referring provider believes the patient needs to be seen preferably within 1 day, rather than hours.

d. A "routine" inpatient consult carries no clinical urgency and is often requested for needs unrelated to the reason for the patient's admission. Patients are not to be admitted solely for the purpose of getting a routine consult, nor should their hospital stay be extended in order to complete a routine consult.

e. Service Agreement. A service agreement is an agreement or understanding between any two or more services, one of which sends work to the other(s), defining the work flow rules. The agreements may exist within one facility or between two or more facilities. Typically this is an agreement that is developed based on discussion and consensus between the involved services and facilities. The core elements of a service agreement would include:
   - Pre-work requirements before sending consult.
   - Referral guidelines that describe clinical conditions suitable for referral
   - Contact information for further discussion.

*Refer to National Consult policy.

f. Inpatient. One receiving acute medical, surgical or psychiatric services.

g. Outpatient. One receiving alternate levels of care & long term care or ambulatory care.

5. RESPONSIBILITY:

a. **The facility Director** is responsible for ensuring that policies and procedures are developed and implemented at their medical centers in order to comply with the VISN 3 Consultation/Specialty Care Referral Policy and VHA National Access Standards.
b. **The Chief of Staff is** responsible for ensuring that Care Lines/Services/Programs under their supervision are implemented and follow processes and procedures delineated in this policy.
c. **The Associate Director** is responsible for ensuring that Care Lines/Services/Programs under their supervision are implemented and follow processes and procedures delineated in this policy. The Associate Director is also responsible to assure that there are processes in place to assure accurate demographics of facility population.
d. **Care Line Managers/Service Chiefs** are responsible for ensuring that their staff/employees follow the processes and procedures delineated in this policy.
e. **Chief of Information Resource Management** is responsible for ensuring that the electronic consult software package is correctly set up to optimally support implementation of this policy and monitoring of use in all clinical settings.
f. **Chair, Clinical Informatics Committee** is responsible for monitoring the implementation of this policy and for reporting to MSEC, on a quarterly basis, activities related to the Electronic Consult Process and any needed recommendations to improve it.
g. **Clinical Applications Coordinators** are responsible for:

1) Developing and submitting for approval to CIC, specific parameters for the Electronic Consults.
2) Data collection in support of monitoring the effective implementation of this policy will be submitted to facility leadership according to local policy.

*As all facilities have different infrastructure, each facility will appoint who is responsible for consult management education and include it in their local policy.

6. PROCEDURES:

A. Technical Procedures:

1) Requests for consultation will be addressed electronically and also communicated directly in the case of stat or urgent requests to the specific specialty/subspecialty service.
2) Duplicate requests for consultation (with the exception of the required notification phone calls for "stat", and "urgent" consultations) shall **not** be issued.
3) Consult services at each facility will set up internal processes to manage incoming consults, schedule the patient to be seen, and document in CPRS according to timeframes specified in this policy. If patients are not able to be contacted after at least 2 documented attempts notated in CPRS within 14 days, the consult may be cancelled and returned to the requesting service via CPRS/VISTA alerts. One of the attempts must include a letter generated to the patient requesting that they call within a specified time frame to schedule the consult or the consult will be cancelled.
4) Interfacility consults:
   a) All initial interfacility consults must first be sent to Eligibility at the receiving site to ensure that the patient is enrolled. This will provide access to patient information throughout his/her visit. Eligibility must enroll the patient within 24 hours of receipt of the electronic consult.
   b) Provisions for electronic inter-facility consults within VISN 3 will be properly set up in advance for any specialty/subspecialty consultation services that may be required.

B. Timing of Inpatient Consults:

1) Facilities will develop an electronic system to notify providers that a "stat" or "urgent" consult has been requested from their specialty/subspecialty Service. Back-up systems will be in place according to local policy to assure notification to the specialty provider of these types of consults if the electronic system is not functional or not answered.

2) Instructions on the electronic consult form require that the consult be identified as "stat", "urgent", or "routine" before the order can be completed.

3) "Stat" inpatient consults will be seen by the specialty/subspecialty Service within 3 hours of receipt of consult request. In addition to completion of a "stat" electronic consult, direct communication between the requesting provider and receiving service must take place. The responsible attending physician is to be informed by the service if he/she was not initially involved. Documentation of the consult will be initiated immediately following the first assessment of patient. Consult must be completed electronically within 24 hrs after the consult was requested.

4) "Urgent" inpatient consults will be seen by the specialty/subspecialty Service and a consult report will be signed and available to the requesting party within

24 hours of consult request. In addition to completion of an "urgent" electronic consult, direct communication between the requesting provider and receiving service must take place and that communication must be documented.

5) "Routine" inpatient consults will be seen by the specialty/subspecialty service and a consult report will be signed and available to the requesting party within 72 hours of being requested. In no instance should an appropriate discharge be delayed pending completion of a routine inpatient consult.

6) Consult Reconciliation for Inpatient Consults: All stat and urgent inpatient consults will be completed prior to discharge. At the time of discharge, all other pending consults will be reviewed for appropriateness by provider and acted on accordingly prior to patient discharge. Consults that are no longer necessary will be cancelled. For those consults deemed necessary, patients will be given an outpatient appointment for follow up by those services.

Type of Consult	Timelines for Response
"Stat" Inpatient Consult	As soon as possible, but at least within 3 hours of request
"Urgent" Inpatient Consult	Within 24 hours of request.
"Routine" Inpatient Consult	No later than 72 hours of request and only if the consult does not delay discharge.

C. Timing of Outpatient Consults:

1) "Stat" inter-facility consultation services will be negotiated between the requesting and receiving facility physicians, and responded to as quickly as possible, and as deemed appropriate, commensurate with the level of urgency and/or patient transport/transfer requirements.

2) "Urgent" outpatient consults will be seen by the specialty/subspecialty Service and a consult report will be signed and available to the requesting party within 72 hours of consult request.

3) "Routine" outpatient intra-facility and inter-facility requests for consultations will be acted upon (removed from pending status) within 7 days. Patient will be seen and consultation report will be signed and generated to referring party within 30days of consult creation date or 14 days for Mental Health referrals unless a later appointment date is explicitly requested by the patient.

4) Initial consult appointment date & times must be coordinated with the patient.

5) If patient chooses to select appointment date beyond 30 days (or 14 days for Mental Health Consults), there must be an entry in the comments as "patient preference".

6) If a patient is going to wait longer than 30 days from the date the consult was originated to be seen by the receiving specialty clinic, that patient must be placed on the Electronic Wait List (EWL) by the Service to which referred, until he is actually seen.

Type of Consult	Timelines for Response
"STAT" Outpatient Consult	As soon as possible, commensurate with the level of urgency and patient transport/transfer requirements
"Urgent" Outpatient Consult	Within 72 hours of the request.
"Routine" Outpatient Consult.	Action within 7 days. Completion no later than 30 days of the request. (14 days for routine Mental Health Outpatient consults)
Consult not seen within 30 days of request	Place on the EWL until actually seen.

D. Role of Consultants:

1) Depending upon the nature of the request and the understanding between the providers, the consultant may have an advisory role or may initiate treatment.

2) When the consultant is in an advisory role, his/her recommendations may or may not be accepted by the provider of record. In that case, the reasons for not following the consultant's recommendations should be carefully documented in the chart by the referring provider.

3) Consultants will develop and execute collaborative Service Agreements with Primary Care/referring services to include embedded referral guidelines into consult template. Effective Service Agreements require active participation of both parties to optimize timely and effective patient care.

E. Resident Supervision:

1) Consistent with the VHA Resident Supervision Handbook 1400.1 when trainees are involved in consultation services, the staff practitioner will be responsible for supervision of these residents. The staff practitioner must meet with and/or

discuss each patient who received consultation by a resident and perform this personal evaluation in a timely manner based on the patient's condition and local policy.

2) The staff practitioner must document this official consultation supervision by any of the 4 types of documentation referenced in the VHA Resident Supervision Handbook: writing a personal progress note, writing an addendum to the resident progress note, co-signing the progress note detailing staff practitioner involvement, or being identified by name with a summary of discussion and level of involvement in the resident note. Residents must have established (permanent employee) surrogates entered in the CPRS/VISTA systems who receive consult alerts in their absence. In all instances, the actual details of the discussion must be documented.

F. Patient Issues:

1) Every effort will be made to ensure that patients referred for outpatient consultation and treatment make the least possible number of visits to the treating facility. Relevant diagnostic testing will be done in advance of the referral visit as specified in service agreements.

2) When the referred patient is to be seen in multiple clinics every effort should be made to bundle appointments and schedules made as flexible as possible.

3) When travel or transfer is required in support of inter-facility consultation, provisions of the VISN 3 Inter-Facility Transfer policy will apply.

G. Assuring Appropriate disposition of uncompleted or pending consults:

1) Facilities will establish written clinic-specific policies for the management of no-shows (or patients who do not present to open appointment clinics) with respect to consult requests. At a minimum, these policies must assure that after the first missed appointment, an automatically generated letter is sent to the patient notifying them to call for an appointment within a specified time frame before the consult is cancelled. After a specified number of no-shows, as determined by facility policy, the consult request may then be cancelled with an alert sent to the ordering provider to determine next appropriate action. For open appointment clinics, there must be two documented attempts to contact the patient prior to cancellation of the consult. Prior to canceling the consult, clinical review by the receiving service may be necessary.

2) By October 1, 2009, the Medical Staff at each facility will review and update written policies/procedures for the timely and clinically appropriate

management/disposition of consults. Facility consult policies need to be amended to comply with this VISN policy.

3) The receiving services will be responsible for routine consult management to address backlog of incomplete/pending consults. The consulting service will:

- Conduct weekly tracking of consults received, cancelled, pending, completion and timeliness of such.
- Review of all backlogged consults by the receiving service to determine appropriate action. The Medical Staff at each facility will develop written policies/procedures for the timely ongoing management of consultation/referral processes to include:
- An ongoing process to review data on intra-facility and inter-facility consult completion rates and patient no-show rates of consult ordering.
- An ongoing process to address Missed Opportunity rates that exceed the targets, duplicative ordering, inappropriate ordering, and/or over-utilization of consultation requests by individual providers.
- An ongoing process to address instances of failure to respond on a timely and/or appropriate basis to a consult request by a consult receiving service or provider.
- Determine when it is necessary to request new consults for patients already being followed in a specialty area (for example, If patients have not been seen by specialty service in two years, or if a patient develops a new/ different problem for which they need to be seen.)

7. REFERENCES:

VISN 3 Inter-Facility Transfer Policy

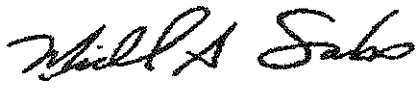
VHA Handbook 1400.1 Resident Supervision
http://vaww.va.gov/oaa/VHA_Handbook_14001_html.asp

VHA Scheduling Directive 2006-055

VHA Consult Directive 2008-056
Attachment A – Service Agreements

VHA Consult Dashboard
Attachment B – Interim VISN 3 Business Rules

8. RECISSION: None



Michael A. Sabo
Network Director

ATTACHMENT A

RECOMMENDED CONTENT FOR SERVICE AGREEMENTS

1. The service agreement is a written agreement made between any two or more parties, where one party sends work to the other, outlining the work flow rules. The agreements may exist within or between facilities. They are developed by consensus; signed by service chiefs from involved services; reviewed or updated as changes are needed, at a minimum annually; and audited.
2. The service agreement is available for reference by posting on the facility or Veterans Integrated Service Network (VISN) website, as appropriate.
3. The service agreement must contain, at a minimum, the following elements:

a. The services covered by the agreement are listed and defined in order to clarify which topics are selected to be covered by the service agreement.

b. The timeframe expected for response from the consultant is established.

c. Judicious and appropriate history, physical, and diagnostic information from the sending provider are provided in order to put the consultant in a position to be able to make a patient care decision on the initial visit.

d. Criteria for discharge from specialty care. It is the expectation that patients are discharged from the specialty clinic once consultation and any needed procedure and follow-up is completed. If ongoing care is co-managed by both the sender and consultant, responsibilities must be clarified.

e. The method for communicating recommendations and treatment plan back to the referring clinician is delineated in order to simplify, standardize, and clarify communication.

f. The agreement has a review and renewal date. ***NOTE:*** *An annual timeframe is recommended.*

4. Additional valuable elements may include:

a. Concurrence signatures of the written agreement by the involved service chiefs, as well as the Chief of Staff (or the Chiefs of Staff and VISN Chief Medical Officer in the event the request is for an Inter-facility Consult (IFC)).

b. Definition of a method for accessing consultants outside of the formal consultation process, so questions may be asked or advice given, potentially avoiding the need for formal consultation.

c. Definition of a method for immediate access to the consulting service for clinical issues that need urgent or emergent attention.

d. A description of how primary care and specialty care evaluate and monitor the service agreement, including identification of data sources.

(1) Adherence to agreements is monitored by measuring the sender responsibilities of sending the right work (right requests) (see Att. A, subpar. 3a) packaged the right way (correct pre-work is included) (see Att. A, subpar. 3c).

(2) The receiver responsibilities are measured by auditing adherence to agreed upon timeliness response standards (see Att. A, subpar. 3b).

e.CPRS Consultation referral templates.

ATTACHMENT B

VISN 3 Interim Business Rules for Consults
December 2012

1. **Inpatient consults:** Consults placed for inpatients require clinical review prior to being discontinued.
2. **Definition of "complete"**: Clinical consults are NOT to be "administratively" completed, e.g. for patient who no-show, or because a specified amount of time has transpired. "Completion" is used in consults when the clinical question/need has been addressed.
3. **Timeliness standards:** Consults are to be acted on within 7 days. Target is to complete at least 85% of consults within 30 days of request, however 100% consults must be addressed within 90 days, unless specifically requested by patient and documented in CPRS.
4. **Business rules when patients can't be reached or are "no-shows":**
   - Reaching patients:

   If patients are not able to be contacted after at least 2 documented attempts notated in CPRS within 14 days, the consult may be cancelled or discontinued and returned to the requesting service via CPRS/VISTA alerts. One of the

attempts must include a letter generated to the patient requesting that they call within 14 days to schedule the consult or the consult may be cancelled.

- Missed appointments:

At a minimum, these policies must assure that after the first missed appointment, an automatically generated letter is sent to the patient notifying them to call for an appointment within a specified time frame* before the consult is cancelled or discontinued. After a specified number of no-shows, as determined by facility policy, the consult request may then be cancelled with an alert sent to the ordering provider to determine next appropriate action. For open appointment clinics, there must be two documented attempts to contact the patient prior to cancellation of the consult.

1. **Patient responds after "allowed" time frame requesting specialty care: Specialty service does NOT require additional consult to be submitted**
2. **CPRS documentation: all attempts at reaching patient for scheduling purposes documented in consult package in CPRS.**

DEPARTMENT OF VETERANS AFFAIRS CENTER MEMORANDUM 11ACHA-01
Northport, NY 11768 September 2, 2005

SUBJ: **CANCELLATION AND RESCHEDULING POLICY**

1. **PURPOSE AND SCOPE**: The Northport VAMC and Satellite CBOC facilities recognize that clinic cancellations, particularly with short notice, affect patient care and customer service. Frequent cancellation and rescheduling contribute to patients being lost to follow-up, decreased patient satisfaction and no-shows. The purpose of this policy is to establish policy and procedures for timely cancellation and rescheduling of clinic sessions, to provide accommodation and minimize adverse impact on scheduled patients when a clinic is canceled and to maintain maximum patient and/or customer satisfaction when a clinic appointment is rescheduled.

2. **DEFINITIONS**:

   a. Elective cancellations are defined as those clinics which are canceled for the convenience of the provider or the local VA facility.
      (1) The clinic appointment is cancelled by clinic because of the planned annual leave, sick leave or authorized absence of the health care provider.
      (2) The clinic appointment is cancelled by clinic because of the departure or reassignment of the health care provider, with reassignment of the patient to a new health care provider.
      (3) The clinic appointment is cancelled by clinic because of the revision of clinic profiles resulting in rescheduling of patient to be seen in another clinic (under a new clinic profile).
      (4) The clinic appointment is cancelled by clinic because it was erroneously entered into the wrong clinic.
      (5) The clinic appointment is cancelled by clinic because VISTA information indicates that the veteran is not entitled to medical benefits and is marked INELIGIBLE.

   b. Non-elective clinic cancellations are those clinic cancellations that are due to unforeseeable circumstances such as provider illness, emergencies, etc.

   c. Patient Cancellations are defined as those appointments cancelled at the request of or on behalf of the patient.
      (1) The clinic appointment is cancelled by patient because the patient or his significant other call to request cancellation or change of appointment date.
      (2) The clinic appointment is cancelled by patient because the patient is an inpatient on the appointment date.

(3) The clinic appointment is cancelled by patient because the patient is known to have improved so that the planned appointment is deemed clinically unnecessary.
(4) The clinic appointment is cancelled by patient because the patient has already been seen or is rescheduled to be seen earlier by the same or another health care provider.
(5) The clinic appointment is cancelled by patient because in the event of an unplanned health care provider absence, the patient agrees to be rescheduled to be seen by another provider under another clinic profile within the same DSS clinic group at the same facility on the same day.
(6) The clinic appointment is cancelled by patient because the patient agrees to be re-scheduled to be seen at another VA facility, or by a non-VA provider, due to inadequate capacity at the facility.
(7) The clinic appointment is cancelled by patient because the patient has moved away from the facility's Patient Service Area.
(8) The clinic appointment is cancelled by patient because the patient is too ill to continue planned treatment (example: chemotherapy).
(9) The clinic appointment is cancelled by patient because VISTA information indicates the patient is deceased.
(10)The clinic appointment is cancelled by patient because of notification from next of kin that the patient is deceased.
(11) The clinic appointment is cancelled by patient when the patient asks to be rescheduled because the appointment conflicts with another scheduled appointment, or because he wants to consolidate his various appointments all onto one day.
(12) The clinic appointment is cancelled by patient when the patient cannot keep their appointment due to DAV/Transportation problems.

3. **POLICY:** Clinic cancellations and rescheduling are disruptive to patients, their families, support personnel, and often create additional work for the provider. However, if after all alternatives have been explored, and a clinic must be canceled, the provider will review the patients scheduled, ensure that all medical problems are addressed in a timely fashion, and reschedule patient appointments. All patients' appointments will be rescheduled within a 30-day window or sooner as clinically indicated.

Note: This memorandum is not intended to address those clinic appointments that are canceled by the patient. It is also recognized that employees are entitled to approved leave. This policy shall in no way serve to monitor or impede an employee's right to leave.

4. **RESPONSIBILITY:** Director, Chief of Staff, Service Chiefs, and ACOS/Ambulatory Care will ensure that healthcare providers with outpatient clinics comply with the guidelines established in this policy.

5. **PROCEDURES:**

   a. Requests to cancel a clinic must be submitted and accompanied by appropriate justification and approved by the requesting provider's supervisor. A minimum 45-day notice should be given prior to elective cancellation of a scheduled clinic date/time. The electronic request must be submitted to the supervising physician, with a rescheduling plan for affected patients based on clinical review.

   b. Prior to canceling a clinic, all alternatives to secure provider coverage or otherwise manage the affected patients should be explored. These alternatives include securing coverage from another provider, use of consultants or attendings, or providers from an affiliate. Overbooks or scheduling an extra clinic during administrative times are also acceptable ways to provide additional clinic time.

   c. The provider or designee whose clinic is canceled will review the patients scheduled for the canceled clinic, ensure via a rescheduling plan that all medical problems are addressed by COB the following day and that those patients whose appointments have been canceled and rescheduled have been prescribed with enough medicine to last until the date of the rescheduled appointment.

   d. When a clinic is canceled, the local electronic scheduling package and electronic mail established are to be used to accrue required information. The facility will use the mailgroup G.Clinic Cancellations in VISTA to communicate all clinic cancellations with areas in the medical center affected by clinic cancellations. i.e. Patient Travel and DAV to assure that contract transportation and DAV are notified to avoid unnecessary use of transportation.

   e. Patients will **not** be rescheduled utilizing the "auto-rebook" process.

   f. The goal for the local clinic scheduling staff will be to re-schedule each patient affected by the cancellation within a 30-day window, or sooner as clinically indicated.

   g. For cancellations not rescheduled within a 7-day window, a note will be entered into CPRS using the "cancellation" progress note, documenting

the review of the patient medical record and the actions taken including assurance of sufficient medication.

h. No patient will be subject to consecutive clinic cancellations (e.g. a patients appointment may not be canceled, rescheduled, and then canceled again.)
i. If the clinic cancellation is less than 30-days prior to the scheduled clinic, the responsible clinic will contact each patient affected by the cancellation by telephone and inform him or her of the new appointment.

j. The supervising physician will be notified **immediately** by the responsible provider or his/her designee in the event of non-elective cancellations. If there is short notice and the provider is not available for the review process, a surrogate will be designated to assume this responsibility. Administrative staff will attempt to contact the patients before their appointments. Every effort will be made to accommodate each patient before rescheduling him/her. Affected patients will be offered the choice of being rescheduled to another day with their provider or being seen by another provider on the same day. If the patient is unable to be contacted and presents for the appointment, under no circumstances will the patient be turned away without seeing a provider, unless he/she prefers to be rescheduled.

k. For those appointments that are canceled on the day of the scheduled appointment, the affected patient(s) shall be offered the following two options:
   - Same day appointment with another provider or:
   - Reschedule the appointment with the original provider if possible within 14 days or sooner as clinically indicated.
   - Note: The supervising physician will be responsible for assignment of an alternative provider as necessary in order to meet the patient's needs and within the specified time limits.

6. TRACKING CLINIC CANCELLATIONS:

a. Each service will accumulate clinic cancellation data quarterly from the scheduling staff, analyze the data, note any trends, and implement appropriate actions to correct trends (see Attachment A).

b. The data collected will include:
   - Stop Code
   - Clinic/ Location Name
   - Cancellation Date
   - Provider
   - Number of Patients Cancelled
   - Number of Patients Rescheduled Within 30 Days

DEPARTMENT OF VETERANS AFFAIRS
NORTHPORT, New York 11768

CENTER MEMORANDUM 11ACHA-01
January 26, 2012

SUBJ: CANCELLATION AND RESCHEDULING POLICY

CM 11ACHA-01, Cancellation and Rescheduling Policy, dated September 2, 2005 is hereby rescinded.

Philip C Moschitta

PHILIP C. MOSCHITTA
Director

Dist. [C]

DEPARTMENT OF VETERANS AFFAIRS
NORTHPORT, New York 11768

CENTER MEMORANDUM 11-206
September 29, 2011

SUBJ: NO-SHOW POLICY

1. PURPOSE AND SCOPE: To establish policy and procedures to provide a no-show process for outpatients. A "no-show" is defined as not arriving at all for a scheduled appointment without *advance* notice to the clinic. No-shows need to be minimized in order to most efficiently utilize medical center resources.

2. POLICY: [ ] No-show appointments will be reviewed to determine the need for clinical intervention. Patients who fail to report for scheduled appointments may be clinically reviewed for urgency of care needs.

3. RESPONSIBILITY: Chief of Staff and Clinical Service Chiefs will ensure that all clinicians who treat outpatients are aware of and follow this policy.

4. PROCEDURE:

[ ]
[A]. Primary Care [ ] Specialty Clinics [ ]

1.) [After the scheduled appointment date/time has passed]: The administrative support staff will [notify clinician of patients who no showed] [ ], disposition a no show in the computer and generate a no-show letter [ ]. [No-show appointments [will not] be automatically rescheduled.] [Follow up actions to be determined by clinician-provide appropriate intervention.]

[B]. [When a patient does not report ("no-show") for a scheduled appointment, the responsible provider, surrogate, or designated team representative may need to review the patient's medical record, including any consult or procedure request received or associated with the appointment and then determine and initiate appropriate follow-up action and document in the "No-show" progress note.]

[ ]

[ ]

[ ]

C. Mental Health Clinic:

1.) All clinical providers are to review their clinic appointment list daily when their clinics are in session. The clerk will mark a copy of the clinic appointment list to indicate "no-shows" and will give this to the provider to review.

2.) All providers of mental health and substance abuse services will be responsible to

telephone patients who fail to show for a scheduled visit. Each patient must be called up to [three (3)] times or until they are contacted. Patients who cannot be contacted should be sent a no-show letter [ ]. The telephone calls must be documented in the medical record as a telephone note. Patients who have a Suicide Risk warning note (CWAD), or who are otherwise at risk and cannot be contacted, should be brought to the attention of the Suicide Prevention Coordinator, who will confer with the ACOS/ Mental Health on appropriate next steps.

3.) High-risk patients may be defined as, but are not limited to, presence of suicide attempt in the past year, less than [thirty (30)] days since discharged from the acute psychiatric unit, or lifetime history of homicide.

4.) At no time, will patients who fail to show for a scheduled appointment, be rescheduled unless personal contact confirms the patient's intent to keep the appointment. (This can be via telephone contact with clinical or clerical staff, at request of case manager or by in person contact with the clinic.)

[5.] [POTENTIAL NO-SHOW STRATEGIES TO IMPLEMENT TO REDUCE NO-SHOWS:]

[A. Decrease the time between making and receiving care. The longer a patient waits between the request and completion of an appointment, the higher the no-show rate:]

[1.) Providers must honestly understand, measure, and balance appointment demand and supply. This means implementing "Advance Clinic Access" in an active and engaged manner. "Today" open clinic slots must be offered to any patient who requests an appointment for any reason. This has a major impact on improving no-shows.]

[2.) Use recall scheduling. Scheduling an appointment closer to the point in time when it will actually occur will decrease the no-show rate. For *appointments longer than 3-4 months into the future,* the patient can be placed on the "recall" scheduling list to program their request so that the appointment is made closer to the point in time when it is desired to occur.]

[B. Engage the patients. Clinics that remind patients of upcoming visits consistently report improvements in no-shows:]

[1.) Call to Remind. Call 2-3 days in advance in addition to one day in advance.]

[2.) Mail a reminder. Review the reminder letter to assure accuracy, and be sure it includes a phone number to call and cancel.]

[3.) Share the effect of not keeping appointments. Veterans especially do respond to the message that a no-show is a wasted opportunity for another fellow Veteran to receive care.]

4.) Make cancellation easy. Simply put, if the patients had difficulty finding a phone number or getting through on the phone to the clinic scheduler, they are less likely to cancel a visit and may just not show up.]

[5.) Engage the providers in reducing missed opportunities:]

[a.) Close the visit. The manner in which a provider ends a patient visit can have a huge impact on no-shows.]

b.) Make each appointment count. Providers will sometimes reappoint a patient even when they expect the patient's clinical condition to improve. This type of appointment is done "just in case" the patient does not get better. This habit can easily fill up the future schedule with low-value visits. Providers may do this with the best of intentions, or to protect themselves from future daily demand.

Alternatively, other providers faced with the same situation will say "you don't need to make an appointment, but if you need to see me, you can call me back at any time"

[c.) Synchronize medication refills with scheduled visits. Patients who depend on VA for medications can be motivated to keep appointments when they are timed with expiring prescriptions.]

[d.) Promote continuity. Primary care patients who see their own provider have fewer no-shows than patients who see provider they do not know.

[e.) Stay on time. Clinics that offer a positive patient experience by managing their cycle times and staying on time through the clinics session will also lower no-show rates.

[4. Measure and Manage clinic operations:]

[a.) Call no-show patients. Calling the no-show patient to inquire about their health and well being in addition to reasons for their no-show can provide rich information about issues the clinic may be able to address and improve.

[b.) Review clinic cancelations. If the clinic is frequently canceling, patients lose confidence their visit will occur of express their feeling of annoyance or disrespect by no-showing.]

[c.) Synchronize and coordinate visits including transportation. Coordinating multiple visits into one trip has tremendous benefits in improving show rates, parking and patient satisfaction.]

[**6.**] **REFERENCE:** VHA Directive 2010-027]

[7.] **RESCISSION:** CM 11-206 No-Show Policy, dated December 28, 2007

[8.] **ATTACHMENT:** A. [Sample-No Show letter]

Philip C. Moschitta

[PHILIP C. MOSCHITTA]
Director

Dist: A
Responsible Service: Chief of Staff (11)

ATTACHMENT A

SAMPLE NO SHOW LETTER:

We regret we missed you at the following appointment, your care is very important to us.
If an appointment was scheduled and you were not aware of it, please accept our apologies.
If you were unable to keep the appointment and would like to reschedule it, please call our clerical associate at_____, between the hours of 8:00 am and 4:30 pm, Monday through Friday.
My HealtheVet is the gateway to veteran health benefits, services and prescription refills.
Register with MyHealtheVet today at www.healthe.va.gov.

Sincerely,
Northport VA Medical Care Teams
Veterans Affairs Medical Center
79 Middleville Road
Northport, NY 11768

June 23, 2014

Northport VAMC Standard Operating Procedure for Agent Orange registration:

Eligible Veterans presenting for enrollment are given Agent Orange information packets and offered an appointment for Agent Orange examination

Appointments are made by the enrollment staff under the NPT-Medical Herbicide clinic profile.

Currently there are same week appointments available. Our last pending appointment is scheduled for tomorrow, June 24th.

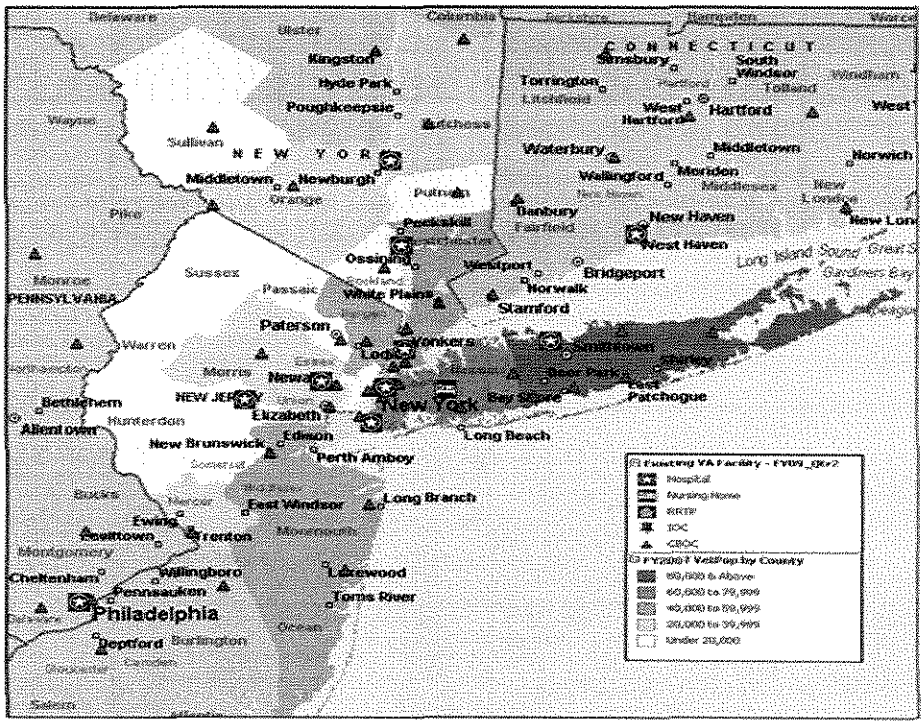
Patients are examined in the Herbicide clinic by provider Tracy Takaki.

Patients are entered onto the EAS registry by the enrollment staff upon completion of exam in the Herbicide clinic.

There have been 1,833 registries into EAS from 10/1/10 to present date for Northport VAMC.

Veterans Rural Health Needs Assessment

VISN 3 New York and New Jersey Network



Bertha Fertil, MPH, MGA
VISN Planner

June 30, 2011

ORH
VHA Office of Rural Health

VA HEALTH CARE
Defining EXCELLENCE in the 21st Century

Table of Contents

EXECUTIVE SUMMARY **2**
- INTRODUCTION 2
- SELECTED FINDINGS 3
- IMPLICATIONS 3
- CONCLUSIONS AND RECOMMENDATIONS 3

VISN 3 OVERVIEW **4**
- *Table 1. VISN 3 Characteristics* *4*
- ORGANIZATIONAL STRUCTURE 4
  - *Table 2. VISN 3 Facilities* *5*
- RURAL HEALTH ORGANIZATIONAL STRUCTURE 5
- SERVICES OFFERED 5
  - *Table 3. Specialized Programs Available in VISN 3* *5*
- VETERAN DEMOGRAPHICS 9
  - *Table 4: Total Veteran Population* *9*
  - *Table 5. Veterans in VISN 3* *9*
  - *Table 6. Service Utilization by Rurality* *12*

GEOGRAPHIC ACCESS ASSESSMENT HIGHLIGHTS – GAP ANALYSIS **13**
- OVERVIEW 13
- HIGHLIGHTS (FY09 DATA) 13
- GEOGRAPHIC GAP ANALYSIS 15
  - *Map 1: VISN 3 Enrollee Population Outside 60 Minutes Travel Time of Existing VHA Primary Care Sites, - Gaps by Zip Code, FY09* *15*
  - *Map 2: VISN 3 Enrollee Population Outside 120 Minutes Travel Time of Existing VHA Acute Care Sites, - Gaps by Zip Code, FY09* *16*
  - *Map 3: VISN 3 Enrollee Population Outside 240 Minutes Travel Time of Existing VHA Tertiary Care Sites, - Gaps by Zip Code, FY09* *17*

RESOURCES **18**
- GOVERNMENT RESOURCES 18
- COMMUNITY RESOURCES 19
- PARTNERSHIPS 19

ORH FUNDED PROJECTS **20**
- VISN PROJECTS FY 2010-2011 20

BEST PRACTICES AND INNOVATIONS **21**

CONCLUSIONS **22**

NEXT STEPS **24**

REFERENCES **26**

Executive Summary

Introduction

The mission of VISN 3 is to provide an accessible, seamless, continuous and comprehensive system of health services for veterans and other eligible beneficiaries residing within the catchment area of VISN 3 as well as those referred to or seeking care from outside the Network. The VISN 3 policies and health delivery systems will ensure that health care is uniformly accessible to veterans receiving care throughout the Network and that the standards of quality are consistently incorporated in all of VISN 3 health care delivery sites. In carrying out this mission, VISN 3 will:

- Ensure the availability and provision of state-of-the-art health care to eligible veterans;
- Be committed to continuously improving the quality of care and service provided patients;
- Promote patient and family education;
- Support the education of staff and the training of health professionals;
- Champion the advancement of scientific knowledge related to the prevention and treatment of disease and disability and health services delivery;
- Seek input from patients, eligible veterans and other patient and veteran advocacy groups ;
- Work in partnership with interested labor organizations, appropriate staff advocacy groups, the community and other internal and external stakeholders;
- Maximize the use of available resources; and
- Increase the number of veterans and other eligible beneficiaries served by the VISN.

Within three health care systems (VA New York Harbor HCS, VA Hudson Valley HCS, and VA New Jersey HCS), nine medical centers and 32 community based outreach clinics (CBOC), VISN 3 provides unprecedented access to care to Veterans living in its Metro New York, Long Island and New Jersey catchment areas. From primary and specialty to inpatient care, outpatient visits and long-term care VISN 3 provides an array of high quality comprehensive services that are nationally recognized and accredited.

Since 1990, the veteran population living in VISN 3 has decreased significantly. In 1990, there were approximately 1,500,000 veterans living in VISN 3's catchment area. However, by 2000 the veteran population had dropped by 19% to 1,210,960 and by 2010, the veteran population further declined by another 34% to 799,182. Even with the return of 13,849 Iraqi and Afghanistan Combat Veterans (OEF/OIF/OND), there continues to be a significant drop in the number of Veterans living in VISN 3 in 2010.

The decline in veteran population directly correlates with the age of the veteran population in VISN 3 and the economy factors – high cost of living, low wages, high property taxes, shrinking job market – that are unique to the northeastern part of the United States. Consequently by 2020, it is projected that the veteran population in VISN 3 will further decrease by another 33% from 799,182 to 534,056. With the continued decline in Veteran population and increase in the trend to deliver health care in outpatient settings as well as the demand for more complex and resource intensive inpatient, there is a continual need to restructure and realign how care is provided throughout – urban, suburban and rural – VISN's catchment area.

The migratory and care seeking patterns amongst VISN 3 veterans are such these veterans live in New York and New Jersey during the fall, summer and spring and migrate to the warmer climates of Florida and Puerto Rico during the winter months. As a result of this movement, VISN 3 veterans tend to get their outpatient care in Florida and Puerto Rico – VISN 8 – and obtain their more resource intensive care in VISN 3. In addition, we are finding that veterans from highly areas of the United States are seeking to have their more complex surgery and/or more intensive care at VISN 3 urban medical facilities, specifically New York VAMC.

Executive Summary

Selected Findings

Several significant findings are presented in this report:

- No access gap exist within VISN 3
- There continues to be a continuous decline in overall veteran population
- There continues to be a decrease in those enrolling for service within the network.
- Within the network a significant majority for the veterans enrolled are over 65 years old.
- Within the user category the number of patients is equally distributed between those over 65 years and those less than 65 years.
- Those who use the services within the network are on average older and present with more complex and intensive medical cases.
- There is a decrease demand for inpatient services
- There is an increase demand for outpatient services
- VISN 3 shares a segment of its population with VISN 8 - Florida and Puerto Rico.
- Veterans living in highly areas are seeking care in VISN 3.

Implications

There are several implications to these findings:

- The way care is provided has to change to reflect the changing veteran demographics.
- The cost to provide care in VISN 3 will increase. As the patient base that present to the network is sicker, there will be less healthy patients to balance the cost structure.
- Infrastructural realignment will be needed
- Increase partnering with other VISNs will be necessary

Conclusions and Recommendations

The veteran population in VISN 3 has been decreasing by an average of 30% each decade since 1990. The veterans who continue to use VISN 3 for their health care on average are older and sicker. These individuals require care that is resource intensive and complex. For the other segment of the VISN 3 veteran population, those less than 65 years old, we are seeing an increase in demand for outpatient services. The issues at VISN 3 are further challenges by the migratory patterns of those using the health care services. One group, specifically those within the 65 years and old category, seeks their outpatient care in the winter in VISN 8, and their more complicated care during the other seasons in VISN 3. Another group travels from highly rural areas to get high resource intensive care from VISN 3 medical centers.

Recommendations

- There needs to be a change – structure, process and outcome – in the way care is provided
- Find ways to attract Veterans.
- VISN 3 should endeavor to modernize its facilities to provide state of the art primary and specialty ambulatory care, specialized geriatric inpatient care, and psychosocial domiciliary care in order to meet the needs of its rapidly aging veteran population.
- Develop Centers of Excellence where other VISNs that have difficulty attracting physician staff would be able to use the services of available VISN 3 medical staff.

VISN 3 Overview

VISN 3 Overview

VA NY/NJ Veterans Healthcare Network (VISN 3) serves the wide diversity of needs for the greater New York and New Jersey Veteran population. The Network provides care in some of the most urban settings in the nation as well as in sprawling suburban and rural areas. A full range of services is provided with each medical center emphasizing primary care complimented by specialized care. Additional services are provided in community based outpatient clinics (CBOCs). The medical centers/systems include: Bronx, Northport (Long Island), VA NY Harbor Healthcare System, which includes Brooklyn, St. Albans, New York (Manhattan), VA Hudson Valley Healthcare System, comprised of Castle Point and Montrose and VA New Jersey Healthcare System comprised of East Orange and Lyons.

The mission of VISN 3 is to provide an accessible, seamless, continuous and comprehensive system of health services for veterans and other eligible beneficiaries residing within the catchment area of VISN 3 as well as those referred to or seeking care from outside the Network.

The 2009-2012 VISN 3 strategic goals are:

- To provide Veteran Centered;
- To expand care for special populations (Women, OEF/OIF and Rural Populations) ;
- To increase fiscal and operational responsibility;
- To outreach and enrollment;
- To become the employer of choice; and
- To end homelessness

In FY2010 the veteran population was 767,183 with the Long Island and New Jersey markets of the network being more densely populated than the rural and highly rural areas of northern Hudson Valley and the eastern end of Long Island.

Table 1. VISN 3 Characteristics

Number of Square Miles	12,480
Number of States Primary	2
Number of States Border	2
Number of Senators	4
Number of Congressmen/Congresswomen	36
Number of VBA Regional Offices	2
Number of VA Cemeteries	2

Organizational Structure

The VA health care systems in VISN 3 are New York Harbor HCSC (with medical centers in Brooklyn, New York and St. Albans), the New Jersey HCS (with medical centers in Lyons and East Orange) and the Hudson Valley HCS (with medical centers in Montrose and Castle Point).

Table 2. VISN 3 Facilities

Facilities	Number
Campus	5
Health Care Systems	3
Medical Centers	9
Community Based Outpatient Clinics (CBOC)	32
Outreach Clinics	2
Vet Centers	11

The Network's organizational structure focuses on the benefits of both a facility-based structure and a patient care service line structure. The three health care systems and two medical centers that make up the network each has a senior leadership team consisting of a Medical Center Director, Associate Director, Chief of Staff, and Nurse Executive. An Executive Leadership Council (ELC), chaired by the Network Director, and comprised of senior leaders from across the Network, Medical Centers and Council Chairs serve as the governing body. Sub-councils of the ELC guide operations – the Chief of Staff Council, the Administrative Operations Council and the Nurse Executive Council. Each Council includes representative from each medical center, service line, and employee bargaining unit.

VISN 3 executive leadership includes following people:

1. Mr. Michael A. Sabo, MBA, Network Director;
2. Ms. Mara Davis, MSW, MPA, Deputy Network Director
3. Joan McInerney, MD, Chief Medical Officer; and
4. Mr. Ekerete Akphan, MBA, Chief Financial Officer.

Rural Health Organizational Structure

VISN 3 has three prominent rural areas. The first is located in the northwestern tier of New Jersey. The second is located in the northern tier of Hudson Valley. The remaining rural area of VISN 3 is located in the eastern Long Island.

All of our rural health facilitates have a home based primary care and a complimentary telehealth presence. In addition, we are in the process of bringing our nationally recognized palliative care programs to our rural areas.

There is a rural health workgroup, which works the direction and vision of the rural initiatives underway in the network. The workgroup includes representative from the three facilities that have rural areas – New Jersey HCS, Hudson Valley HCS and Northport VAMC.

The VISN Rural Consultant is a member of the following committees:

- Telehealth;
- Home Based Primary;
- Geriatrics and Extended Care; and
- Health Care Planning Workgroup.

Services Offered

Veterans who receive care at VISN 3 health care facilities have access to an integrated health care delivery system that offers a comprehensive array of primary, specialty and long term care services. The network's staff of highly trained doctors, nurses, social workers, technicians and other healthcare professionals annually serve over 184,000 patients, through inpatient care, emergency room treatment or outpatient services. The geographic regions from which our primary and secondary service area is comprised of urban, suburban and rural.

The following sites provide inpatient medicine and surgery:

- Bronx VAMC
- New York VAMC
- East Orange VAMC
- Northport VAMC

The following sites have telehealth services:

- Bronx VAMC
- Brooklyn VAMC
- New York VAMC
- East Orange VAMC
- Lyons VAMC
- St. Albans VAMC
- Northport VAMC
- Castle Point VAMC
- Montrose VAMC

The following sites have a community living center:

- Lyons VAMC
- St. Albans VAMC
- Northport VAMC
- Castle Point VAMC
- Montrose VAMC

In addition, to the services offered above VISN 3 facilities also offer a large array of specialized programs that are unique to this network.

Table 3. Specialized Programs Available in VISN 3

Specialized Programs	Locations
Spinal Cord Injury and Rehabilitation	Bronx, NY, Castle Point, NY and Lyons, NJ
Women's Sexual Trauma	Lyons, NJ
Patient-Centered Care (PCC)	East Orange, NJ
Field Implementation Team (FIT)	East Orange, NJ
Pebble Project: Pharmacy Redesign	East Orange, NJ
Integrative Medicine	East Orange, NJ
Veteran's Directed Home and Community Based Program	East Orange and Lyons, NJ
Sleep Lab	East Orange, NJ
Visual Impairment Services Outpatient Rehabilitation Program	East Orange, NJ
HARP Unit	East Orange, NJ
Lyons Club House	Lyons, NJ
The Diabetes Wellness program	Northport, NY

Optometry	Northport, NY
Northport VAMC Homeless Services Program	Northport, NY
The Northport Palliative Care Program	Northport, NY
The DAV Transportation Call Center	Northport, NY
Emergency Management Program:	Northport, NY
RH/East End Health Care Program	Northport, NY
The Center of Balance	Northport, NY
Northport Health Informatics	Northport, NY
Paralympic Adaptive Sports Program	Northport, NY
Recreation Therapy Service	Northport, NY
Fly Fishing Clinic	Northport, NY
Healthy Cooking Is Fun!	Northport, NY
Team River Runner Adaptive Kayak Program	Northport, NY
Adaptive Golf Program	Northport, NY
Horses for Heroes Program	Northport, NY
MOVE Walk and Talk Clinic	Northport, NY
BSL3 Laboratory	New York, NY
Cardiac Surgery Referral Center	New York, NY
Interventional Cardiology	New York, NY
Neurosurgery Referral Program	New York, NY
Interventional Pain Management	New York, NY
Interventional Oncology	New York, NY
Simulation Laboratory / New York Campus	New York, NY
Simulation Laboratory-Medical / Brooklyn Campus	Brooklyn, NY
Simulation Laboratory-Surgical / Brooklyn Campus	Brooklyn, NY
Hepatocellular Carcinoma (HCC) Referral Program	New York, NY
Metabolic Stone Clinic	New York, NY
Mohs Micrographic Surgery Center	New York, NY
Mental Health Acute Psychiatry Short Stay Unit	New York, NY
Dental Residency Programs	New York, NY
Radiation Oncology	New York, NY
PET Center	New York, NY
VISN 3 Prosthetics/Gait and Motion Analysis Laboratory	New York, NY
VISN 3 Prosthetics/Participation in the Optimization Study of the DEKA Arm System	Brooklyn, NY

VISN 3 Overview

VISN 3 Prosthetics/Other Initiatives (Helix Hip, Genium X2 Microprocessor-Controlled Knee, PowerFoot BiOM by IWalk)	New York, NY
VISN 3 Textile Care Facility	St. Albans, NY
Mental Health Clinics – Military Sexual Trauma (MST)	Montrose, NY
Furniture Donation Program	Montrose and Castle Point, NY
Veterans Food Pantry	Montrose and Castle Point, NY
Senior Support Services Program	Montrose and Castle Point, NY
IDES (Integrated Disability Evaluation System)	Castle Point, NY
Low Vision Program and Mobile Clinic	Castle Point, NY
Spinal Cord Injury Outpatient Program	Castle Point, NY
Driver Rehabilitation Program	Castle Point, NY
The Labyrinth	Montrose, NY
CLCs – Musicians on Call Program	Montrose and Castle Point, NY
Recreation and Creative Arts Therapy Internship Program	Montrose and Castle Point, NY
Veteran's Industries	Castle Point, NY
Psychosocial Rehabilitation Recovery Program (PRRC)	Montrose and Castle Point, NY
PTSD Residential Rehabilitation Treatment Program (RRTP)	Montrose and Castle Point, NY
Domiciliary Alumni Group	Montrose and Castle Point, NY
Shelter Plus Care (S+C) Supported Housing	Montrose and Castle Point, NY
CWT Transitional Residence (CWT/TR)	Montrose and Castle Point, NY
Community Based Programs – Community Residential Care (CRC)	Montrose and Castle Point, NY
Health Care for Re-Entry Veterans (HCRV)	Montrose and Castle Point, NY
Mental Health Clinics - Tele-Psych	Montrose and Castle Point, NY
Virtual Reality Therapy Program	Montrose and Castle Point, NY
Outpatient Art Therapy	Montrose and Castle Point, NY
Orthopedics Spine Surgery	Bronx, NY
Regional Nurse Telephone Triage	Bronx, NY
Electroconvulsive (ECT) Program	Bronx, NY
The Polytrauma/TBI program	Bronx, NY
EEG lab at the James J. Peters Veterans Affairs Medical Center	Bronx, NY
Vestibular Disorders Evaluation Clinic (VDEC),	Bronx, NY
Allergy-immunology Service	Bronx, NY
Chiropractic Program Amputation Rehabilitation Program	Bronx, NY
VISN 3 Network Telephone Care Program (NTCP)	Bronx, NY

Otolaryngology Subspecialty Service	Bronx, NY
Comprehensive Head and Neck Surgery Center	Bronx, NY
Bariatric Surgery Program	Bronx, NY
Research Centers	**Locations**
Mental Illness Research, Education and Clinical Center (MIRECC)	Bronx, NY
Geriatric Research, Education and Clinical Center (GRECC)	Bronx, NY
War-Related Illness and Injury Study Center (WRIISC)	East Orange, NJ

Veteran Demographics

VISN 3 has over 300,000 enrolled veterans or approximately 39% of the veteran population in the geographic area. In general the veteran population in VISN 3 is made up of primarily male veterans that served in Korea or Vietnam living in urban areas. Our largest patient demographic is aged 65-84 with over 129,000 veterans enrolled in this group. The majority of veterans in VISN3 live in urban areas.

Table 4: Total Veteran Population

Veteran Categories	VISN 3		National VA	
	Number	Percent	Number	Percent
Total Veteran Population	799,120		22,593,677	
Total VA ***Enrollees***	308,971	39%	7,982,513	35%
Total VA ***Uniques***	184,499	23%	5,638,491	25%

Table 4 above compares VISN 3 veteran population, enrollee and number of uniques with the national VA numbers.

Table 5: Projected Veteran Population, Enrollment and Market Penetration Rate

VISN 3 Projected Veteran Population, Enrollee and Market Penetration											
Categories	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
EOY Veterans	835,024	799,120	767,183	736,298	706,366	677,745	650,526	624,737	600,159	576,896	554,824
EOY Enrollees	314,648	308,971	303,915	298,713	294,803	289,885	284,647	279,217	273,837	268,337	262,899
Market Pen	37.68%	38.66%	39.61%	40.57%	41.74%	42.77%	43.76%	44.69%	45.63%	46.51%	47.38%

Graph 1: Comparison of VISN 3 Projected Veteran Population, Enrollment and Market Penetration Rate

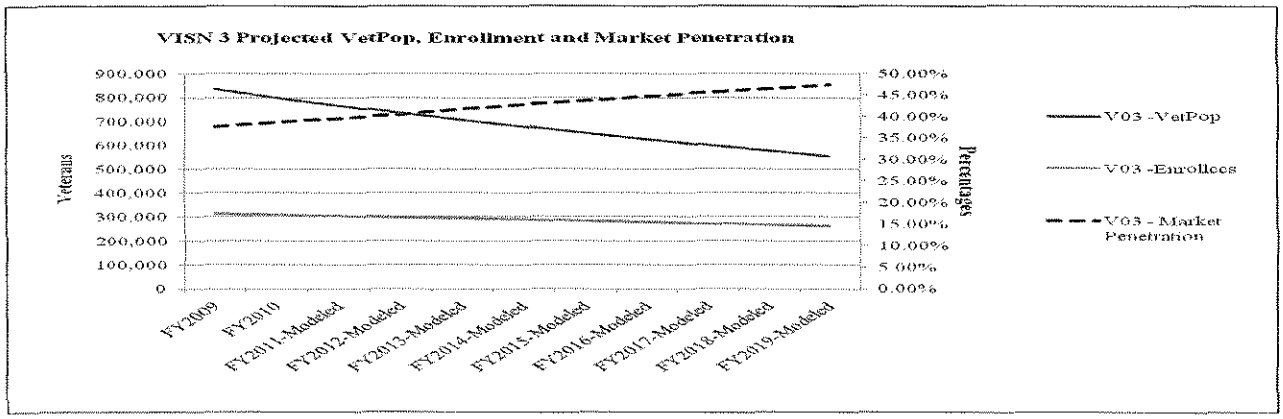


Table 5 and Graph 1, its pictorial representation, show that the decline of the networks veteran population and enrollment as well as the increase in market penetration due to the overall veteran population decline.

Table 6: VISN Operations Overview (Uniques, Visits, Admissions and Beds)

Table 6 below is a view of our operations over a three year period and the percentage changes within each category. Note that while the overall number of unique patients is decreasing the number of patients requiring more intensive care (Dom & PRRTP BDOC and nursing home) are increasing.

Category	Measure	FYTD through May			September (EOY)		3 Year % Change
		2009	2010	2011	2009	2010	May
Total Uniques	Unique Patients	162,770	163,721	162,887	182,203	182,504	0.10%
	Unique Women Veterans	5,882	6,421	7,196	6,772	7,218	22.30%
	Unique OEF/OIF	9,226	11,654	12,176	12,087	13,849	24.23%
Visits	Outpatient Visits	1,540,995	1,592,730	1,614,523	2,367,521	2,412,344	4.80%
Inpatient Bed Days of Care	Hospital BDOC	149,380	142,385	138,265	219,149	209,813	-7.40%
	Dom & PRRTP BDOC	80,396	82,569	85,825	119,622	124,761	6.80%
	NH BDOC	170,553	166,014	160,791	254,545	246,678	-5.70%
	Total BDOC	400,329	390,968	384,881	593,315	581,251	-3.90%
Admissions	Hospital Admissions	15,234	14,336	14,735	22,745	21,651	-3.30%
	Dom & PRRTP Admissions	1,234	1,304	1,281	1,896	2,143	3.80%
	NH Admissions	663	587	656	994	905	-1.10%
	Total Admissions	17,131	16,227	16,672	25,635	24,699	-2.70%
Beds	Hospital Operating Beds	1,358	1,360	1,330	1,360	1,360	-2.10%
	Dom & PRRTP Operating Beds	438	438	438	438	438	0.00%
	NH Operating Beds	1,026	1,026	1,026	1,026	1,026	0.00%
	Total Operating Beds	2,822	2,824	2,794	2,824	2,824	-1.00%
ADC	Hospital ADC	615	586	569	600	575	-7.50%
	Dom & PRRTP ADC	331	340	353	328	342	6.60%
	NH ADC	702	683	662			-7.40%
	Total ADC	1,647	1,609	1,584	1,626	1,592	-3.80%
Occupany Rates	Hospital Occupancy%	45.30%	43.10%	42.80%	44.10%	42.30%	-5.50%
	Dom & PRRTP Occupancy%	75.60%	77.60%	80.60%	74.90%	78.10%	6.60%
	NH Occupancy%	68.40%	66.60%	64.50%	67.90%	65.90%	-5.70%
	Total Occupancy%	58.40%	57.00%	56.70%	57.60%	56.40%	-2.90%

Table 7 gives a more infinite breakdown of the Veterans who use the services within our network. Note that within the network a significant majority for the Veterans enrolled are over 65 years old. However, within the user category the numbers are equally distributed between those over 65 years and those less than 65 years.

Table 7. Veterans in VISN 3

Veteran Categories	Enrollees		Users	
	Urban	Rural (R+HR)	Urban	Rural (R+HR)
Gender	#			
Male	291,356 (83%)	43,626 (12%)	150,635 (82%)	23,202 (13%)
Female	12,350 (4%)	1,761 (1%)	8,206 (4%)	993 (1%)
Race/Ethnicity	Data Currently Not Available in VHA Data Systems			
Non-Hispanic White				
Black/African American				
Hispanic				
Asian/Pacific Islander				
Native American/American Indian				
Other				
Age				
<45	39,854	5,542	20,259	2,461
45-64	92,364	15,395	50,826	8,655
65-84	129,341	20,047	67,016	10,988
85+	43,343	4,403	20,810	2,091
Priority Status				
P1-P6	172,838	25,277	103,802	15,866
P7-P8	132,064	20,110	51,488	8,165
			Users (FY2010)	
OEF/OIF/OND			13,849	
Special Populations (list)				
Homeless			3,980	
Spinal Cord Injury			40	
Other Disease Cohorts (list)				
TBI			1,438	
Substance Use			1,120	
Diabetic			51,095	

Table 8. VISN 3 Projected Service Utilization by Strategic Planning Categories (BY2009-FY2015)

Projected Utilization	FY2009 Baseline	FY2010 Modeled	FY2011 Modeled	FY2012 Modeled	FY2013 Modeled	FY2014 Modeled	FY2015 Modeled
Outpatient							
Primary Care-Geriatrics-Urgent Care	530,397	551,730	551,816	546,495	538,751	522,742	504,043
Mental Health Programs	633,338	705,849	747,745	763,503	755,408	741,233	724,602
Dental Clinic	171,783	177,525	180,211	182,654	184,821	186,888	187,749
Laboratory and Pathology	504,697	525,719	526,449	522,933	517,357	503,389	486,101
Medical & Other Non-Surgical Specialties	602,105	628,880	630,903	626,149	617,893	600,026	579,134
Radiology and Nuclear Medicine	169,536	178,115	178,417	176,053	172,608	165,976	158,434
Surgical Specialties	303,344	314,318	314,789	312,718	309,110	301,170	291,643
Pharmacy	6,450,834	6,566,926	6,605,771	6,606,466	6,602,350	6,534,118	6,457,310
Supplies-Equipment-Prosthetics-Ambulance		752,916	811,107	878,549	947,836	1,014,547	1,076,126
Inpatient							
Acute Inpatient Medicine	86,875	84,955	80,998	76,710	72,890	68,759	64,868
Acute Inpatient Mental Health	41,919	41,856	39,950	37,778	35,625	33,246	31,007
Acute Inpatient Surgery	40,439	40,046	38,228	36,281	34,301	32,241	30,200
Inpatient Residential Rehab Mental Health Programs	155,515	159,274	160,129	156,604	153,009	148,766	144,855
Spinal Cord Injury	12,018	12,433	12,617	12,913	13,228	13,494	13,720
Blind Rehab	1,527	1,609	1,641	1,662	1,682	1,690	1,689

Table 6 shows that over time the service utilization in all of the strategic planning categories decreases. Although the rate of decline in the outpatient categories is slow with several increases during the middle years, the rate of decline in the inpatient services is more dramatic with consistent drops in service utilization each year.

Geographic Access Assessment Highlights – Gap Analysis

Geographic Access Assessment Highlights – Gap Analysis

Overview[1]

The overall objective of this project was to conduct a needs assessment in VISN 3 to identify potential geographic access gaps in primary, acute, and tertiary care for rural areas of the Network. In developing planning initiatives in potentially underserved area in VISN 3, this is an essential first step in assigning priority to service needs and developing strategies to address them. It is necessary to define and understand the met and unmet needs.

Highlights (FY09 data)[2]

Approximately 95% of the VISN 3 enrollees are located within 30 minutes of an existing VA facility. Over 95% enrollees were located within 60 minutes of an existing VISN 3 primary care facility. There are existing non-VA health care resources in areas not covered by the VA health care system that could potentially be used to fill in primary care accessibility for VISN 3 enrollees

With the existing VISN 3 medical centers, over 80% of enrollees reside within two hours of VA acute care services. Approximately 99% of enrollees reside within a four hour drive time of VHA tertiary care.

In FY2010, 95.25% of the 350,055 VHA enrollees were located within 30 minutes of an existing VHA facility that provides primary care. This exceeds the 70% VISN enrollee coverage marker recommended by the Capital Asset Realignment for Enhanced Services (CARES) Commission.

Table 9. FY2010 Market Travel Time Access Compared to National Guidelines

Type of Care	Travel Time Guidelines	Market Guideline For % Enrollees Living Within Travel Time	Market Performance		
			Long Island	Metro New York	New Jersey
Primary Care	30 minutes – Urban	70%	96%	99%	91%
	30 minutes – Rural				
	60 minutes – Highly Rural				
Acute	60 minutes – Urban	65%	97%	100%	80%
	90 minutes – Rural				
	120 minutes – Highly Rural				
Tertiary Care	240 minutes – Urban	65%	95%	95%	95%
	240 minutes – Rural				
	Community Standard – Highly Rural				

At present there are only two enrollees who reside outside of the primary care access guidelines and one person who lives outside of the acute care guidelines.

Table 10. VISN 3- Access and Time Bands (FY2010)

VISN 3 - Access and Time Bands (FY2010)							
		Enrollees			Patients		
Geographic Locators	Measure	Primary Care	Secondary Care	Tertiary Care	Primary Care	Secondary Care	Tertiary Care
Access	Population Total	64,389	64,389	64,389	32,168	32,168	32,168
Access	Population Within Access Guideline	63,274	63,833	64,389	31,608	31,877	32,168
Access	Population Outside Access Guideline	1,115	556	0	560	291	0
Access	% Within Access Guideline	98	99	100	98	99	100
Access	% Outside Access Guideline	2	1	0	2	1	0
Travel Time Bands (minutes)	0-30 Minutes Travel Time	63,274	50,685	15,898	31,608	25,091	7,606
Travel Time Bands (minutes)	30-60 Minutes Travel Time	989	11,757	38,516	485	6,107	19,461
Travel Time Bands (minutes)	60-90 Minute Travel Time	125	1,633	8,185	75	803	4,212
Travel Time Bands (minutes)	90-120 Minutes Travel Time	0	313	1,528	0	167	750
Travel Time Bands (minutes)	Greater Than 120 Minutes Travel Time	1	1	0	0	0	0

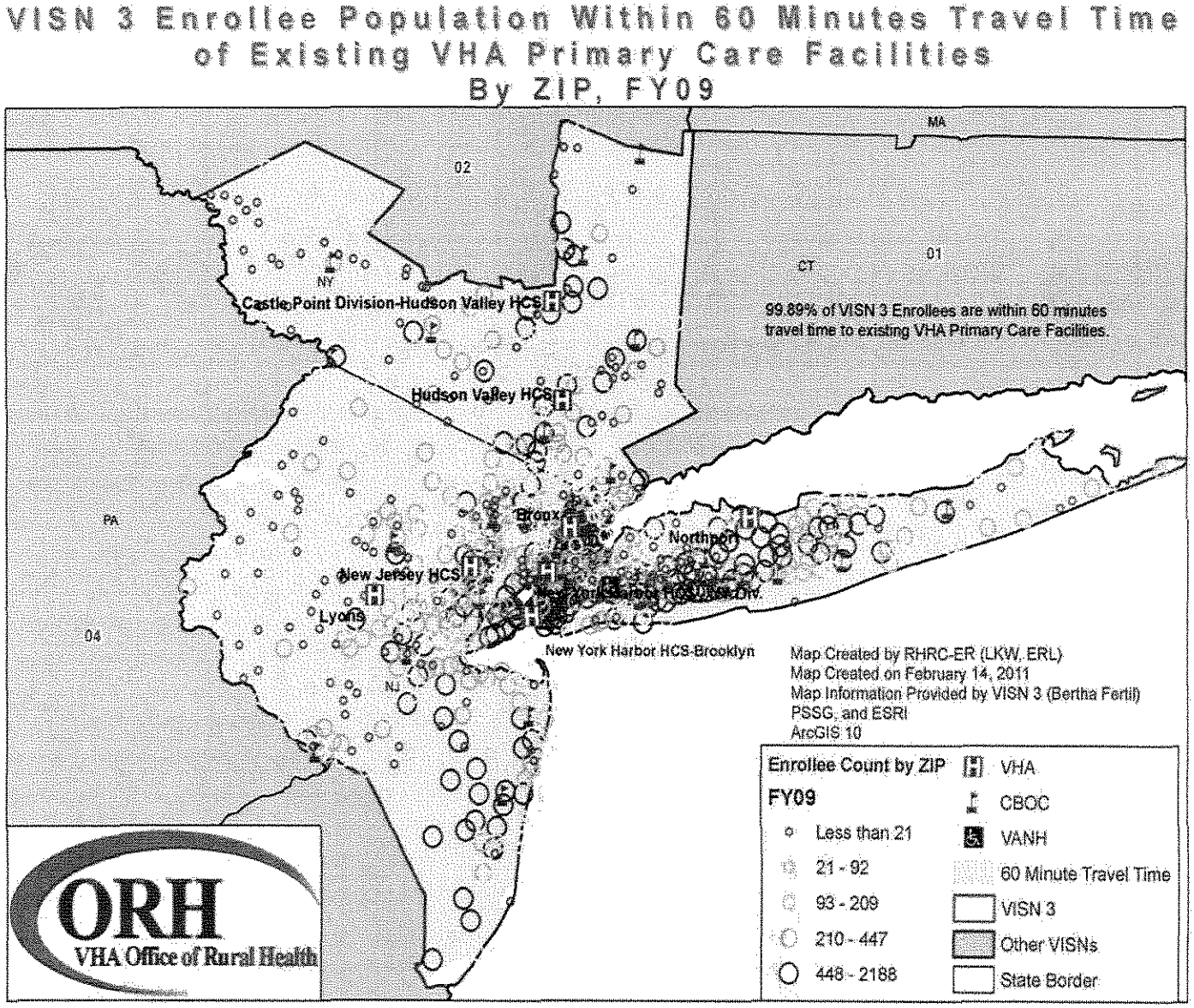
Overall, geographic access for VHA enrollees in VISN 3 is excellent – exceeding 95% coverage in travel time to primary (30 and 60 minutes), acute (120 minutes), and tertiary (240 minutes) care. That geographic coverage is excellent does not imply that there are not access issues in this Network. There are multiple domains involved with 'access' to health care including the ability to drive (cognitive impairments, lack of social support), affordability (cannot afford to pay for gas or public transportation), acceptability (nearest facility does not provide the type of care needed or the facility is in a dangerous area), accommodation (facility is not open after hours or weekends and patients cannot take time off work, arrange for child care, etc), as well as many other confounders to VHA patients' access.

Maps 1-3 identify areas in VISN 3 where there are gaps in primary, acute and tertiary care respectively. Each map will show that the gaps in access to care in VISN 3 are negligible

Geographic Access Assessment Highlights – Gap Analysis

Geographic Gap Analysis

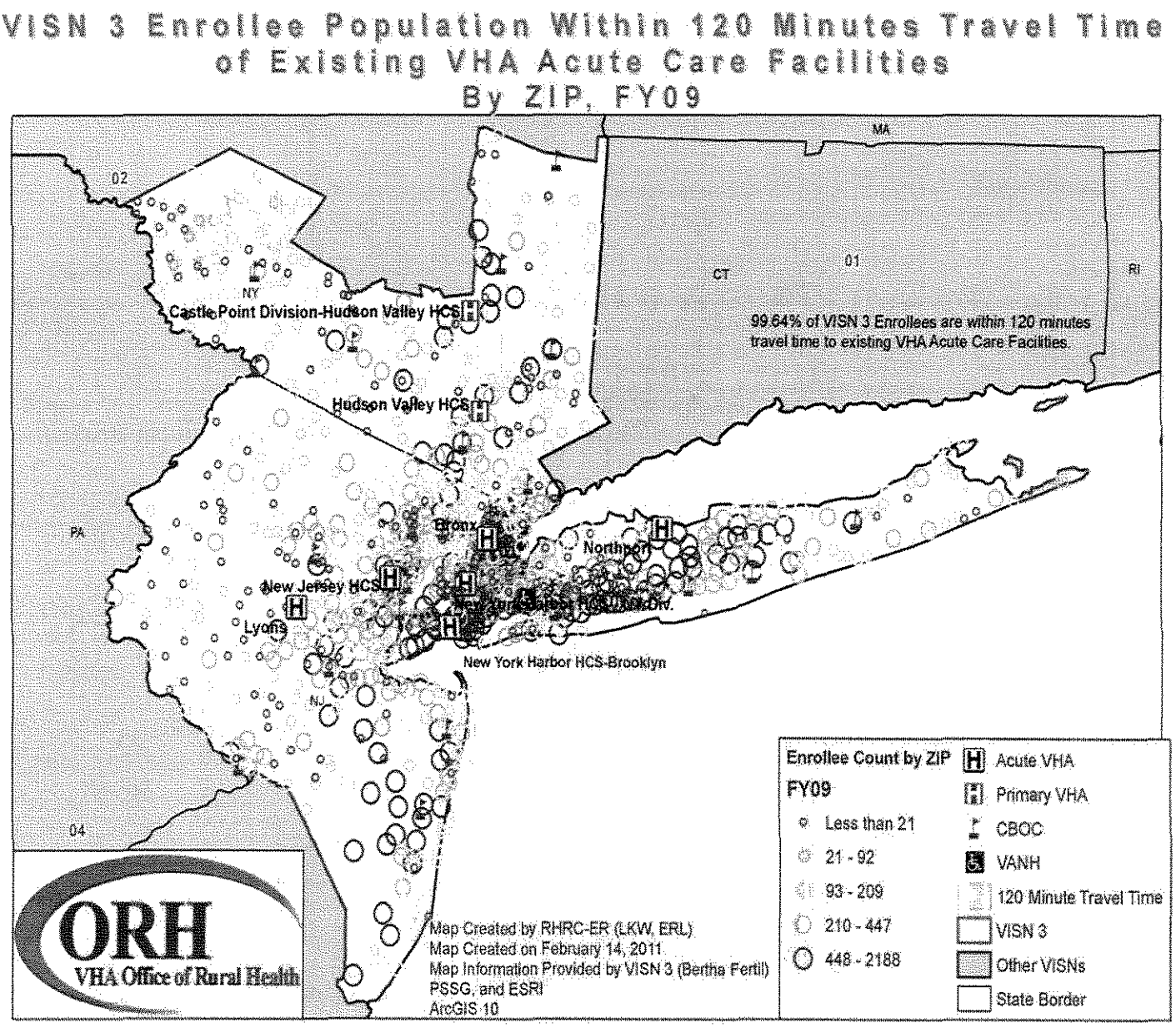
Map 1: VISN 3 Enrollee Population Outside 60 Minutes Travel Time of Existing VHA Primary Care Sites, - Gaps by Zip Code, FY09



In Map 1, the coverage to VHA acute care is displayed. As seen, 98% VISN 3 enrollees are within a 60 minute travel time to this level of care. Those in the rural areas have an access time of 93%.

Map reproduced from Cowper Ripley DC, Litt ER (2010). Access to Primary, Acute and Tertiary Care for VHA Enrollees: VISN 3 Geographic Access Assessment, Veterans Rural Health Resource Center – Eastern Region p. 11. See Appendix A for full report.

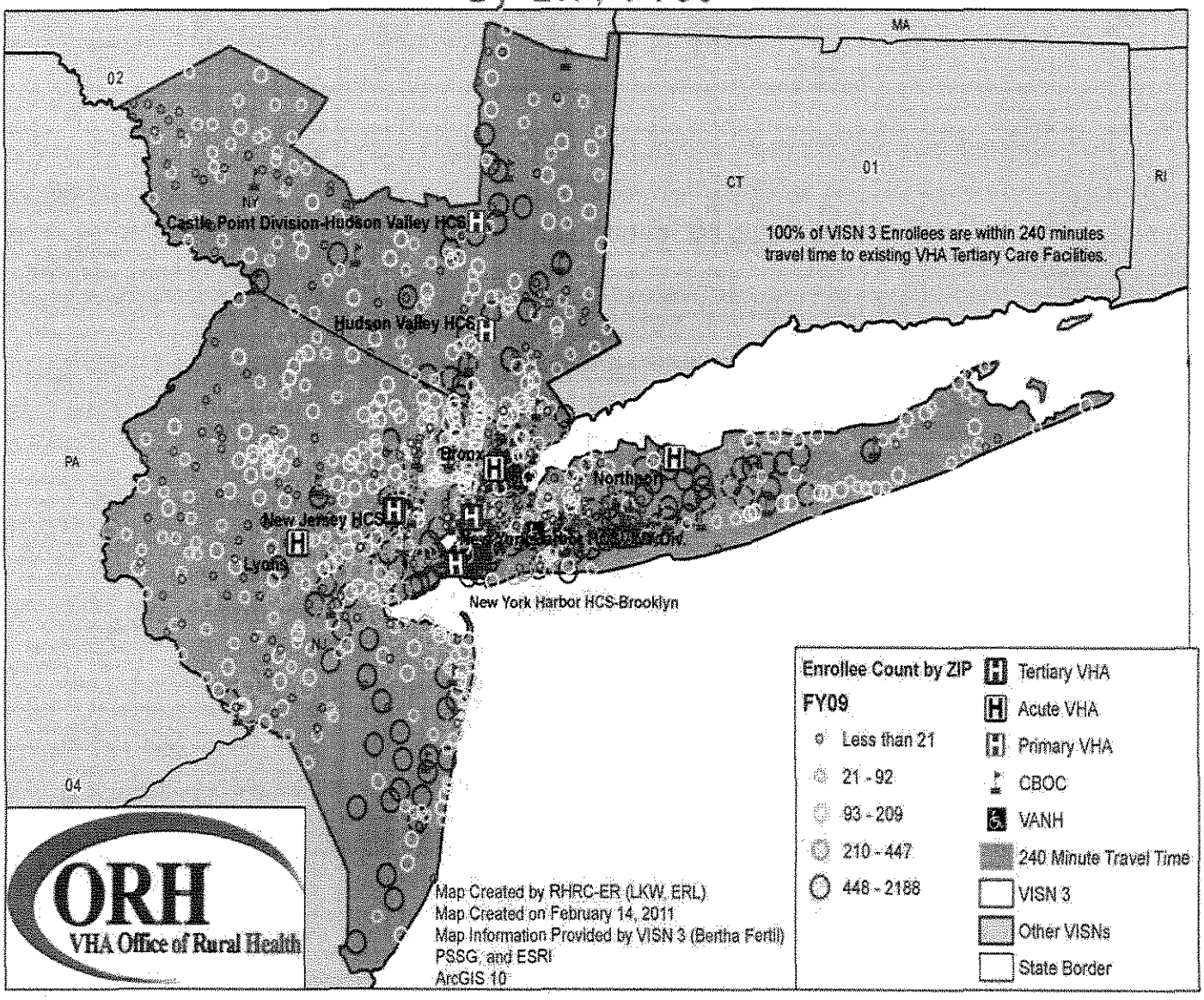
Map 2: VISN 3 Enrollee Population Outside 120 Minutes Travel Time of Existing VHA Acute Care Sites, - Gaps by Zip Code, FY09



In Map 2, the coverage to VHA acute care is displayed. As seen, 99.64% of VISN 3 enrollees are within a two hour travel time to this level of care.

Map reproduced from Cowper Ripley DC, Litt ER (2010). Access to Primary, Acute and Tertiary Care for VHA Enrollees: VISN 3 Geographic Access Assessment, Veterans Rural Health Resource Center – Eastern Region p. 12. See Appendix A for full report.

Map 3: VISN 3 Enrollee Population Outside 240 Minutes Travel Time of Existing VHA Tertiary Care Sites, - Gaps by Zip Code, FY09



In Map 3, the coverage to VHA acute care is displayed. As seen, 100% of VISN 3 enrollees are within a three-hour travel time to this level of care.

Map reproduced from Cowper Ripley DC, Litt ER, Wilson LK (2010). Access to Primary, Acute and Tertiary Care for VHA Enrollees: VIS 3 Geographic Access Assessment, Veterans Rural Health Resource Center – Eastern Region p. 13. See Appendix A for full report.

Resources

Government Resources

Local and State Government

Suffolk County (County Seat)

New Jersey Department of Health

- New Jersey State Office of Rural Health

New York State Department of Health

- Office of Rural Health

New York State Veteran Homes

- St. Albans, NY
- Montrose, NY

New York City Department of Health

Federal Government

United States Department of Defense

- McGuire Air Force Base
- West Point Military Academy
- Fort Hamilton

United States Department of Health and Human Services

- Indian Health Services

Vet Centers

VISN 3 continues to have a strong working relationship with all 12 of the Vet Centers within its catchment area.

- Middletown Vet Center, Middletown, NY
- Brooklyn Veterans Resource Center, Brooklyn, NY
- Staten Island Vet Center, Staten Island, NY
- Manhattan Vet Center, New York, NY
- Harlem Vet Center, New York, NY
- Babylon Vet Center, Babylon, NY
- White Plains Vet Center, White Plains, NY
- Bronx Vet Center, Bronx, NY
- Queens Vet Center, Woodhaven, NY
- Newark Vet Center, Bloomfield, NJ
- Jersey City Vet Center, Secaucus, NJ
- Trenton Vet Center, Ewing, NJ

Veteran Services Organizations

Within New York State there are over a total of 100 veteran services organizations and agents. However, only one in VISN 3's catchment area is formally recognized and accredited, National Amputation Foundation, Incorporated.

Within New Jersey State there are over a total of 50 veteran services organizations. However, only one in VISN 3's catchment area is formally recognized and accredited, New York Department of Military and Veterans Affairs.

Resources

Community Resources

Within the rural and urban areas of New York and New Jersey Veterans and community members have access to numerous food banks, pantries and shelters ran by both public and private non-profit organizations. At our Montrose facility in Hudson Valley VISN 3 has both a shelter (see special programs) and food program.

Partnerships

New York City Department of Homeless
New York Homeless Coalition

Suffolk County Seat
Shinnecock Nation
Poospatuck Reservation

United States Department of Veteran Affairs

- Veteran Benefits Administration
- National Cemeteries Administration

United States Department of Labor

- New York Regional Office
- New Jersey Regional Office

University Affiliations

- University of Medicine and Dentistry of New Jersey
- Robert Wood Johnson School of Medicine
- State University of New York – Stony Brook
- New York University School of Medicine
- State University of New York – Downstate
- Mount Sinai School of Medicine School
- Columbia University College of Physicians and Surgeons
- Hospital for Special Surgery
- Weill Cornell School of Medicine

ORH Funded Projects

ORH Funded Projects

VISN 3 has been in partnership with the VHA Office of Rural Health since 2008. Through this partnership VISN 3 has in 2008 was able to expand its home based primary care services into the rural areas of the northern tier of Hudson Valley and northwestern frontier of New Jersey (2008). During this same time VISN 3 was able to expand with the help of ORH funds its telehealth and teleretinal services in the rural areas located in New Jersey, Hudson Valley and Long Island (2008). In 2009, this partnership was instrumental in assisting the VISN in establishing a rural CBOC in Riverhead, Long Island. The Riverhead CBOC is a key service provider for veterans residing in the eastern end of Long Island. In addition, through its mobile clinic, the Riverhead CBOC serves the Veteran population of the Shinnecock Indian Reservation, Poospatuck Indian Reservation and the Suffolk County Correctional Facility. Also, in 2009 ORH funding was instrumental in helping the HBPC program integrate telehealth services at the Monticello CBOC.

Currently, in the FY2010-2011 cycle the ORH partnership with VISN 3 is making it possible for HBPC program to begin to expand into Dutchess County and Port Jervis, the other two rural areas in Hudson Valley and to continue its northern tier of Hudson Valley and northwestern frontier of New Jersey expansions.

VISN Projects FY 2010-2011

Home Based Primary Care (HBPC) Expansion	Dr. Joanne Malina	Primary ORH Focus Area	Primary VRHAC Guiding Principle
Home Based Primary Care Expansion			

The expansion of the HBPC program increases access to rural veterans in the following manner:

- Primary care and mental health services with multidisciplinary involvement for individual patients
- Direct communication/consultation with providers at the medical center/remote location by utilizing video conferencing technology
- Tele-health technology

The geographic regions served by the expansion of Home Based Primary Care programs are within two of VISN 3 markets – Metro New York and New Jersey. In Hudson Valley the following areas are counties are served the rural catchment areas of Orange County, NY, Sullivan County, NY, & Dutchess County, NY. In the New Jersey market the following counties were served: Warren County, NJ, Hunterdon County, NJ, Sussex County, NJ & Mercer County, NJ. All of the counties served are located in Metro New York and New Jersey markets, and coordinated out of Hudson Valley HCS CBOC located in Monticello, N Y are 80% rural.

Expansion of Rural CBOC and Community Collaboration	Joanne Anderson, NP	Primary ORH Focus Area	Primary VRHAC Guiding Principle
Riverhead CBOC & Mobile Clinic			

This program was designed to bring a continuum of services to underserved veterans in our catchment area by locating the community based Home Based Primary Care (HBPC) program and mobile clinic within a VA designated rural community based outreach clinic (CBOC). With the Riverhead CBOC as the collaborative partner the HBPC program, mobile clinic and telehealth services will worked closely with the rural staff to bring services to underserved veteran population living in rural areas and promote the goal of maintaining veterans in their home and community.

The geographic region served by the expansion of the Riverhead CBOC is the most eastern end of Long Island. The other regions served are within the Shinnecock Indian Reservation, the Poospatuck Indian Reservation and the Suffolk County Correctional Facility.

Best Practices and Innovations

VISN 3 is leading the nation in the areas of palliative care, homeless alleviation, pharmaceutical research and access as well as developing new methods of health care delivery. Below are some of the innovations and best practices that have emerged from VISN 3 staff and partnerships

Operation Home: VISN3/NYC Partnership to end Veteran homelessness

- Memorandum of Agreement between VISN 3 and NYC Department of Homeless Services (DHS) (Dec. 06).
- Opening multiservice center operated by NYC Department of Homeless Services (DHS) and VA staff.
- VHA-DHS task force convened creating "Operation Home"
  - Develop processes for Veterans to quickly and effectively access continuum of homeless services.
  - Achieved goal of moving 100 Veterans from shelter to transitional housing in the first 100 days of the initiative.
  - Connected More than 1,000 homeless Veterans to health care and homeless services.
  - Expanded to include additional transitional housing and more than 1,000 H.U.D. vouchers for permanent housing.
  - Placed more than 800 Veterans in permanent housing through this initiative to date.

The VISN 3 Palliative Care Program: A national VA best practice

- Hallmarks of the program include:
  - Partnerships with community hospice on national, state, VISN and regional levels
  - Provides leadership, training and mentorship to VA's and VISN's throughout VHA
  - Major focus on education and outreach to Veterans
- Quality outcomes since 2002 include:
  - Increase in hospitalized Veterans who died that have had a palliative care consult from 23% to 74% (projected) for 2009
  - Development of standardized electronic palliative care consult to assure all critical elements are addressed
  - Implemented Bereaved Family Survey on care provided at end of life – results identified an increase in emotional support, spiritual support and education provided before death by the Palliative Care Teams
  - Initiation of Palliative Care Comfort and Communication Bundle in the ICU
- Access outcomes since 2002:
  - Increase in annual home hospice referrals from 177 to 359 (projected) for 2009
  - Exceeded performance measure for ADC for VA-paid home hospice

Health Care Simulation Center

- Provides health care education to trainees in simulated settings
  - Existing models on simulator include:
    - Placement of central and arterial lines and performance of thoracenteses and paracenteses
    - Basic airway management skills
    - Rapid response and cardiac arrest management
    - Management of shock and chest pain
  - Future plans include:
    - ICU nurse recognition of ventricular arrhythmias
    - Mock "codes"
    - Anesthesiology/surgery/nursing team crisis training

Centralized Pharmacy Call Center: Providing technical and professional assistance to Veterans' medication needs

- Centralized Pharmacy Call Center staffed by PharmDs and Pharmacy Technicians that provide technical and professional assistance to Veterans for their medication needs
  - Serves Veterans by:
    - Assisting with refills
    - Educating Veterans about their medications, side effects, dosing questions
    - Assuring appropriate follow-up care
  - Supports providers by:
    - Identifying potential drug side-effects/interactions and alerting providers
    - Assisting Veterans in complying with medication schedules
  - Supports VISN PBM by:
    - Identifying major variations in pharmacy practice across VISN
    - Identifying common medication questions/problems needing improved process

Network Prosthetics Service: Fabricating state-of-the-art devices that exceed quality standards and Veteran expectations

- Since 1996, VISN 3 has successfully operated the first consolidated prosthetics services, which fabricates state-of-the-art devices for VHA and DoD that exceed quality standards and Veteran expectations.
- Responsible for Telehealth devices, custom wheelchairs, custom limbs, home oxygen, eyeglasses and automobile adaptive equipment
- VISN 3 fabricates over 90% of all artificial limbs in-house, and supports several other VISNs.
- VISN 3 was first to test and evaluate the DEKA experimental upper extremity prosthesis – mimicking the natural arm.
  - Next step is to partner with VISNs 8 and 22 in teaching and evaluating with Veteran patients.

Technology Assessment & Requirements Analysis (TARA): Providing information to make informed decisions and develop priorities for imaging equipment needs

- TARA provides information to make informed decisions and develop priorities for imaging equipment needs:
  - Modeled after Army process
  - Reviews current facility imaging equipment inventory
  - Examines imaging equipment utilization
  - Identifies new and replacement equipment needs
  - The results of TARA implementation
    - Standardization
    - Cost avoidance

Conclusions

Conclusions

Through the continued hard work of VHA VISN 3's dedicated staff, the VA has a recognizable footprint within the greater New York/ New Jersey area. Comprised of five medical centers, 32 community-based clinics, , two domiciliary, and three community living centers, VISN 3 carries out this responsibility through the efforts of nearly 12,000 employees, in almost 200 occupations, who are in service to over 184,499 of our nation's Veterans. In addition, with its strong connection with 12 Vet Centers, long standing academic affiliations and numerous community partners, VISN 3 ensures that the care provided to veterans is of the highest quality, comprehensive and accessible.

Advances in medicine have significantly changed the delivery of care in all health care sectors. Medical technology and pharmacology advances have shifted health care delivery from an inpatient to outpatient setting, significantly reducing the amount of inpatient acute care requirements. VA as well as the entire health care community has reduced and/or changed its inpatient capacity and shifted resources to expand its outpatient services. The VA's current Veteran centered care initiative will further decrease demand for inpatient services by improved coordination of care, patient monitoring, and early intervention to avoid the need for hospitalization.

This is an extremely important effort as the veterans who use the services of the VA in VISN 3 are older and present with more complex medical conditions. In addition, as veterans from highly rural areas of the United States seek care as VISN 3 facilities, we have to begin to think differently care to how care is provided and how we provide that care.

There are several ways in which the VISN 3 would be able to be proactive in address the issues it will face in the future. Below are a list of recommendations to mitigate the enrollment and patterns of care changes faced by VISN 3:

- **There needs to be a change – structure, process and outcome – in the way care is provided**

- **Find ways to attract Veterans.**
  There are over 20,000 rural veterans residing the VISN 3 catchment area. However, only above 9,000 use VHA services to obtain their care. Of the more than 11,000 who are either not enrolled or enrolled, but do not use VHA services, an effort needs to be made to reach out to them.

- **VISN 3 should endeavor to modernize its facilities to provide state of the art primary and specialty ambulatory care, specialized geriatric inpatient care, and psychosocial domiciliary care in order to meet the needs of its rapidly aging veteran population.**
  As the veteran population decreases in New York, the VA should look into rightsizing its footprint in order to provide quality care in the most appropriate of settings.

- **Develop Centers of Excellence where other VISNs that have difficulty attracting physician staff would be able to use the services of available VISN 3 medical staff.**
  Currently, VISN 3 has excess capacity in some physician services. These resources could be pooled together and classified so that other facilities in need of them could access these services in order to provide immediate care for their patients.

Next Steps

As the patient landscape within the VISN 3 changes we continue to champion the enhanced coordination of care through preventive assessment and intervention. Moving into telehealth and the Systems Redesign (SR) model where patients will be seen based on need instead of a pre-determined schedule, we remain forward looking in our efforts to provide the high quality of care. Thus, facilities may have the ability to see more patients with existing staffing. The Systems Redesign model is also being adopted for business processes including Human Resources, in attempts to decrease vacancy periods. In each of these efforts staff members are being developed to integrate technology in the everyday practice of health care. To this effort, VISN 3 is also training its workforce to be more knowledgeable of new innovation in medicine and to be readily adaptable to environmental changes. In addition, staff members are incorporating into their daily practice patient centered care team initiatives that will enable them to better serve the Veterans and their families in a manner that is more comprehensive and integrates the Veteran's perceptive in his or her care. To this end, the VISN 3 Rural Health Workgroup was developed.

The workgroup works to ensure that the future health needs of VISN 3's rural communities are met in a way which promotes individual well-being. The workgroup is in the process of developing a plan that incorporated the VISN's and ORH's planning priorities.

The plan is grounded in strong evidence from the successes we have been able to accomplish from our current rural health projects, VISN best practice and community views of current and future need. It identifies the need to rethink the ways primary and community services are provided in rural areas.

Three key themes have emerged which are also common to other strategic developments in rural areas:

- Access to services. Improving access to services across the spectrum from emergency to routine services.
- The need and opportunities for closer service integration. Integrated service models, workforce planning and systems are necessary to improve service provision and ensure effective use of resources and skills within communities.
- Community cohesion and engagement. This is an important resource and is of immense potential to rural and urban settings. Community cohesion, engagement and ownership needs to be a key element of service planning.)

The workgroup will be focusing on the following initiatives:

CBOC Expansion and Re-Alignment based on Secretary's New Care Continuum Model
The workgroup will continue to work to diversify the services and expand access hours of VISN 3's rural CBOCs. The workgroup will also work with the VISN Planner to ensure that the rural CBOCs are re-aligned based on Secretary's New Care Continuum Model

- Port Jervis
- Pine Plains
- Monticello
- Riverhead

Expansion of CBOC Telehealth Services
The expansion of CBOC Telehealth Services will provide the resources needed to implement and enhance focus on care for Veterans in rural with both chronic medical and high risk mental health conditions. Services will provide treatment for Veterans who require assistance managing their chronic medical conditions, monitor medication compliance and

medication benefits, and engage combat Veterans suffering from post-traumatic stress disorder and/or substance abuse.

Expansion of Home Based Primary Care Program in Additional Rural Areas
In response to the anticipated growth of the veteran population with chronic disabling diseases, VISN 3 is expanding its Home Based Primary Care (HBPC). The focus of the expansion will be a home care program that specifically targets individuals with complex chronic disabling disease, with the goal of maximizing the independence of the patient and reducing preventable emergency room visits and hospitalizations. VISN 3 understands that HBPC programs provide comprehensive longitudinal primary care by an interdisciplinary team in the homes of veterans with complex chronic disease, who are not effectively managed by routine clinic-based care. The expanded HBPC targets persons with advanced chronic disease, rather than remediable conditions. HBPC provides comprehensive care of multiple co-morbidities, rather than problem-focused care. HBPC is delivered by an interdisciplinary team, rather than one or two independent providers.

Integrating Palliative Care into Services Offered in Rural Communities
VISN 3 will use a multidisciplinary care management approach to integrate palliative care into the rural communities. The program is designed to facilitate the transition from acute to palliative care during the last 12 months of life with the goal of improving quality of life through the provision of symptom control and pain relief, emotional and spiritual support, and patient education in a setting of the individuals choosing.

Increasing Staff Development for Staff in Rural Areas
This effort is to develop some solutions for improving staff development in rural settings, including: (1) linking rural staff with programs within VHA and outside experts through V-tel and live meetings; (2) encouraging staff ownership of training for planning and delivering training sessions; (3) improving on-the-job performance by training staff to apply the concepts immediately to real-life situations at the CBOC; and (4) fostering stronger collaboration among rural staff through cooperative learning projects. Distance education and communication technologies can give staff in rural communities the opportunities to upgrade their skills when more conventional forms of training are not available to them.

Further Development of Our Community Partnerships
The Workgroup will work with the VISN Outreach Committee to continue to develop partnerships with public and private organizations within our rural areas.

Conducting Studies in the following areas:

- Women and Rural Health
- Mental Health and Rural Health

References

References

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5. Health Care Planning Model
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7. VISN 3 Geographic Access Analysis – Full Report
8. Rural Health Briefing Book
9. Office of Rural Health Strategic Plan
10. VISN 3 Strategic Plan
11. VSSC Strategic Planning Categories Cube
12. VSSC OEF/OIF Dashboard
13. VSSC Women Dashboard
14. VISN 3 Special Programs Report
15. 2010 VISN 3 Workforce Strategic Planning
16. Ashton CM, Weiss TW et al. "Changes in VA hospital use 1980-1990." Houston Center for Quality of Care and Utilization Studies, VA Medical Center, TX 77030.

DEPARTMENT OF VETERANS AFFAIRS
NORTHPORT, NEW YORK

RURAL HEALTH COORDINATOR
Nurse III
FUNCTIONAL STATEMENT

Qualifications:

1. Current, active, full and unrestricted registration as a graduate professional nurse.
2. BSN from a NLN accredited program; with three years of successful nursing practice, or Master's degree in Nursing or related field with a BSN from a NLN accredited program; with two years of successful nursing practice.
3. Current Basic Life Support (BLS) training. Certification in related specialty, preferred
4. Knowledge of principles and techniques of fiscal and/or business management; strategic planning, monitoring, auditing and evaluating community service programs and/or volunteer management service; the principles and processes of agency administration and operations; basic budgeting and cost accounting processes.
5. Home health experience preferred
6. Minimum two years varied medical/surgical clinical experience as an RN with above average clinical and health assessment skills required.
7. Demonstrated strong teaching skills
8. Excellent skills in interpersonal relations with the health care team and general public; strong/family advocate required.
9. Prepares annual Budgets
10. Monitors and oversees Fund Control Points
11. Excellent skills in interpersonal relations with the health care team and general public;
12. Ability to independently conduct health seminars.
13. Strong computer skills.
14. Collect, develop and analyze data
15. Utilize appropriate clinical indicators and monitoring activities.
16. Creativity, flexibility, strong organizational skills with ability to prioritize and multitask

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RESPONSIBLE TO: The incumbent reports to the Executive Assistant to the Director and indirectly to the Director but largely operates on a day-to-day basis in an independent manner, with full responsibility to keep the supervisor apprised of activities and any issues in need of close collaboration.

RESPONSIBILITIES: Essential Administrative/Supervisory Responsibilities Include:

1. Has direct administrative and professional supervision of 4 staff:
    a) 1 Community Relations Supervisor
    b) 1 Outreach Nurse Practitioner/Mobile Unit Coordinator
    c) 1 Health Screening Nurse Practitioner
    d) 1 Outreach Registered Nurse

2. Has service line administrative and professional supervision/accountability for 7 additional staff reporting to intermediate supervisors (a &b above):
    a) 4 Eligibility Staff
    b) 2 Medical Support Assistants
    c) 1 Mobile Unit Driver/Medical Support Assistant
3. Fiscal Responsibilities:
    a) Manages all financial processes, procedures, and reconciliation for multiple federal grants to ensure fiscal accountability to Chief Financial officer and the Office of Rural Health (ORH).
    b) Prepares monthly and annual reports evaluating various funding activities;
    c) Monitors progress of all required applications and RFPs to insure deadlines are met.
    d) Prepares and presents financial reports to facility leadership and Chief Financial Officer.
    e) Manages the fiscal activity and compliance reporting of multiple programs' receiving ORH funding.
    f) Reviews and analyzes requirements for multiple federal
    g) Reviews new federal policies that relate to funding grants and supervises the implementation of those policies.
    h) Develops monitoring tools and works collaboratively with Fiscal Service regarding periodic auditing and annual on-site compliance visits
    i) Provide support for federal site visit and fiscal audits; makes arrangements for and accompanies federal aid inspectors to insure that necessary documents are available for audit.
    j) Forecasts future funding requirement when required.

4. Has clinical duties which are carried out throughout the medical center, community based outpatient clinics (CBOCs), mobile unit and other settings, including all clinical and other patient care areas involved with providing diagnostic and treatment services to veterans. The role of the Rural Health Coordinator (RHC) is to assess the need for services for veterans and implement and oversee services as they are carried out. The RHC executes comprehensive planning for health issues that improves the overall quality of care provided to veterans and achieves program goals and outcomes
5. The RHC will oversee the regulatory requirements on the Mobile Medical Unit and in Health Screening Clinic to ensure the external standards such as the External Peer Review Program (EPRP), Occupational Safety and health Administration (OSHA) and the Joint Commission (JC) are met.

6. Plan for the establishment of new specialty or primary programs and the expansion of existing programs to meet the needs of rural veterans who are currently seeking care within the facility and the CBOCs.
7. Consults with VA specialty services within a comprehensive, integrated health care network; coordinate medical and/or surgical health care services and support psychological care and mental health needs for rural veterans.

8. Collects and monitors reliable, current data on the care of rural veterans including patient workload statistics (demographics, specialty visits, stop codes, Current Procedural Terminology (CPT)-4, International Classification of Diseases, 9th Edition (ICD-9) and Decision Support System (DSS) Codes).

9. Keeps current with Office of Rural Health (ORH) Policies and Procedures. Coordinates facility level actions with coordination of the VISN 3 Rural Health Consultant.

10. Maintains resource allocations within Rural Health Initiative authority:
    a) Ensures efficient operation of the Community Relations and Mobile Unit Program
    b) Prepares annual Budgets
    c) Monitors and oversees 2 Fund Control Points
    d) Seeks additional resources as warranted, with use of data-driven criteria in support of all requests
    e) Respond to general ORH Requests for Proposals (RFPs) which improves the general healthcare of rural veterans
    f) Respond to targeted ORH RFPs that solicit proposals in specific program areas which will expand and/or develop programs that address ORH strategic goals
    g) Adhere to the RFP timeline and requirements.
    h) Coordinate budgetary oversight of funds with Fiscal Service and CFO
    i) Coordinate funding with specific facility level teams and personnel

    j.)Submit data regarding proposal measures to ORH on a quarterly basis and more frequently as needed.

11. Coordinates outreach programs with the Community Relations Supervisor to identify and locate rural veterans in need of health care services. Outreach is to include extensive communication and coordination with state veterans' offices and other social services agencies in the geographic area of Northport VAMC.

12. Communicates as necessary and participates in executive-level decision-making at the facility level that will impact the care of rural veterans. Consultation with the Primary Healthcare Team, Mental Health Teams and Specialty Care Services is expected in an effort to provide greater understanding of psychosocial dynamics and special concerns of rural veterans.

13. Executes supervisory responsibilities which include:
    a) Management of Human Resource aspects of service line operations, including hiring and disciplinary action, Labor/Management relations, performance appraisals, and professional boarding procedures for various disciplines.
    b) Primary responsibility for all aspects of administration both within Rural Health/Community Relations/Mobile Unit Departments and in the relationship of Rural Health to the VA Medical Center at large.

c) Monitors and reports to facility and VISN leadership regarding status of Rural Health Performance Measures for the Medical Center, with preparation and implementation for any corrective actions necessary.

14. Supports the management of the Mobile Unit Program in conjunction with the Mobile Unit Coordinator for all mechanical and clinical aspects.
    a) Ensures Environment of Care standards are met according to VA Medical Center guidelines.
    b) Ensures that the coordination of clinical care occurs within the guidelines of VA Medical Center Infection Control policies and procedures and Emergency protocols and procedures.
    c) Ensures that the coordination of clinics utilize scheduling mechanisms for outpatient clinics.
    d) Ensures that routine, urgent and emergent mechanical repairs occur with the guidance of the Motorpool Manager and Chief of Environmental Management Services (EMS).
15. Oversees Program Evaluation:
    a) Monitors outcome measurements within programs using data-driven quality assurance processes.
    b) Is responsible for timely completion of all program evaluations and documents required by the Medical Center or healthcare system, VISN, and ORH, ensuring compliance with appropriate accrediting bodies (such as Joint Commission Organization, Inspector General Association) and monitoring entities (such as ORH) as appropriate.
    c) Consults with and serves as a resource for other service lines and facility leadership concerning the need for the development of mental health services.

16. The Rural Health Coordinator implements educational programs as necessary.
17. This position may require travel between the main campuses and CBOC's

PRACTICE DIMENSION (Practice, Ethics, Resource Utilization):

Provides leadership in the application of the nursing process to client care, organizational processes and/or systems, improving outcomes at the program or service level. Provides leadership in identifying and addressing ethical issues that impact clients and staff, including initiating and participating in ethical consultations. Manages program resources (financial, human, material or informational) to facilitate safe, effective and efficient care).

a. Applies the nursing process (assessment, diagnosis, outcome identification, planning, implementation, and evaluation) to systems or processes at the core team level to provide veteran-driven holistic care.
b. Provides nursing and medical services to Veterans and their families/caregivers in both individual and group settings.
c. Emphasizes health promotion and disease prevention; diagnose and manage acute, chronic and episodic illnesses.
d. Teaches and counsels Veterans, families/caregivers and groups.

e. Collects and analyses data to identify opportunities for improvement and shares results in a manner that is informative and useful in decision making processes to facilitate continuous improvement and to support organizational goals.

f. Designs educational programs, educating and encouraging patient self-management.
g. Maintains an ethical practice according to the code of ethics as outlined in the employee bylaws.
h. Serves as a resource and advocate for protecting the rights of patients/families/staff.
i. Maintains privacy and confidentiality of all patient information, including electronic, print and conversations.
j. Collaborates with other disciplines and community resources to insure continuity of care.
k. Supports the facility's EEO/affirmative action programs by executing assigned duties and responsibilities in a professional manner.
l. ADP Security: The incumbent must protect printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, Federal regulations, VA statutes and policy, and VHA policies. The employee must protect the data from unauthorized release or from loss, alteration, or unauthorized deletion. The employee must follow applicable regulations and instructions regarding access to computerized files, release of access codes, etc., as set out in the computer access agreement that the employee signs.
m. Promotes cost effective use of resources, safety of care delivery and participates in the established system to measure the use of resources provided.

PROFESSIONAL DEVELOPMENT DIMENSION (Education/Career Development, Performance):

Implements an educational plan to meeting changing program or service needs for self and others. Maintains knowledge of current techniques, trends and professional issues. Uses professional standards of care and practice to evaluate programs and/or service activities.

a. Demonstrates ability to work effectively with patients, significant others, professional and supportive personnel who provide patient/supportive care.

b. Demonstrates the ability to participate in interdisciplinary groups to establish relationships with professional and/or other health related groups within the community.

c. Participates in the development, implementation, review and/or revision of practice standardization tools to insure integration of "best practices".

d. Assures compliance with directives, policies, standards and SOP's.

e. Assures compliance with external regulatory requirements

f. Identifies and resolves system issues which negatively impact the plan of care

g. Facilitates open exchange of ideas between peers, co-workers, management; creatively respond to and evaluates suggestions for improvement.

h. Plans problem-solving strategies with other disciplines.

i. Initiates and implements collaborative practice.

j. Establishes patient/family teaching and/or counseling for specific patients.

k. Acquires and maintains current knowledge relevant to the standards, principles, practices and techniques associated with Quality and Performance Improvement.

l. Integrates knowledge relevant to the current research, standards, principles, practices and techniques associated with Quality and Performance Improvement into own practice.

m. Assesses the learning needs of units'/clinical programs' staff related to quality and performance improvement.

n. Collaborates with Education Services and others to plan, implement, and evaluate staff training based on expressed quality/performance improvement learning needs.

o. Maintains knowledge and skills to maintain expertise in area of practice.

p. Accepts personal responsibility for ongoing professional development related to competence, including but not limited to, continuing education related to prescriptive authority and health management.

q. Participates in professional organizations, working to support agendas that enhance high quality, cost-effective health care.

r. Mentors, educates and disseminates information regarding current clinical practice issues.

COLLABORATIVE DIMENSION (Collaboration, Collegiality):

Uses group process to identify, analyze and resolve care problems. Coaches colleagues in team building. Makes sustained contributions to health care by sharing expertise within and/or outside the facility.

a. Participates in community organizations and coordinates educational related activities

b. Demonstrates professional behavior (i.e. respect, civility, ability to accept constructive criticism), effective communication and interpersonal skills.

c. Uses team process to identify, analyze and resolve care problems. Communicates appropriately and regularly with team members for continuity of care with patient's life plan.

d. Maintains a work environment that honors diversity.

e. Shares clinical/professional expertise with others within the facility, and outside the facility with community groups, network and VHA staff.

f. Collaborates with peers, physicians, and other health care providers in the management and coordination of health care needs of the patient.

g. Assists individuals and families in developing problem solving abilities regarding health care and use of appropriate community health resources.

SCIENTIFIC INQUIRY DIMENSION (Quality of Care, Research):

Initiates interdisciplinary projects to improve organizational performance. Collaborates with others in research activities to improve care. Evaluates and improves the quality and effectiveness of nursing practice and health care delivery.

a. Provides management, teaching, consultation and support to individuals and their families with chronic stable illnesses regarding medications, therapeutic nutrition, environment, psychosocial, economic, adaptive and rehabilitative needs and/or problems.

b. Demonstrates a leadership role in that includes innovation, consultation, advocacy, accountability and responsibility for improved health services to clients and families.

c. Initiates/participates in quality improvement activities that result in improved outcomes.

d. Actively collaborates with interdisciplinary and non-clinical providers in the assessment, planning and implementation of the case management processes.

e. Identifies and resolves system problems which impact the plan of care.

f. Ensures the collection of data leading to the identification of patterns and/or trends, and ways to modify and/or improve care practices in order to facilitate accomplishment of quality patient care.

g. Incorporates research findings into performance improvement activities.

h. Applies research findings as appropriate to improve care.

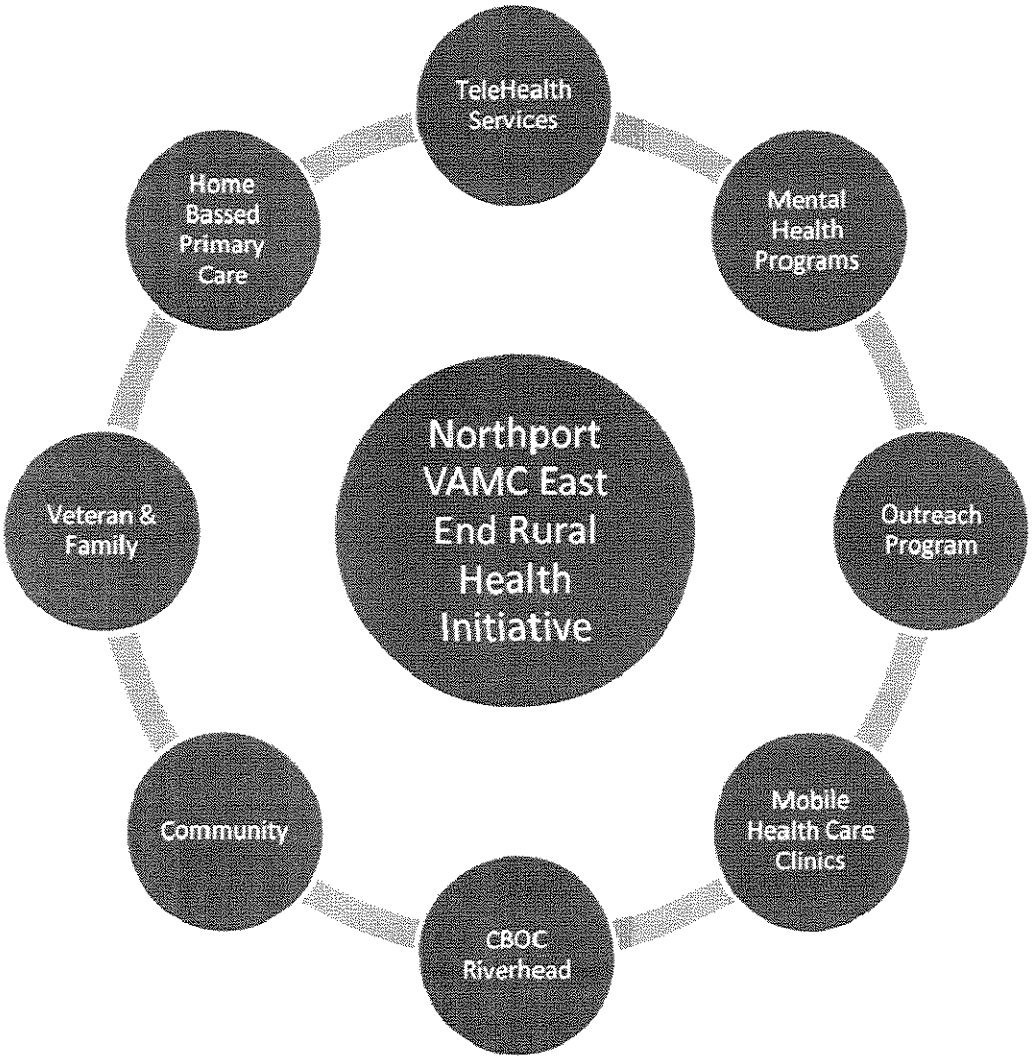
i. Promotes and assists others in the application of findings from research and/or studies.

Philip Moschitta

Director

NORTHPORT VAMC

EAST END HEALTH CARE PROGRAM FY 2010



Integrating, sharing and expanding services in support of health care options for Veterans residing in areas of eastern Long Island, New York.

November 2010

SPECIFIC DUTIES FOR RURAL HEALTH POINT OF CONTACT

1. ***Rural Health***
   - Directly report to the Executive Assistant to the Director and indirectly to the Director.
   - Coordinate facility level actions with VISN 3 Rural Health Consultant
   - Keep current with Office of Rural Health (ORH) Policies and Procedures
   - Respond to general ORH Requests for Proposals (RFPs) which improves the general healthcare of rural veterans
   - Respond to targeted RFPs that solicit proposals in specific program areas which will expand and/or develop programs that address specific ORG strategic goals
   - Adhere to the RFP timeline and requirements.
   - Coordinate budgetary oversight of funds with Fiscal Service and CFO
   - Coordinate funding with specific facility level teams and personnel
   - Submit Quarterly data regarding proposal measures to ORH
   - Communicate with facility level leadership routinely regarding RH issues, concerns and potential growth opportunities. All urgent concerns should be reported in a timely matter.
   - Participate in ORH specific education: national level conferences, regional conferences, VeHU conferences and seminars
   - Coordinate monthly meetings with facility stakeholders and document with meeting minutes.
   - Provide updates to facility staff and employees by conducting presentations at the Director's Monthly Staff Meetings, and through Facility Newsletter
   - Provide updates to non-VA stakeholders such as VSOs and Suffolk County Legislature
   - Supervise Mobile Unit Employees, Community Relations Employees and Health Screening employees. The reporting structure is: the Community Relation Supervisor and Mobile Unit Coordinator report directly to the RH Coordinator.
   - Ensure all Time and Leave issues are addressed in a timely matter as per Human Resources, AFGE and NFEE.
2. ***Community Relations***
   - Oversee scheduling of Outreach events. The direct coordination of all aspects for all events will be by the Community Relations Supervisor.
   - Meet routinely with the Community Relations Supervisor to provide guidance and support for program related issues.
   - Coordinate monthly facility Outreach Council Meetings.
   - Participate in monthly VISN 3 Outreach Meetings.
3. ***Mobile Unit***
   - Oversee use of all facility Mobile Medical Units. The direct coordination of all aspects for Mobile Unit use will be by the Mobile Unit Coordinator.

- Meet routinely with the Mobile Unit Coordinator to provide guidance and support for program related issues.

RH/East End Health Care Program- JoAnne Anderson RN MSN

- This program supports the increased accessibility for health services on the eastern end of Long Island. There are approximately 160,000 Veterans in Suffolk County ,enrollment is approximately 42,000 which is only ¼ of Veterans. Reasons for lack of enrollment is that the Northport VAMC main campus is inconveniently far from existing CBOCs or Main campus.
- Relocation of Westhampton CBOC from secure Air Force Base to central Riverhead CBOC at the Suffolk County Center May 2011
- Expand Riverhead CBOC hours of operation to include evenings, weekends and urgent care modality
- Increase usage of the mobile unit for Wellness programs, POC vesting exams. This is being done by creating a prescheduled route to begin April 2011. Mobile Unit will be scheduled at American legion Halls on the North Fork, South Fork and Shelter Island. Schedule will be posted on Northport webpage.
- Expansion of the Home Based Primary Care Program. Creating a new Teamlet is projected to increase services for additional 100 Veterans with a projected the growth from the 70 Veterans to 200.
- Support the integration of TeleHealth options into care management: 1 Teleretinal camera for Riverhead CBOC, group program participation via Tanndenberg camera, 1:1 sessions using MOVI camera
- Increase networking with 2 Native American Indian tribes: Shinnecock and Poospatuck. Collaborative meeting at Shinnecosk Reservation for 2/25/2011, Elder conference with Tribal Leaders be planned for 2011.
- Increase continuing education programs for all staff at the Riverhead CBOC to support staff working at the top of their licensure.
- Continue Outreach Efforts within communities by participating in community hospital meetings as a "guest" to promote a collaborative relationship with community providers to support the Dual Care concept.

Rural Health Initiative Overview J. Anderson 4/6/2011

1. **What is your role as East End Health Care Coordinator for Northport VAMC?**
   - This is a new position for Northport VA.
   - I have served in this role since November 2010.
   - As a coordinator, I help my facility director manager implement their strategic initiatives. The duties may vary depending on the business needs. Typically the tasks involve administrative or operational duties. The main job task for an administrative coordinator is acting as a liaison between varied departments, outside vendors, and staff members. In order to function effectively, most organizations have a complex hierarchy of individuals and specialists that must work together in order to get things done. Administrative coordinators typically organize, supervise, and facilitate this cooperation.

2. **What is the vision and goals of the Rural Health Initiative?**
   - The mission of VISN 3 and Northport VAMC is to provide an accessible, seamless, continuous and comprehensive system of health services for veterans and other eligible beneficiaries residing in areas of eastern Long Island.
   - VISN 3 and Northport VAMC will become #1 in veteran centered care.
   - Value service, integrity, excellence and teamwork

3. **Describe who our Veterans might be.**
   - Caucasian, African-American, Latino, Asian and Native-American
   - Male and female, of all ages
   - Single, married and divorced, urban and rural
4. **Describe Planning** A market health care planning analysis was used based on the HCPM (Health Care Planning Model) developed by the Office of Strategic Planning and Analysis to provide a uniform VHA approach to planning for market gaps in Veteran health care In FY 2009 VISN planners were asked to identify at least 2 gaps per market and to develop an initiative to address each gap.
   - Looked at all sources of VA delivered care and non-VA Health care supply, community health providers on Long Island
   - Included status of any existing and potential partnering relationships
   - VISN 3 utilized this information to create plans to meet the projected demand and to improve access to primary care and mental health services for enrollees
   - Other programs that may be enhanced by the Rural Health Initiative: HBPC, Telehealth, Mobile Unit Program.
5. Riverhead CBOC is planned to open May 2011. The Westhampton CBOC will not be used once patients have fully transferred over to the new setting.

Promoting innovative solutions to identified barriers to accessing health care!!!!

The Northport VA Medical Center Mobile Medical Unit Program seeks to expand care in all communities on Long Island, New York. VA is working to shift the current health care system from problem-based disease care to one that is personalized, proactive and patient-centered. This change is being accomplished by adapting the VA health care delivery to the changing demographics and needs of veterans of all ages across Long Island.

The Mobile Unit Program is able to provide quality health promotion and wellness programs in the convenience of the local community areas that might otherwise not engage in VA healthcare programs. They are able to bridge the care provided at the medical center and the outpatient clinics offering_wellness programs, informational sessions vaccinations, vesting exams and specific treatments for Veterans and their family members family and community members.

The program has expanded over the past 10 years in fleet size from 1 vehicle to 5.

History

The 2 Mobile Medical Units were purchased with Special Purpose Emergency Management Performance Improvement Funds (EMPIF), the first arriving on station in 1998 and the second in 2009. Both vehicles are 40 feet in length. The older vehicle is a cab and chassis style and is equipped with 2 exam rooms. The second and newer vehicle has 3 exam rooms with a restroom and a computer work station area.

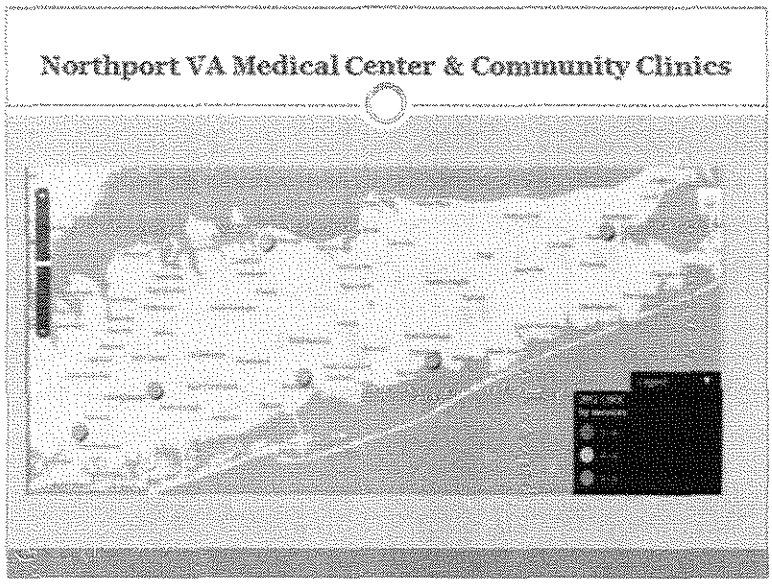
Four years ago in 2010, both vehicles were use used sporadically on a monthly basis to supplement outreach events. The intent was to provide mechanical readiness for emergency use; however it supplemented only a small proportion of outreach events. In October 2010, VAMC Northport embraced the concepts of the Rural Health Initiative and worked diligently to increase access to VHA for veterans residing on eastern Long Island.

The usage for outreach events has increased from one time per month to 2 times per week. A Mobile Unit Podiatry program also operates 3 days per week for a 12 month period. A pilot program started March, 2012 and provided over 554 visits

during the first 6 months. Due to the overwhelming positive response, the program has expanded in 3 phases to a full time program, servicing over 50 veterans per week providing nearly 1200 appointments in 2013 and 1,000 appointments in the first 6 months of 2014... Two podiatrists work with an RN and a medical support assistant 2-3 times per week providing basic podiatric care as well as "Shoe Clinic".

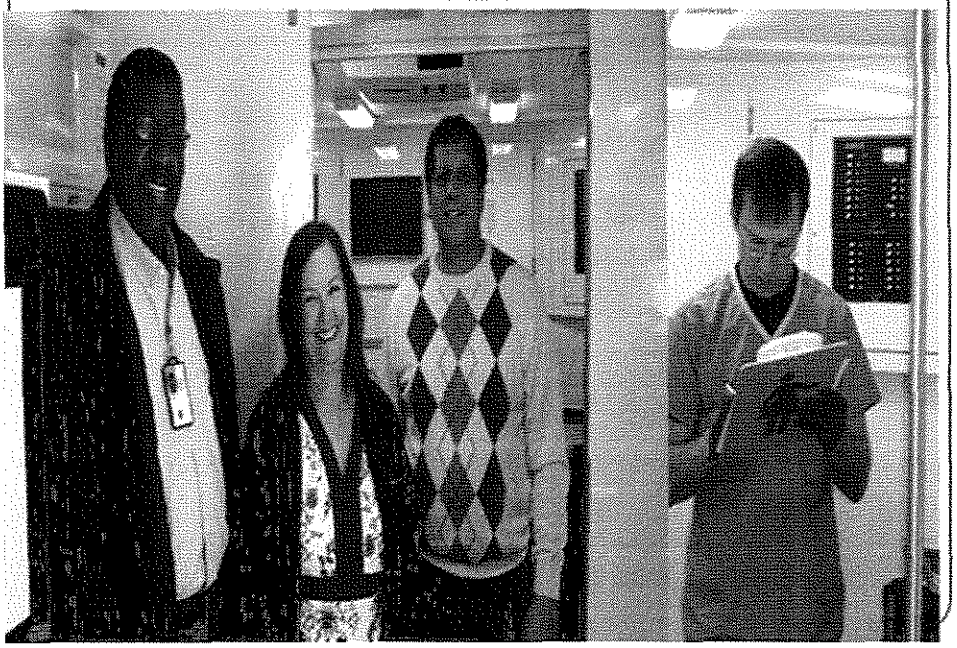
Out of 90 outreach events conducted in 2013, nearly half utilized the mobile medical unit to augment enrollment in VHA. A team of 5 specialists provides a comprehensive and streamlined enrollment opportunity with the support of Eligibility Specialists, a Nurse Practitioner and Registered Nurse as well as computer access to validate military service.

The program collaborates with community partners all across Nassau and Suffolk counties to bring programs to public libraries, veteran service organizations, college campuses, health fairs and community events.



Mobile Unit Program Overview

Staff



Start Date: March 6,2012

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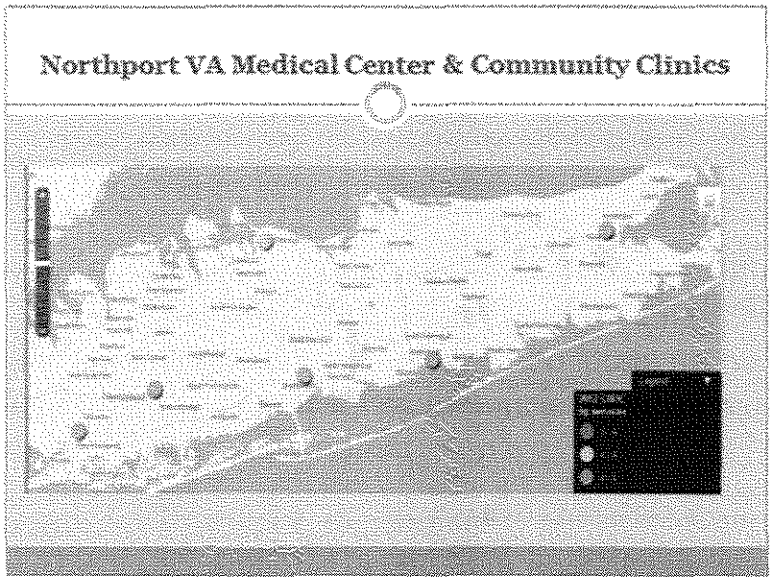
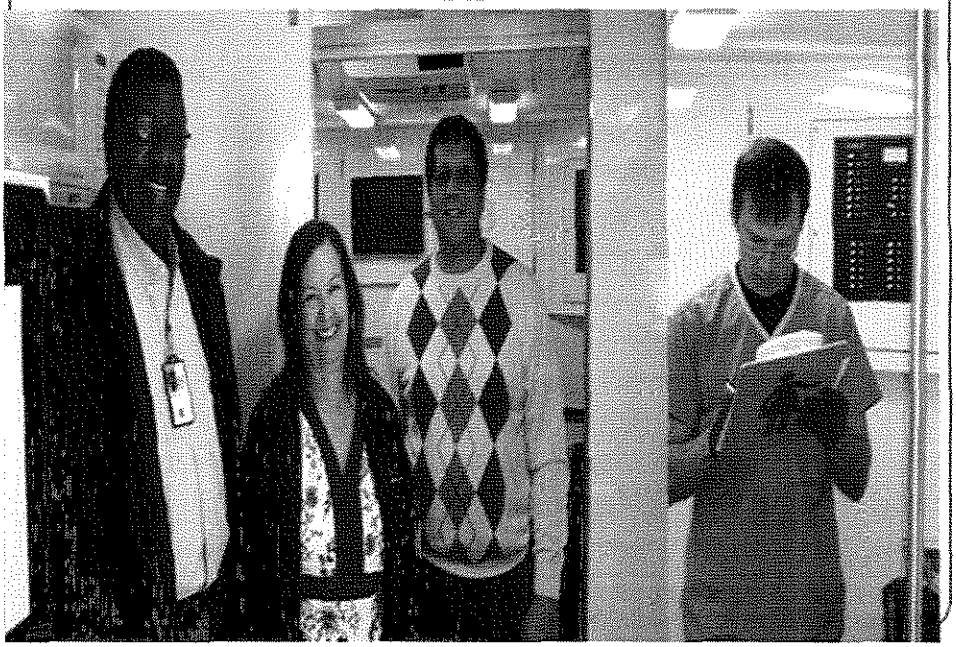


Mobile Unit Program Overview

Staff



Start Date: March 6,2012

1.) Actions to increase healthcare access for Veterans who live in rural areas.

- Supporting Riverhead CBOC Primary Care- weekly visits with staff as well as clinic managers. Support acquit ion of supplies, JC readiness.
- Supporting Riverhead CBOC Mental Health Care- weekly visits with staff
- Supporting HBPC Satellite team- attendance at weekly IDT team meetings to support logistical concerns as the program grows.
- Supporting growth of Telehealth programs at Riverhead CBOC- work with facility Telehealth Coordinator to increase CVT classes, Teleretinal imaging
- Planning Outreach Enrollment events on eastern Long Island, Informational sessions

2.) Plan to achieve greater access for rural Veterans

- For Q3 and Q4 continue emphasis on Outreach Enrollment events-2/month for next 24 weeks
- Support Teleeretinal Imaging by working with facility/VISN Telehealth Coordinators

3.) 2012 Accomplishments

- Outreach Enrollment Events- libraries, senior centers, supermarkets,
- Mobile Unit Podiatry Program at 2 CBOCs- starts 3/6/2012. Morning session (4 hours) at the Riverhead/Patchogue CBOC. Scheduled appointments for Northport podiatry clinic are re-scheduled for Riverhead/Patchogue location to decrease driving burden. Sessions are staffed by Podiatrist, RN and Mobile Unit driver/Medical support assistant.
- Satellite HBPC program- census at 40 patients. Support staff in acquiring vehicle, laptops, navigational system, review policy and procedure, assist with CVT meeting between HBPC team in Riverhead and PM&R staff at Northport
- Audiology Services at Riverhead CBOC- Actively working with Suffolk County Department of Public Works at the Riverhead County Center to secure additional space
- Native American Veteran enrollment events- Shinnecock reservation 5/5/2012, Possepetuck Tribe 5/19/2012

4.) Issues/Risks and Mitigations

- Teleretinal training and TCTs fully oriented....working with Facility Telehealth coordinator
- Anticipate change in staff- Mobile Unit Driver – will post/hire/select if position becomes vacant
- Connecting with Possepetuck Tribe- seeking POC through Suffolk County Legislator prior to 5/19/2012

NORHTPORT VAMC : EXPANSION OF RURAL HEALTH PROGRAM 2012 Annual Report

Program is consistent with the VISN 3, VHA and ORH priority of increasing access to care for veterans residing on eastern Long Island, NY.

- Increase Access to VHA for non-users by emphasizing Outreach efforts at the community level using the mobile unit for Wellness programs, POC vesting exams. Mobile Unit will be scheduled at American legion Halls on the North Fork, South Fork and Shelter Island.

- Satellite HBPC Program with an average daily census of 60 veterans

- Support the integration of TeleHealth options into care management: 1 Teleretinal camera for Riverhead CBOC, 16 different CVT classes offered weekly at the Riverhead CBOC

- Increase networking with 2 Native American Indian tribes: Shinnecock and Poospatuck. Collaborative meeting at Shinnecock Reservation for May 201

2.) 2013 Accomplishments

- FY 2012 Office of Rural Health funding for expanded programs $2,329, 000 plus

$ 736,080 Out of Cycle Funding

- Overall trends in workload remain steady, the following trends are notable:

- Riverhead CBOC has seen a 20% increase in Unique Veterans compared to the same time period in FY11

- Riverhead CBOC has seen a 60% increase in encounters compared to the same time period in FY11

- Targeted Outreach Enrollment Events Suffolk County - 25 events for FY13 at public libraries, Senior Centers, supermarkets, Department of Labor, college campuses, Fire Departments,

- Mobile Unit Podiatry Program at 2 CBOCs- starts 3/6/2012. Morning session (4 hours) at the Riverhead/Patchogue CBOC. Scheduled appointments for Northport podiatry clinic are re-scheduled for Riverhead/Patchogue location to decrease driving burden. Sessions are staffed by Podiatrist, RN and Mobile Unit driver/Medical support assistant. As of 11/15/2012 Mobile Unit podiatry program will increase to a full time program offering podiatry care at 4 locations on eastern Long Island

- Support Teleretinal Imaging by working with facility/VISN Telehealth Coordinators. As of 4/11/2012 thru 10/1/2012- 90 images from Riverhead CBOC.

- My HealtheVet enrollment-

- Audiology Services at Riverhead CBOC started April 10, 2013. The clinic provides hearing aid fittings and repairs two days per week for an eight hour session under the direction of an Audiologist. In a two week period over 60 veterans have had appointment sand received services locally, decreasing the burden of driving to Northport VAMC.

- Native American Veteran enrollment events- Shinnecock reservation 5/5/2012, Poosepetuck Tribe 5/19/2012

- Women's Health- Collaborate with Women's Health Coordinator

- Partner with Non-VA professionals: Suffolk County office of Aging, Suffolk County Veterans Agency, Suffolk County Legislators, Eastern Long Island Hospital, Peconic Bay Medical Center, Southampton Hospital, Suffolk County Department of Public Works- Additional space

Northport VAMC RURAL HEALTH REPPORT 10/1/2012

RURAL HEALTH COORDINATOR- JoAnne Anderson RN MSN

1.) Actions to increase healthcare access for Veterans who live in rural areas of eastern Long Island, New York:

- Supporting Riverhead CBOC Primary Care- weekly visits with staff as well as clinic managers. Support acquit ion of supplies, JC readiness.
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- *Targeted Outreach Enrollment Events* Suffolk County - 22 events for FY12 at libraries, Senior Centers, supermarkets, Department of Labor, College campuses, Outpatient Clinics at Riverhead and Patchogue, Fire Departments,
- *Mobile Unit Podiatry Program* at 2 CBOCs- starts 3/6/2012. Morning session (4 hours) at the Riverhead/Patchogue CBOC. Scheduled appointments for Northport podiatry clinic are re-scheduled for Riverhead/Patchogue location to decrease driving burden. Sessions are staffed by Podiatrist, RN and Mobile Unit driver/Medical support assistant. As of 11/15/2012 Mobile Unit podiatry program will increase to a full time program offering podiatry care at 4 locations on eastern Long Island
- *Support Teleretinal Imaging* by working with facility/VISN Telehealth Coordinators. As of 4/11/2012 thru 10/1/2012- 90 images from Riverhead CBOC.
- *Continuous Video Teleconferencing (CVT)* classes available to rural veterans at Riverhead CBOC- 10 classes/week.

- *Smoking Cessation classes at Riverhead CBOC*
- *My HealtheVet enrollment-* dedicated enrollment kiosk at Riverhead CBOC

- *Satellite HBPC program-* census at 45 patients with over 100+ evaluated for program. Support staff in acquiring vehicle, laptops, navigational system, review policy and procedure, assist with CVT meeting between HBPC team in Riverhead and PM&R staff at Northport
- *Audiology Services at Riverhead CBOC-* Part time audiology services: hearing aid repair and servicing to be offered by FY13 Q2 at Riverhead CBOC. Actively working with Suffolk County Department of Public Works at the Riverhead County Center to secure additional space
- *Native American Veteran enrollment events-* Shinnecock reservation 5/5/2012, Poosepetuck Tribe 5/19/2012

- *Decrease Homelessness-* enrollment events at Yaphank Homeless Shelter

- *Women's Health-* Collaborate with Women's health Coordinator
- *Fully Operational Workforce Plan:* Hiring of competent and engaged workforce- 3 employees- 3 Eligibility Officers, provide orientation and training, support retention and recruitment process by selecting staff who reside in local areas

- *Strengthening Partnerships with Non-VA professionals*: Suffolk County office of Aging, Suffolk County Veterans Agency, Suffolk County Legislators, Eastern Long Island Hospital, Peconic Bay medical center, Southampton Hospital, Suffolk County Department of Public Works- Additional space

- *Support Incarcerated Veteran Program-* Attend meetings with Suffolk County Sherriff Department regarding Veterans Cohort ring program and increasing enrollment in VHA

- *Data Management to* support expansion plans- population comparisons and trends of users and non-users of VHA.

Northport VAMC RURAL HEALTH REPPORT 10/1/2012

RURAL HEALTH COORDINATOR- JoAnne Anderson RN MSN

Collaborative project with Long Island State Veterans Home- This project is an initiative to provide a personal, on-site VHA enrollment evaluation for veterans utilizing the Long Island State Veterans Home. The aim is to: Assist veterans and their families to understand the services and healthcare benefits available to them. And to promote use of programs which may be of benefit to the veterans and family: Caregiver Support, Home Based Primary Care, and Non-Institutional Care.

Fall 2012 Rural Health Planning Meeting- September 21, 2012- Meeting attended by 30 staff at Riverhead CBOC for those professionals engaged in care delivery and program development. Discussed expansion plans , collaborative efforts and needs assessment of rural veterans for FY13.

RURAL HEALTH FALL MEETING
Friday September 12, 2012 12p-4p Riverhead CBOC

PRESENT: JoAnne Anderson Rural Health Coordinator, Bertha Fertil VISN 3 Rural Health Consultant, Bonnie Armstead RN, Michael Brody DDPM, Louise Burns Facility Telehealth Coordinator, R. Castagnino MD, C. Castiglia RN, J. De Marco Community Relations, D. Demulder Health Tech, Wendy Eberhardt HBPC Manager, Joyce Feldma Clinic Manager, Sharon Friedrich Community Relations, Melinda Gagne RN, Maryann Grow Audiology, Bill Hollup DAV, Jacqueline Hastings Clinic Manager, Brima Jallo TCT, William Jantzen PT, Brent Kempf DDPM, Russell Lhommedieu PT PhD, Debbie Marro MSA, Christine Mason HBPC RN, Shannon Jones MSA, Michael Parrinello HI NP, Rebecca Petrie LCSW HBPC, Susan Pisano Acting Chief Rec Therapy Service ,Michael Poindexter Mobile Unit Driver, Julie Rinaldi MSA, Jorge Riveros Community Relations, Wendy Robertson Community Relations Supervisor, Valerie Savarino Chief Audiology, Dorothy Schumejda NP, Ann Vasquez-Kosta LCSW,

Excused: Joann Beckman, Dr. Charlene Thomesen, Joe Sledge, Richard Kitson, Dr. Limb

TOPIC	FINDINGS/ DISUSSSION	Responsible Service or Person	Follow-up/Status
Welcome	Welcoming Remarks and Plan for Meeting TMS credit to be submitted and entered for attendees Lunch Power Point Presentation: Riverhead CBOC pictures may 2011 thru present Review of funding FY10, FY11, Out of Cycle funding, FY12, FY13 Office of Rural health funding opportunities Video- "Leadership and the Dancing Guy VISN 3 Rural health Needs Assessment 2010 ORH Strategic Plan Refresh FY 2012-2014	JoAnne Anderson Rural Health Coordinator	**NA**
Rural Health Overview	Ms. Fertil discussed the Northport Rural Health program from conception in 2008/2009 to present. Ms. Fertil reported that the original proposal was written by Mr. Moschitta and submitted to ORH for review. Northport VA was awarded start-up funds which were utilized for staffing, equipment, and support for the Riverhead CBOC, and Mobile Unit expenses. Ms. Fertil also reported on the growth of funding opportunities as new programs have started and existing programs have grown.	Bertha Fertil MPH MGA VISN 3 Rural Health Consultant	**NA**
Team Overview	Each team provided an overview of current services and plans for FY13. Some highlights of the presentations include: • Mental Health care is provided 2 days/week and then 3days/week by Dr. Dana Cohen. Smoking Cessation Program is offered upon request of patient through MH RN. • The Heritage Prescription Plan is used for urgent care at the Riverhead CBOC. Approximately 6 prescriptions/week are written. • Requests for more Nutrition services and education • DAV transportation for veterans for morning appointment at Northport from the north and south fork. Rides can be scheduled through DAV or CBOC clerk. • Zostavax vaccine and other vaccines requested for administration at CBOC to avoid sending patients to Northport. Vaccine is frozen which requires special handling. • PACT guidelines are used which is 3 ancillary staff/provider. Additional LPN will be starting. Patients receive Discharge phone call t within 2 days of discharge.	**Mental Health- J. Anderson** **Primary Care- R. Castagnino MD, J. Feldman NM** **HBPC- W. Eberhardt, M. Parrinello** **DAV - W. Hollup** **Audiology- V. Savarino** **Podiatry- M. Brody/B. Kempf** **Non- Institutional Care- A. Vasquez-Kosta** **Telehealth- L. Burns**	

	• Discharge summary and patient records retrieval from non-VA facilities is being developed with hospitals on Long island such as Catholic Health Services, North Shore/Long Island Jewish • HBPC has grown to census > 42 patients. New 0.5 RN has started. HBPC satellite team has expanded catchment area beginning at Rte 112 to Montauk/Orient Point and Shelter Island. • Dementia support group is important for veterans at risk of social isolation. • HBPS Social Worker supports HBPC and PC patients as needed. • Transfer Care Program exists and is executed by Joyce Feldman. For details or referrals contact J. Feldman. Purpose of program is to streamline transfer of patients from non-VA facility or other VA facilities and to assist with psycho-social assessment. • Overview of contract nursing facilities (CNH) adult day healthcare (CADHC) and contract homemaker/home health aide program (CH/HHA). Most veterans can receive up to 12 hours/week of services if they qualify. • Respite care for the caregiver may be available- contact Ann Vasquez-Kosta. • PM&R support via the HBPC team is available. Some adaptive equipment can be sent to Riverhead CBOC via courier and then dispensed to veterans home. • PM&R expansion plans to Riverhead area or eastern Long Island would decrease driving burdens for veterans who may receive up to 35 treatments for PT services. Referrals can be for chronic pain management, post-surgery rehabilitation and other diagnosis. • Audiology services will be available for hearing aid repairs or servicing 2 days /week in FY13. Initial audiology screening will still be performed at Northport in the sound booth. • Podiatry program has just completed a 6 month trial on the Mobile Unit 2 days/week at the Riverhead and Patchogue CBOC. Program will expand to full time in FY13 at the Riverhead CBOC, Patchogue CBOC and 3 additional locations. Scheduled patients and "walk-ins" can be accepted as schedule permits. • Dr. Kempf advised the group to be mindful of explaining programs to non-VA providers in the community setting prior to programs starting to avoid any misinterpretation of VA presence. • Digital imaging and x-rays would be helpful to assist with diagnosing foot problems. • Home Telehealth programs are available to augment the treatment of hypertension, depression, diabetes, obesity and COPD. If you have a referral send/call Louise Burns or call the hotline at 1-877-925-5090. • CVT classes are available. Fall calendar to be attached. • Teleretinal exams available 5 days/week. • Teledermatology and teleaudiology exams will be available soon.	**Outreach- W. Robertson**	
RH Measures Report	J. Anderson reviewed the FY13 reporting tool for RH programs for Northport. See attached.	**J. Anderson** **Quarterly data accepted from each team**	
Space Utilization	J. Anderson and J. Feldman assisted the group to review current and possible space utilization options at the Riverhead CBOC. • HBPC Team to be relocated from room 212 to either additional space at County center or the Gabreski Air Force base • Audiology Service to use part of Room 212 if approved by MH • Podiatry Service to use Room 220 or another exam room as available on Tuesdays • Space may be available for evening and weekend services and appointments.	**J. Anderson** **J. Feldman**	
Closing	Yellow pieces of paper in RH folders to be used for comments or requests for assistance.	**J. Anderson**	

Remarks	• Request to expand HBPC recreation Therapy services and backfill Northport staff and perhaps add new FTEE for Rural health. • East end Audiologist referral • Verify DAV transportation availability •		

Time adjourned: Meeting adjourned at 4pm
Date of Next Meeting: VANTS phone call t is scheduled: tentative for 10/17/2012 at 1:30pm code # 5994

Recorder: J. Anderson

Distribution: RH contact list

Matches:

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ID	Click to Update / View	Visn	Status	Project #	Name	Facilities	Start Date	End Date	Total Budget	Status	Date Updated	Updated By
1064	Update	3	ACTIVE	N03-FY13Q1-S1-P00409	Audiology Services at CBOC	(V03) (632) Northport, NY	10-01-12	09-30-13	$124,050.00	ACTIVE	01-08-13	Pegler, JoAnne
1066	Update	3	ACTIVE	N03-FY13Q1-S1-P00411	Mobile Unit Podiatry Program	(V03) (632) Northport, NY	10-01-12	09-30-13	$157,376.00	ACTIVE	01-08-13	Pegler, JoAnne
1068	Update	3	ACTIVE	N03-FY13Q1-S1-P00414	Rural Non-institutional Care and Respite	(V03) (632) Northport, NY	10-01-12	09-30-13	$1,995,900.00	ACTIVE	01-08-13	Pegler, JoAnne
700	Update	3	SAVED	S03-FY12Q1-S2-P00333	Expansion CBOC Services on eastern Long Island	(V03) (632) Northport, NY	10-01-11	09-30-12	$1,001,780.00	SAVED	09-13-12	Klobucar, Thomas
699	Update	3	SAVED	S03-FY12Q1-S2-P00334	Implementing Telehealth on eastern Long Island	(V03) (632) Northport, NY	10-01-11	09-30-12	$64,584.00	SAVED	11-14-12	FERTIL, BERTHA
701	Update	3	SAVED	S03-FY12Q1-S2-P00335	Improving Rural Veterans Mental Health Care on eastern Long Island	(V03) (632) Northport, NY	10-01-11	09-30-12	$143,176.00	SAVED	04-11-12	FERTIL, BERTHA
1067	Update	3	ACTIVE	S03-FY12Q1-S2-P00336	Mobile Unit Program and Outreach on Eastern Long Island	(V03) (632) Northport, NY	10-01-12	09-30-13	$513,587.00	ACTIVE	01-08-13	Pegler, JoAnne
703	Update	3	SAVED	S03-FY12Q1-S2-P00336	Mobile Unit Program and Outreach Opportunities on eastern Long Island	(V03) (632) Northport, NY	10-01-11	09-30-12	$495,489.00	SAVED	04-11-12	FERTIL, BERTHA
1065	Update	3	ACTIVE	S03-FY12Q1-S2-P00337	Satellite HBPC on eastern Long Island	(V03) (632) Northport, NY	10-01-12	09-30-13	$973,096.00	ACTIVE	12-10-12	MANN, DONALD
702	Update	3	SAVED	S03-FY12Q1-S2-P00337	Satellite HBPC Program on eastern Long Island	(V03) (632) Northport, NY	10-01-11	09-30-12	$314,630.00	SAVED	05-28-12	ALVAREZ, COLETTE

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Proposal Funding Request Form

Project Name:	**Implementing Telehealth on eastern Long Island**		
a. Type of Request	Project Sustainment ☒	Project Expansion ☐	New Project ☐
b. For Sustainment or Expansion Projects Enter Original Project Number and Name:	FY10CBOC- V03-A **Riverhead CBOC**		
c. VISN or VHA National Program Office:	VISN 3		
d. Project Director/Lead Name:	Mailing Address	Phone	Email
JoAnne Anderson RN MSN Rural Health Coordinator	79 Middleville Road Northport, NY 11768	631-261-4400 x 4590	joannecatherine.anderson@va.gov
Younghee Limb, MD ACOS Geriatrics/Extended Care	79 Middleville Road Northport, NY 11768	631-261-4400 x 2959	younghee.limb@va.gov
Louise Burns MSN Acting Facility Telehealth Coordinator	79 Middleville Road Northport, NY 11768	631-261-4400x	louise.burns2@va.gov
e. VISN Rural Consultant (VRC): Bertha Fertil MBA	130 West Kingsbridge Road, Bronx, NY 10468	718-741-4105	Bertha.fertil@va.gov
f. Key Stakeholders and/or Collaborative Partners: Nassau /County Veterans, Veteran families Legislators	**Suffolk & Nassau County Veterans, Veteran families, Legislators, VSOs, Office of the Aging, Suffolk County Public health Nurses, County health center, County Sheriff's office, LI cares Food pantry**		
g. Implementation Sites/Facilities:	Northport VAMC, VA Clinic at Riverhead, 300 Center Drive, Riverhead, NY 11901		
h. VISN Director or National Program Chief (Endorsement Required)	VISN 3 Director- Michael Sabo		
i. Medical Center Director Endorsement (from all affected)	Philip C. Moschitta		
j. VRC Endorsement	Eastern Region		
k. Total Funding Requested for this Project:	$ 64, 584		
l. Have you requested funds from other sources? If yes, please explain:	Collaboration and coordination with T21 funding and resource allocation		

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Proposal Funding Request Form

FY11 Report of project measures and accomplishments to demonstrate the impact of the project on Veterans served in the table below:

Measure:	Data Source	FY11 QTR 1	FY11QTR 2	FY11QTR 3	FY11QTR 4
Access	VSSC Number of veterans impacted, OTS	NA	NA	NA	
Access	CVT encounters	NA	NA	NA	10
Staff satisfaction:	CVT sessions/remote staff meetings/AES	NA	NA	2	6
Patient satisfaction	SHEP scores, veteran comment cards	NA	65%	60%	
Access: secure messaging	Enrollment: MyhealtheVet, dedicated kiosk in reception area of Riverhead CBOC	NA	NA	NA	12
Quality: teleretinal Imaging for Diabetic Retinopathy	Facility Equipment spreadsheet	NA	NA	Equipment installed/training. Collaborative efforts with VISN teleretinal reader, Boston Training center	Continued training
Quality: Telemedicine cart/Polycom cart for physical assessment	Facility Equipment spreadsheet	NA	NA	Equipment installed/training	Continued training
Quality: Home telehealth	Facility Equipment spreadsheet	NA	NA	Equipment installed/training	Continued training
Quality: Recruit and retain staffing	Facility spreadsheet, training records	NA	Rural health Professions Institute attendance by Telehealth lead	Hiring process	Miniresidency: Attendance of 10 facility personnel
Quality: Program development	Facility records	NA	Clinic stop codes created	Procedural memos	SOPs created

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1. **Overview and objectives:** The primary objective of this project was to increase the size and scope of telehealth usage in the plan of care for veterans residing on eastern Long Island as part of the Northport VAMC. Integrating telehealth opportunities at the new Riverhead CBOC is intended to expand access to care and offer more timely care to Veterans and their caregivers. The burden of driving nearly 80 miles one way from remote towns on eastern Long Island to the Northport VAMC has been a deterrent to veterans to use VA healthcare. With the completion of a new 4,000 square foot clinic in Riverhead, NY , access to care has become less burdensome since its location is in the hub of public transportation and resides in a county-level building. This continuation of the CBOC telehealth expansion project has undertaken the task to ensure that telehealth technology is available for Veterans, their families and the staff who serve them. This 3-year plan reflects the commitment to ensure that the Riverhead CBOC is a site of virtual medicine. The requested funding will be used to cover the costs of existing staff performing the functions of telehealth expansion and will supplement the T21 pooled funds. Specific programs include: teleMOVE, teleretinal imaging, and telemedicine.

2. **Project strategy and feasibility –**

   - **Overview of the program/project strategy:**

   Year 1 of the project (FY10) focused on moving from the planning and development phase of integrating equipment into specific locations in the anew 4000 square foot CBOC in Riverhead,

   Year 2 of the project (FY11) focused on hiring/training staff, development of interventions and recruitment strategies. The facility telehealth program was analyzed and restructured. Comprehensive efforts and coordination of teams were undertaken between OI&T, Biomed, Nursing Service and leadership at the facility, VISN and national level to support the full spectrum of telehealth care.

   Year 3 of the project (FY12) will focus increasing enrollment, expanding provider hours, educational opportunities for staff and veterans using Clinical Video Teleconferencing (CVT), Home telehealth (HT), Store and Forward Telehealth (SFT) and MyhealtheVet.

   Literature Review

Agency for Healthcare Research and Quality. Health IT in Small and Rural Communities. Available at http://
heal thi t .ahrq.gov/por tal/server .pt ?open=514&obj ID=5 554&mode=2&holderDi splayURL=ht tp://
prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k_o/knowledge_library/key_topics/
health_briefing_09202006031947/health_it_in_small_and_rural_communities.html. Accessed February 10, 2009.

Center on an Aging Society. 2003. Rural and Urban Health. Washington, DC: Georgetown University.

Goetz, Stephan J. 2008. "Self-Employment in Rural America: The New Economic Reality." Rural Realities, Vol. 2, Issue 3, 2008.

Weeks WB, Wallace AE, Wang S, Lee A, Kazis LE. Rural-urban disparities in health related quality of life within disease categories of Veterans. 2006 Journal of Rural health 22: 204-211.

United States Administration on Aging, Statistics on the Aging Population, 2007.

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a. **Project aims and methods.**

Aim - Increase Number of veterans impacted by 10%, Number of patients who had appointments with providers in Riverhead CBOC.

Method:

- Support opening of CBOC of 05/02/2011 complete with virtual telehealth equipment
- Offer tours of facility to enhance interest and excitement in receiving care in a modern and fully equipped facility
- Explain services available and highlights of care at new location
- Expand opportunities for encounters from 24 hours/week to 40 hours/week
- Advertise and promote telehealth program to providers, Veterans and their caregivers within and outside Northport VAMC. Actively market program and participate in Outreach and In-reach events.
- Support professional engagement and decrease professional isolation through use of clinical video conferencing for staff meetings, participation in classes at home facility
- Support staff participation in Rural Health Professions Institute (1/30/2011)
- Support staff participation in Sunshine Training Mini-Residency Program (8/2011)

- **Describe potential problems and address alternative approaches.**

1. Workforce Challenges such as supply and demand.
2. Information Silos- Staff has worked for many years in a solo structure. Getting people to work as a team requires new ways of communication such as electronic messaging and interdisciplinary team meetings. Approaches to team building and collaboration between all staff working out of the Riverhead CBOC: primary care staff, mental health staff, HBPC staff, and Telehealth staff.
3. Problem of burdened staff who will assume operation of telehealth equipment this as a collateral duty until dedicated telehealth technicians (TCTs) have been recruited and trained.

- **Detail how the program/project will be integrated into VISN/Program Office operations.**

This program will be integrated into VISN 3 Rural Health programming structure through the daily support of the facility Rural Health Coordinator acting as a communication link between front line staff and the VISN Rural Consultant. Monthly meetings and individual team meetings at the facility level will be supported by the facility leadership team and the VISN-RC.

- **Address the relevance of the project to rural and highly rural Veteran populations.**

The Northport VAMC is a general medicine and surgical facility which is part of the New York/New Jersey VISN 3. Northport is a suburban town located in western Suffolk County, Long Island. The medical center provides inpatient and outpatient Veterans with medical, surgical, psychiatric, rehabilitative and skilled nursing care. In addition to the main 200 bed facility, it offers services in 3 community-based outpatient clinics, a myriad of outreach programs, a robust mental health program and a Home Based Primary Care Program. Suffolk County has over 160,000 Veterans as residents, has the highest concentration of veterans per capita in NY state.

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The East End Health Care Program was created in October 2010 in an effort to support the healthcare needs of Veterans on 3 levels: in the comfort of home, in the ease of the community and in the comprehensive setting of the medical center. The goal of the telehealth program at this rural CBOC is to enhance and supplement care for the Primary Care program, Home Based Primary Care Program, Mental health care program as well as care giver support. Decreasing the burden of drive time can make the difference between

choosing VA health care and other options and telehealth can ease the tedium of long driving distances, hazards due to congested towns and expense due to rising costs of vehicles and gas.

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- **Collaborations with other VHA facilities and/or public and private entities**

  Northport VAMC collaborates with all sister facilities in VISN 3 to enhance daily operations. Collaborative efforts include sharing SOPs for disruptive behavior, exchanging information regarding telecommunications such as EKG transmission, sample letters of correspondence and staffing methodology.

- **Address impact on health care service delivery for rural Veterans.**

The program aims to serve almost 20,000 potential non-user veterans residing in Suffolk County New York. Utilizing the Riverhead CBOC would enable veterans to have access to primary care, mental health care, home based primary care, telehealth care and phlebotomy services all in a single site. Veterans have the option to have access to secure messaging through a MyHealtheVet kiosk which is conveniently located in the reception area and there is always staff support to assist with enrolling. Patient centered comprehensive care for women veterans is also available. Improved care coordination through preventative health lectures and educational opportunities will advance care provided to all Veterans and improve patient satisfaction by decreasing the burden of lengthy drive time to the nearest VA facility.

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3 Budget

This CBOC budget is based on a staffing plan which is currently in place to provide virtual medicine telehealth to the existing 1,692 enrolled Veterans utilizing the Riverhead CBOC as well as a potential 19,000 non-users and non-enrolled veterans in eastern Suffolk County. The staffing plan has been built to accommodate approximately 2,400 enrollees for a 2 year period FY 11-FY12. The overall goal is to provide telehealth services to all Veterans utilizing the Riverhead CBOC. The overall goal is to support the transformation of healthcare delivery to provide more patient centric care which requires a staffing plan which is reflected in the current retention of staff on board. This budget request reflects the sustainment of staffing expenditures for 1 Telehealth Program Support Assistant utilizing Rural Health funds.

Estimate resources requested:

Category	Resource Request			Comments
	MS	MF	MSC	
Staffing				
Telehealth Program Support Assistant	$64,584			Sustainment (1FTE)
Total	$64, 584			

MS = Medical Services MF= Medical Facilities MSC=Medical Support and Compliance

4 **Service Area Environment –**

- The FY 2010-21012 Rural Health Initiative for Northport VAMC will continue to take place in Suffolk County, NY. Healthcare delivery will be delivered from the Riverhead, NY CBOC with support from the main medical center. Institutional support will include medical center leadership, OI&T, telecommunications, EMS, PM&R clerical. Additional program support from Mental Health, and VISN level Office of Telehealth Services exists.

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5 **Program/Project Evaluation –**

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Projected outcomes include increased enrollment by 10% for Suffolk County Veterans using healthcare services in primary care at the Riverhead CBOC. The measure will be evaluated monthly and reviewed by the Telehealth team as well as the Rural health Coordinator.

Additional evaluations will also reflect the number of comprehensive programs offered for OEF/OIF/OND, Native American Veteran population, women's health and wellness/behavioral support programs offered via CVT (tobacco cessation, weight management, diabetes wellness, caregiver support, MOVE etc).

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Proposal Funding Request Form

PROJECT NAME: **Implementing Telehealth on eastern Long Island**

Section I: Overview and objectives: the table below describes the project goals and milestones

Project Objectives	**Milestones/Key Events** (e.g. contracts awarded and FTEE on board)			
	FY12 QTR 1	FY12 QTR 2	FY12 QTR 3	FY12 QTR 4
Improve rural Veterans' access to teleretinal screening for diabetic retinopathy	Equipment trial Complete training, begin imaging	12 images/month	24 images/month	30 images/month
Increased CVT encounters for patient education	2/month	4/month	6/month	8/month
Increased CVT opportunities for staff education	2/month	3/month	4/month	5/month
Increase CCHT to help patients living in rural areas manage diabetes and hypertension	2 Educational sessions for providers and patients	Promote referrals to program	Education for community setting	Promote referrals to program

Section II: Innovation and Likely Impact:.

NUMBER OF RURAL VETERANS, ENROLLEES, OR PATIENTS IMPACTED:				
Geographic Area Impacted	Total Number of Rural and Highly Rural Veterans in Impacted Area	Expected number of rural Veterans that will be affected by this project		
		FY11	FY12	FY13
VISN 3 Northport VAMC eastern Long Island catchment area	Highly Rural= 6,492 Rural= 34	10	100	200

Section III: Program/Project Evaluation: measures for FY12, the timing of evaluation

Measure:	**Data Source**	FY12QTR 1	FY12 QTR 2	FY12 QTR 3	FY12 QTR 4
Veterans Served monthly review	VSSC ProClarity Report ~~Telehealth data cube~~	10	100 rural Veterans impacted	150 rural Veterans impacted	200 rural Veterans impacted
Veteran Mileage Saved for annual retinal exam/monthly review	Facility spreadsheet	No data	Saved 25 Veterans 830 driving miles	Saved 35 Veterans 900 driving miles	Saved 50 Veterans 1000 driving miles
Quality: technology-assisted programs- Care	OTS, facility records	10	15	20	30

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Coordination, Home Telehealth					

Department of Veterans Affairs

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Office of Rural Health
Proposal Funding Request Form

Project Name:	**Expansion of CBOC Services on eastern Long Island**		
a. Type of Request	Project Sustainment [x]	Project Expansion [ ]	New Project [ ]
b. For Sustainment or Expansion Projects Enter Original Project Number and Name:	FY10CBOC- V03-A **Riverhead CBOC**		
c. VISN or VHA National Program Office:	VISN 3		
d. Project Director/Lead Name:	Mailing Address	Phone	Email
JoAnne Anderson RN MSN Rural Health Coordinator	79 Middleville Road Northport, NY 11768	631-261-4400 x 4590	joannecatherine.anderson@va.gov
Philip Weisbroat Facility Planer	79 Middleville Road Northport, NY 11768	631-261-4400 x 7891	Philip.weisbroat@va.gov
Mandar Tank, MD	79 Middleville Road Northport, NY 11768	631-261-4400 x 2042	Mandar.tank@va.gov
Joyce Feldman, CBOC Nurse Manager	79 Middleville Road Northport, NY 11768	631-261-4400 x 2051	Joyce.feldman@va.gov
e. VISN Rural Consultant (VRC): Bertha Fertil	130 West Kingsbridge Road, Bronx, NY 10468	718-741-4105	Bertha.fertil@va.gov
f. Key Stakeholders and/or Collaborative Partners: Nassau /County Veterans, Veteran families Legislators	**Suffolk &Nassau County Veterans, Veteran families, Legislators, VSOs, Office of the Aging, Suffolk County Public health Nurses, County health center, County Sheriff's office, LI cares Food pantry**		
g. Implementation Sites/Facilities:	Northport VAMC, VA Clinic at Riverhead, 300 Center Drive, Riverhead, NY 11901		
h. VISN Director or National Program Chief (Endorsement Required)	VISN 3 Director- Michael Sabo		
i. Medical Center Director Endorsement (from all affected)	Philip C. Moschitta		
j. VRC Endorsement	Eastern Region		
k. Total Funding Requested for this Project:	**1,001,780**		
l. Have you requested funds from other sources?	No		

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Proposal Funding Request Form

To be completed for Sustainment or Expansion of Projects Only: Provide a FY11 Report of project measures and accomplishments to demonstrate the impact of the project on Veterans served in the table below:

Measure: (Quality, Access, Cost, Satisfaction, etc.)	**Data Source** (VSSC, CHAPS, PSSG, OQP/SHEP, Veteran Comment Cards, etc.)	FY11 QTR 1	FY11 QTR 2	FY11 QTR 3	FY11 QTR 4
Access	VSSC- Number of veterans impacted	1038	650	850	1400
	Facility- Hours of operation	24 hrs/week	24 hrs/week	24 hrs/week	40 hrs/week
	VSSC- Number of rural patient encounters	45 Veterans	175 Veterans	200 Veterans	225 Veterans
	SHEP scores	NA	65%	60%	65%

1. **Overview and objectives:** The primary objective of this project was to open a 4,000 square foot, community based out-patient clinic in a new location on eastern Long Island. The previous clinic operated for nearly 10 years on the premises of a maximum security facility: the Westhampton Air National Guard. While the VA enjoyed the collaborative arrangement, barriers to care provision became apparent over the years. Some of these barriers included, limited hours of operation to 3 days per week, lack of opportunity for evening or weekend hours, burdensome entry to the clinic due to security regulations, limited exam room and reception area space, abrupt cancellation of clinic hours during periods of heightened national security. This project's aim was to increase access to comprehensive, quality care for Veterans residing on eastern Long Island, New York. The geographic area includes NY States' highest concentration of Veteran population. The VA Medical Center is situated in a suburban area on the mid-eastern area of Long Island. The most eastern towns are 80 miles away from the VAMC and 40 miles from the newest eastern CBOC (Riverhead CBOC). Travel is not only encumbered by mileage but by factors such as single lane roads for over 30 miles, an island which is accessible only by ferry transportation, seasonal traffic congestion. This comprehensive, multi-year project addresses the commitment of the VHA to expand services to the underserved Veteran population on eastern Long Island. The VA leadership worked closely with Suffolk County officials for over eight years to plan and build a new clinic to provide Veteran healthcare closer to the most eastern Long Island communities. This location was favorable as it is the hub of commerce, public transportation and county government.

2. **Project strategy and feasibility –**

   - **Overview of the program/project strategy:**

   Year 1 of the project (FY10) focused on moving from the planning and development phase of a new 4000 square foot CBOC in Riverhead, NY to commencing of construction.

   Year 2 of the project (FY11) focused on hiring/training staff, development of interventions and recruitment strategies. This was successfully completed, although delays were experienced in hiring additional providers.

   Year 3 of the project (FY12) will focus increasing enrollment, expanding provider hours, educational opportunities for staff and veterans using clinical video teleconferencing.

Literature Review

Agency for Healthcare Research and Quality. Health IT in Small and Rural Communities. Available at http:// heal thi t .ahrq.gov/por tal/server .pt ?open=514&obj ID=5 554&mode=2&holderDi splayURL=ht tp:// prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k_o/knowledge_library/key_topics/ health_briefing_09202006031947/health_it_in_small_and_rural_communities.html. Accessed February 10, 2009.

Center on an Aging Society. 2003. Rural and Urban Health. Washington, DC: Georgetown University.

Goetz, Stephan J. 2008. "Self-Employment in Rural America: The New Economic Reality." Rural Realities, Vol. 2, Issue 3, 2008.

United States Administration on Aging, Statistics on the Aging Population, 2007.

a. Develop project aims and methods.

Aim - Increase Number of veterans impacted by 10%, Number of patients who had appointments with providers in Riverhead CBOC.

Method:

- Support opening of CBOC of 05/02/2011
- Transition patients from previous clinic setting to new setting by sending out letter of relocation, providing directions and hours of operation, answer telephone questions regarding move to new location
- Offer tours of facility to enhance interest and excitement in receiving care in a modern and fully equipped facility
- Explain services available and highlights of care at new location: phlebotomy, primary care, mental health care, DAV transportation support
- Expand provider hours from 24 hours/week to 40 hours/week
- Retain staffing accomplished in FY11 Q3 and Q4: 1 additional full time provider (Nurse practitioner or physician), 1 additional full time registered nurse, 1 additional medical support assistant
- Expand laboratory services and courier hours to bring specimens back to main facility for processing
- Advertise within and outside Northport VAMC, support 30 day hiring process
- Support professional engagement and decrease professional isolation through use of clinical video conferencing for staff meetings, participation in classes at home facility
- Support staff participation in Rural Health Professions Institute (1/30/2011)
- Support staff participation in PACT training and Geriatric Scholars program

• Describe potential problems and address alternative approaches.

1. Workforce Challenges such as supply and demand.
2. Information Silos- Staff has worked for many years in a solo structure. Getting people to work as a team requires new ways of communication such as electronic messaging and interdisciplinary team meetings. An alternative approach would be to emphasis and nurture the PACT team concept between all staff working out of the Riverhead CBOC: primary care staff, mental health staff, HBPC staff, and Telehealth staff

• **Detail how the program/project will be integrated into VISN/Program Office operations.**

This program will be integrated into VISN 3 Rural Health programming structure through the daily support of the facility Rural health Coordinator acting as a communication link between front line staff and the VISN Rural Consultant. Monthly meetings and individual team meetings at the facility level will be supported by the facility leadership team and the VISN-RC.

- **Address the relevance of the project to rural and highly rural Veteran populations.**

The Northport VAMC is a general medicine and surgical facility which is part of the New York/New Jersey VISN 3. Northport is a suburban town located in western Suffolk County, Long Island. The hospital provides veteran inpatients and outpatients with medical, surgical, psychiatric, rehabilitative and skilled nursing care. In addition to the main 200 bed facility, it offers services in 3 community-based outpatient clinics, a myriad of outreach programs, a robust mental health program and a Home Based Primary Care Program. Suffolk County has over 160,000 Veterans as residents, has the highest concentration of veterans per capita in NY state.

The East End Health Care Program was created in October 2010 in an effort to support the healthcare needs of Veterans on 3 levels: in the comfort of home, in the ease of the community and in the comprehensive setting of the medical center. Care on the 3 levels is provided via a Home Based Primary Care Program, a Mobile Unit Program and a new 4000 square foot CBOC in the town of Riverhead which is located in eastern Suffolk County. Long Island is approximately 118 miles long and 20 miles at its widest point. The east end of the island is made up of two forks. The north fork is approximately 28 miles long, the south fork is about 44 miles in length. Peconic and Gardiners Bays separate the two forks and are where Shelter Island and Gardiners Island are located. Traveling by car can be tedious due to distances, hazardous due to congested towns and expensive due to rising costs of vehicles and gas.

- **Collaborations with other VHA facilities and/or public and private entities**

Northport VAMC collaborates with all sister facilities in VISN 3 to enhance daily operations. Collaborative efforts include sharing SOPs for disruptive behavior, exchanging information regarding telecommunications such as EKG transmission, sample letters of correspondence and staffing methodology.

- **Address impact on health care service delivery for rural Veterans.**

The program aims to serve almost 20,000 potential non-user veterans residing in Suffolk County New York. Utilizing the Riverhead CBOC would enable veterans to have access to primary care, mental health care, home based primary care, telehealth care and phlebotomy services all in a single site. Veterans have the option to have access to secure messaging through a MyHealtheVet kiosk which is conveniently located int eh reception area and there is always staff support to assist with enrolling. Patient centered comprehensive care for women veterans is also available. Improved care coordination through preventative health lectures and educational opportunities will advance care provided to all Veterans and improve patient satisfaction by decreasing the burden of lengthy drive time to the nearest VA facility.

3 Budget

This CBOC budget is based on a staffing plan which is currently in place to provide primary care to the existing 1,692 enrolled Veterans utilizing the Riverhead CBOC as well as a potential 19,000 non-users and non-enrolled veterans in eastern Suffolk County. The staffing plan has been built to accommodate approximately 2,400 enrollees for a 2 year period FY 11-FY12. The overall goal is to provide care utilizing the patient centered medical home model known as PACT. The overall goal is to support the transformation of healthcare delivery to provide more patient centric care which requires a staffing plan which is reflected in the current retention of staff on board. Of important note are the vigorous efforts expended to select and hire 3 additional staff members during FY 11 Q3 and Q4: 1 Nurse Practitioner, 1 Medical Support Assistant and 1 Registered Nurse. This is in an effort to support a staffing ratio of 3:1 support staff to each Primary Care provider by the end of FY12. The team has developed an implementation plan to hire, realign and train staff so to ensure the PACT model of care.

Estimate resources requested:

Category	Resource Request			Comments
	MS	MF	MSC	
Staffing		$	$	
Rural Health Coordinator	$ 152, 000			Sustainment
CBOC MD (existing) 1 FTE	$ 160,000			Sustainment
CBOC NP (existing) 2 FTE	$ 306,540			Sustainment ($ 153,270 each)
CBOC RN- 2 FTE	$ 280, 176			Sustainment ($140, 088 each)
CBOC Medical Support Assistant -2 FTE	$ 129, 168			Sustainment ($ 64,584 each)
CBOC Health Tech 1 FTE	$ 74, 412			Sustainment ($ 64,584 each)
Other				
Office /medical CBOC supplies		$4000		
EMS contract		$ 38,484		
Security contract Riverhead CBOC		$ 9,000		
Total	**950,296**	**$51,484**		**$1,001,780**

MS = Medical Services MF= Medical Facilities MSC=Medical Support and Compliance

4 **Service Area Environment –**

- The FY 2012 Rural health Initiative for Northport VAMC will continue to take place in Suffolk County, NY. Healthcare delivery will be delivered from the Riverhead, NY CBOC, and the Mobile Unit with support from the main medical center. Institutional support will include medical center leadership, OI&T, telecommunications, EMS, clerical, laboratory courier support, infection control. Additional program support from Mental Health, and VISN level Office of Telehealth Services exists.
- A Memo of Understanding was renewed between the 106th Rescue Wing/ New York Air National Guard regarding treatment of urgent care for on-duty service members

5 **Program/Project Evaluation –**

Projected outcomes include increased enrollment by 10% for Suffolk County Veterans using healthcare services in primary care at the Riverhead CBOC. The measure will be evaluated monthly and reviewed by the CBOC Pact team as well as the Rural health Coordinator.

Additional evaluations will also reflect the number of comprehensive programs offered for OEF/OIF/OND, Native American Veteran population, women's health and wellness/behavioral support programs offered (tobacco cessation, weight management, diabetes wellness, caregiver support etc).

Department of Veterans Affairs

ORH VHA Office of Rural Health

Office of Rural Health
Proposal Funding Request Form

PROJECT NAME: Expansion of CBOC Services on eastern Long Island

Section I: Overview and objectives: In the table below concisely describe the project goals and list project milestones.

Project Objectives	**Milestones/Key Events** (e.g. contracts awarded and FTEE on board) **By Quarter or more often as necessary & Targeted Completion Dates**			
	FY12 QTR 1	FY12 QTR 2	FY12 QTR 3	FY12 QTR 4
Improve rural Veterans' access to Telehealth care	Training started 2 staff	Training completed	begin imaging of rural Veterans	Program fully operational, teleretinal and CVT
Expand hours of care: evening and weekends	2 evenings/month	2 evenings/month 1 weekend days/mo	2 evenings/month 2 weekend days/mo	Work towards Open Access care

Section II: Innovation and Likely Impact: Please fill out table below.

NUMBER OF RURAL VETERANS, ENROLLEES, OR PATIENTS IMPACTED:				
Geographic Area Impacted	Total Number of Rural and Highly Rural Veterans in Impacted Area	Expected number of rural Veterans that will be affected by this project		
		FY11	FY12	FY13
VISN 3 Northport VAMC eastern Long Island , New York	Highly rural=34 veterans Rural= 6,492 Veterans	1692	1900	2000+

Section III: Program/Project Evaluation:

Measure: (Quality, Access, Cost, Satisfaction, etc.)	**Data Source** (VSSC, CHAPS, PSSG, OQP/SHEP, Veteran Comment Cards, etc.)	FY12 QTR 1	FY12 QTR 2	FY12 QTR 3	FY12 QTR 4
Veterans Served	VSSC Rural Health ProClarity Report	1700	1800	1900 Rural Veterans	2000 rural Veterans
Veteran Mileage Saved	Northport/Riverhead data compiled from CPRS, PSSG	Saved 50 Veterans 1000 driving miles	Saved 60 Veterans 1100 driving miles	Saved 70 Veterans 1200 driving miles	Saved 80 Veterans 1300 driving miles

Department of Veterans Affairs

ORH
VHA Office of Rural Health

Office of Rural Health
Proposal Funding Request Form

Project Name:	**Improving Rural Veterans Mental Health Care on eastern Long Island**		
a. Type of Request	Project Sustainment ☒	Project Expansion ☐	New Project ☐
b. Sustainment Project Original Project Number	FY10CBOC- V03-A- **Riverhead CBOC**		
c. VISN or VHA National Program Office:	VISN 3		
d. Project Director/Lead	Mailing Address	Phone	Email
e.			
JoAnne Anderson RN MSN Rural Health Coordinator	79 Middleville Road Northport, NY 11768	631-261-4400 x 4590	joannecatherine.anderson@va.gov
Charlene Thomesen MD Chief Psychiatry Service	79 Middleville Road Northport, NY 11768	631-261-4400 x	charlene.baldwin@va.gov
f. VISN Rural Consultant (VRC): Bertha Fertil	130 west Kingsbridge Road, Bronx, NY 10468	718-741-4105	Bertha.fertil@va.gov
g. Key Stakeholders and/or Collaborative Partners:	**Suffolk &Nassau County Veterans, Veteran families, Legislators, VSOs, Office of the Aging, Suffolk County Public health Nurses, County health center, County Sheriff's office, LI cares Food pantry**		
h. Implementation Sites/Facilities:	Northport VAMC, VA Clinic at Riverhead, 300 Center Drive, Riverhead, NY 11901		
i. VISN Director or National Program Chief (Endorsement Required)	VISN 3 Director- Michael Sabo		
j. Medical Center Director Endorsement (from all affected)	Philip C. Moschitta		
k. VRC Endorsement	Eastern Region		
l. Total Funding Requested for this Project:	$143,176		
m. Have you requested funds from other sources	No		

Office of Rural Health
Proposal Funding Request Form

FY11 Report of project measures and accomplishments

Measure:	Data Source	FY11 QTR 1	FY11 QTR 2	FY11 QTR 3	FY11 QTR 4
Access Number of veterans impacted:	VSSC, facility DSS	117	121	143	180
Access: Relocating services from community VSO center to designated MH space at CBOC	Facility spreadsheet and timeline	VSO center	VSO center	Designated space at CBOC May 2011	Designated space at CBOC May 2011
Access: hours of operation	CPRS, DSS	8 hours/week	8 hours/week	8 hours/week	16 hour/week
Access: group educational opportunities	Facility spreadsheet	NA	NA	1 class: PTSD	
Patient satisfaction					
Staff satisfaction					

1. **Overview and objectives:** The primary objective of this project was to open a 4,000 square foot, community based out-patient clinic in a new location on eastern Long Island. The previous clinic operated for nearly 10 years on the premises of a community Veteran's of Foreign War facility. While this arrangement was extremely helpful to providing mental health care in the community setting, barriers to care became evident over time. Some of these barriers included, limited hours of operation to one day per week, lack of opportunity for evening or weekend hours, limited exam room space, abrupt cancellation of clinic hours during periods of building use for other purposes. The under-treatment of mental illness has long been a concern of Veterans and their care givers. Combining the comorbidity of chronic disease with mental illness especially for the rural veteran population puts these patients at greater risk for under treatment and a pro-longed course of disease management. This project's aim was to increase access to comprehensive, quality care for Veterans residing on eastern Long Island, New York. The geographic area includes NY States' highest concentration of Veteran population. The VA Medical Center is situated in a suburban area on the mid-eastern area of Long Island. The most eastern towns are 80 miles away from the VAMC and 40 miles from the newest eastern CBOC (Riverhead CBOC). Travel is not only encumbered by mileage but by factors such as single lane roads for over 30 miles, an island which is accessible only by ferry transportation, seasonal traffic congestion. This comprehensive, multi-year project addresses the commitment of the VHA to expand services to the underserved Veteran population on eastern Long Island. The VA leadership worked closely with Suffolk County officials for over eight years to plan and build a new clinic to provide Veteran healthcare closer to the most eastern Long Island communities

2. **Project strategy and feasibility –**

   - **Overview of the program/project strategy:**

   Year 1 of the project (FY10) focused on moving from the planning and development phase of a new 4000 square foot CBOC in Riverhead which is designed to provide mental health care as well as primary care to commencing of construction. Design specifications include office space for individual provider-patient encounters as well as larger conference rooms for group encounters.

   Year 2 of the project (FY11) focused on hiring/training staff, development of interventions and recruitment strategies.

   Year 3 of the project (FY12) will focus increasing enrollment, expanding provider hours, educational opportunities for staff and veterans using clinical video teleconferencing.

Literature Review

19 Agency for Healthcare Research and Quality. Health IT in Small and Rural Communities. Available at http:// heal thi t .ahrq.gov/por tal/server .pt ?open=514&obj ID=5 554&mode=2&holderDi splayURL=ht tp:// prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k_o/knowledge_library/key_topics/ health_briefing_09202006031947/health_it_in_small_and_rural_communities.html. Accessed February 10, 2009.

Center on an Aging Society. 2003. Rural and Urban Health. Washington, DC: Georgetown University.

Bartels SJ: Caring for the whole person: integrated health care for older adults with severe mental illness and medical comorbidity. J. Am Geriatr. Soc. 2004;52S249-257.

Kessler LG, Cleary PD, Burke JD, Jr.: Psychiatric disorders in primary care. Results of a follow-up syudy. Archives of General Psychiatry 1985; 42:583-587.

a. **Develop project aims and methods.**

Aim - Increase Number of veterans impacted by 10%, Number of patients who had appointments with mental health providers in Riverhead CBOC.

Method:

- Support opening of CBOC of 05/02/2011
- Transition patients from previous clinic setting to new setting by sending out letter of relocation, providing directions and hours of operation, answer telephone questions regarding move to new location
- Offer tours of facility to enhance interest and excitement in receiving care in a modern and fully equipped facility
- Expand provider hours from 8hours/week to 16 hours/week
- Retain staffing accomplished in FY11 Q3 and Q4
-

- **Describe potential problems and address alternative approaches.**

1. Workforce Challenges such as supply and demand.
2. Information Silos- Staff has worked for many years in a solo structure. Getting people to work as a team requires new ways of communication such as electronic messaging and interdisciplinary team meetings. An alternative approach would be to emphasis and nurture the PACT team concept between all staff working out of the Riverhead CBOC: primary care staff, mental health staff, HBPC staff, and Telehealth staff

- **Detail how the program/project will be integrated into VISN/Program Office operations.**

This program will be integrated into VISN 3 Rural Health programming structure through the daily support of the facility Rural health Coordinator acting as a communication link between front line staff and the VISN Rural Consultant. Monthly meetings and individual team meetings at the facility level will be supported by the facility leadership team and the VISN-RC.

- **Address the relevance of the project to rural and highly rural Veteran populations.**

The Northport VAMC is a general medicine and surgical facility which is part of the New York/New Jersey VISN 3. Northport is a suburban town located in western Suffolk County, Long Island. The hospital provides veteran inpatients and outpatients with medical, surgical, psychiatric, rehabilitative and skilled nursing care. In addition to the main 200 bed facility, it offers services in 3 community-based outpatient clinics, a myriad

of outreach programs, a robust mental health program and a Home Based Primary Care Program. Suffolk County has over 160,000 Veterans as residents, has the highest concentration of veterans per capita in NY state.

- **Collaborations with other VHA facilities and/or public and private entities**

  Northport VAMC collaborates with all sister facilities in VISN 3 to enhance daily operations. Collaborative efforts include sharing SOPs for disruptive behavior, exchanging information regarding telecommunications such as EKG transmission, sample letters of correspondence and staffing methodology.

- **Address impact on health care service delivery for rural Veterans.**

The program aims to serve almost 20,000 potential non-user veterans residing in Suffolk County New York. Utilizing the Riverhead CBOC would enable veterans to have access to primary care, mental health care, home based primary care, Telehealth care and phlebotomy services all in a single site. Group mental health interventions as well as individual interventions will be more easily provided in the new clinic setting and will hopefully be more utilized by Veterans. An anticipated outcome of this project is to decrease the stigma of mental health care and offer non-pharmacologic approaches to care.

Budget

This CBOC budget is based on a staffing plan which is currently in place to provide mental health care to the existing 1,692 enrolled Veterans utilizing the Riverhead CBOC as well as a potential 19,000 non-users and non-enrolled veterans in eastern Suffolk County. The overall goal is to provide care utilizing the patient centered medical home model. The overall goal is to support the transformation of healthcare delivery to provide more patient centric care which requires a staffing plan which is reflected in the current retention of staff on board. Of important note are the leaderships efforts to transition staff to the new operational setting as well as to expand hours provided by providers and to offer group setting classes.

Estimate resources requested:

Category	Resource Request			Comments
	MS	MF	MSC	
Staffing				
Psychiatrist	$ 61,308			Sustainment (0.4 FTE)
Registered Nurse	$ 56,035			Sustainment (0.4 FTE)
Medical Support Assistant	$ 25,833			Sustainment (0.4 FTE)
Total	**$143,176**			

MS = Medical Services MF= Medical Facilities MSC=Medical Support and Compliance

3 **Service Area Environment –**

- The FY 2012 Rural health Initiative for Northport VAMC will continue to take place in Suffolk County, NY. Healthcare delivery will be delivered from the Riverhead, NY CBOC, and the Mobile Unit with support from the main medical center. Institutional support will include medical center leadership, OI&T, telecommunications, EMS, clerical, laboratory courier support, infection control. Additional program support from Mental Health, and VISN level Office of Telehealth Services exists.
- MOU ??????

4 **Program/Project Evaluation –**

Projected outcomes include increased enrollment by 10% for Suffolk County Veterans using healthcare services in primary care at the Riverhead CBOC. The measure will be evaluated monthly and reviewed by the CBOC Pact team as well as the Rural health Coordinator.

PROJECT NAME: Improving Rural Veterans Mental Health Care on eastern Long Island

Section I: Overview and objectives: In the table below concisely describe the project goals and list project milestones

Project Objectives	**Milestones/Key Events** (e.g. contracts awarded and FTEE on board) **By Quarter or more often as necessary & Targeted Completion Dates**			
	FY12 QTR 1	FY12 QTR 2	FY12 QTR 3	FY12 QTR 4
Improve rural Veterans' access to teleretinal screening for diabetic retinopathy part of annual exam for patients receiving psychotropic meds	Equipment Purchased	1 FTEE Screener on board	Complete training, begin imaging of rural Veterans	Program fully operational, actively screening Veterans
Increase hours of care	16 hrs/week			

Section II: Innovation and Likely Impact:

Department of Veterans Affairs

ORH VHA Office of Rural Health

Office of Rural Health
Proposal Funding Request Form

NUMBER OF RURAL VETERANS, ENROLLEES, OR PATIENTS IMPACTED:				
Geographic Area Impacted	Total Number of Rural and Highly Rural Veterans in Impacted Area	Expected number of rural Veterans that will be affected by this project		
		FY11	FY12	FY13
VISN 3 Northport VAMC eastern Long Island catchment area		180	225	265

Section III: Program/Project Evaluation: Please fill out table below.

If this is a **new, sustainment, or expansion** project, list intended measures for FY12, the timing of evaluation and including a description of who (what office or individual) will conduct the evaluation and how frequently the data will be collected and reported to ORH.

Measure: (Quality, Access, Cost, Satisfaction, etc.)	**Data Source** (VSSC, CHAPS, PSSG, OQP/SHEP, Veteran Comment Cards, etc.)	FY12 QTR 1	FY12 QTR 2	FY12 QTR 3	FY12 QTR 4
Veterans Served	VSSC Rural Health ProClarity Report	No data	100 rural Veterans impacted	225 rural Veterans impacted	265 rural Veterans impacted
Veteran Mileage Saved	Northport/Riverhead data compiled from CPRS, PSSG	No data	Saved 25 Veterans 500 driving miles	Cumulative: Saved 60 Veterans 1700 driving miles	Data unavailable

FY 09 TDA's

VISN	Sta.	CO	Station Transfer Number
3	632	86359	386

FY 10 TDA's

VISN	Station	CO	Station Transfer Number
3	632	5204	24
3	632	5958	31
3	632	7242	32
3	632	48291	233
3	632	62966	290
3	632	63340	291
3	632	63454	292
3	632	64082	294
3	632	73370	330
3	632	73374	331
3	632	73380	332
3	632	75117	339
3	632	77481	349
3	632	77816	353
3	632	77906	354
3	632	100656	469
3	632	108711	501
3	632	111869	515
3	632	111871	516
3	632	113632	518
3	632	115623	526
3	632	120612	552

KLF SOA Sept 30 2010 END OF FISCAL YEAR 2010

FUND	BFY	EFY	Program
0160BR	2009	2010	1
0160BR	2009	2010	1
0160BR	2009	2010	1
0160BR	2010	2011	1
0160BR	2010	2011	1
0160BR			
0162BR	2009	2010	1
0162BR	2009	2010	1
0162BR			

0162RH	2010	1
0162RH	2010	1
0162RH		

Ledger Notation	Appropriation	Program
V3RURALHEALTH	369/00160	870

Ledger Notation	Appropriation	Program
V3RHTELEHEALTHTELERETINAL	369/00160	870
V3RHTELEHEALTHTELERETINAL	369/00160	870
V3RHTELEHEALTHTELERETINAL	369/00160	870
V3-RURAL-HEALTH-TRF-NJ-TO-NP	369/00160	870
1RURALHEALTHVAN-RICHARDKITSON	369/00162	870
1RURALHEALTHVAN-RICHARDKITSON	369/00162	870
1RURALHEALTHVAN-RICHARDKITSON	369/00162	870
1RURALHEALTHVAN-RICHARDKITSON	369/00162	870
V3RHTELEHEALTHTELERETINAL	369/00160	870
V3RH-OCCS	369/00160	870
V3-RH-FEE	360/10160	870
1RURALHEALTHVAN-RICHARDKITSON	369/00162	870
1RURALHEALTHVAN-RICHARDKITSON	360/10160	870
1RURALHEALTHVAN-RICHARDKITSON	360/10160	870
1RURALHEALTHVAN-RICHARDKITSON	369/00160	870
V22FY10-GEC-FR-STA691-TRVL-CGARKLAVS	369/00160	870
V22FY10-GEC-FR-STA691-TRVL-RCASTAGNINO	369/00160	870
FY10RURALCBOCADDITIONALFUNDINGOPPORTUNITY	369/00160	870
FY10RURALCBOCADDITIONALFUNDINGOPPORTUNITY	3600162	870
FY10RURALCBOCADDITIONALFUNDINGOPPORTUNITY	3600162	870
FY10RURALCBOCADDITIONALFUNDINGOPPORTUNITY-REVERSING-A	3600162	870
FY10RURALCBOCADDITIONALFUNDINGOPPORTUNITY	3600162	870

ORGN/ACT Name	FUND & ACC
0100201M7	0160BR0100201M720092010
010024106	0160BR01002410620092010
UNDIST	0160BRUNDIST 20092010
0100201M7	0160BR0100201M720102011
UNDIST	0160BRUNDIST 20102011
	0160BR
010050141	0162BR01005014120092010
UNDIST	0162BRUNDIST 20092010
	0162BR

010040101	0162RH010040101
UNDIST	0162RHUNDIST
	0162RH

Limitation	FMS Fund	FMS BFY	FMS EBFY	FMS Program
2	0160BR	2009	2010	100

Limitation	FMS Fund	FMS BFY	FMS EBFY	FMS Program
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
2	0162BR	2009	2010	100
2	0162BR	2009	2010	100
2	0162BR	2009	2010	100
2	0162BR	2009	2010	100
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
2	0160BR	2010	2011	100
2	0162BR	2009	2010	100
2	0160BR	2010	2011	100
2	0160BR	2010	2011	100
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
2	0160BR	2009	2010	100
1	0162RH	2010		100
1	0162RH	2010		100
1	0162RH	2010		100
1	0162RH	2010		100

VISTA FCP#	VISTA DESCRIPTION	ORGN/ACT Name	QTR4 Budget Amount	QTR4 Oblig Amount
7900	RURAL HEALTH CARE	RURAL HEALTH RESOURCE	$1,111,659.00	$1,111,659.00
		OTHER SALARIES-NURSIN	$0.00	$0.00
		UNDIST TO PROGRAM	$0.00	.
7911	RURAL HEALTH CARE	RURAL HEALTH RESOURCE	$125,845.00	$125,845.00
		UNDIST TO PROGRAM	$0.00	.
			$1,237,504.00	$1,237,504.00
9066	VHA VANS/OTH TRANS	VHA VANS/OTHER TRANSP	$0.00	$0.00
		UNDIST TO PROGRAM	$0.00	.
			$0.00	$0.00

SAL - MEDICAL CARE	$0.00	$0.00
UNDIST TO PROGRAM	$0.00	
	$0.00	$0.00

Quarter1 Amount	Quarter2 Amount	Quarter 3 Amount	Quarter 4 Amount	Total Amount	From Mnemonic
$0	$0	$114,770	$0	$114,770	RHLH60-910

Quarter1 Amount	Quarter2 Amount	Quarter3 Amount	Quarter4 Amount	Total Amount	From Mnemonic
$ 27,486.00	$ -	$ -	$ -	$ 27,486.00	RHLH60-910
$ 27,486.00	$ -	$ -	$ -	$ 27,486.00	RHLH60-910
$ (27,486.00)	$ -	$ -	$ -	$ (27,486.00)	RHLH60-910
$ -	$ 167,256.00	$ -	$ -	$ 167,256.00	RHLH60-910
$ -	$ -	$ -	$ -	$ -	RHLH62-910
$ -	$ -	$ -	$ -	$ -	RHLH62-910
$ -	$ -	$ -	$ -	$ -	RHLH62-910
$ -	$ -	$ 35,000.00	$ -	$ 35,000.00	RHLH62-910
$ -	$ -	$ (27,486.00)	$ -	$ (27,486.00)	RHLH60-910
$ -	$ -	$ 27,486.00	$ -	$ 27,486.00	RHLH60-910
$ -	$ -	$ 125,845.00	$ -	$ 125,845.00	RHLH60-011
$ -	$ -	$ (35,000.00)	$ -	$ (35,000.00)	RHLH62-910
$ -	$ -	$ 35,000.00	$ -	$ 35,000.00	RHLH60-011
$ -	$ -	$ (35,000.00)	$ -	$ (35,000.00)	RHLH60-011
$ -	$ -	$ 35,000.00	$ -	$ 35,000.00	RHLH60-910
$ -	$ -	$ -	$ 2,336.00	$ 2,336.00	RHLH60-910
$ -	$ -	$ -	$ 2,336.00	$ 2,336.00	RHLH60-910
$ -	$ -	$ -	$ 762,475.00	$ 762,475.00	RHLH60-910
$ -	$ -	$ -	$ 374,218.00	$ 374,218.00	RHLH62
$ -	$ -	$ -	$ (374,218.00)	$ (374,218.00)	RHLH62
$ -	$ -	$ -	$ 374,218.00	$ 374,218.00	RHLH62
$ -	$ -	$ -	$ (374,218.00)	($374,218)	RHLH62
				$1,237,504	

QTR4 Unoblig Amount	FYTD Budget Amount	FYTD Oblig Amount	FYTD Unoblig Amount
$0.00	$1,111,659.00	$1,111,659.00	$0.00
$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	.	$0.00
$0.00	$125,845.00	$125,845.00	$0.00
$0.00	$0.00	.	$0.00
$0.00	$1,237,504.00	$1,237,504.00	$0.00
$0.00	$0.00	$0.00	$0.00
$0.00	$0.00	.	$0.00
$0.00	$0.00	$0.00	$0.00

$0.00	$0.00	$0.00	$0.00
$0.00	$0.00		$0.00
$0.00	$0.00	$0.00	$0.00
	$1,237,504.00		

To Mnemonic	Date of Release	Date of Confirmation
RHLH60.910	23-Jun-09	23-Jun-09

To Mnemonic	Date of Release	Date of Confirmation
RHLH60.910	16-Dec-09	16-Dec-09
RHLH60.910	23-Dec-09	23-Dec-09
RHLH60.910	4-Jan-10	4-Jan-10
RHLH60.910	31-Mar-10	31-Mar-10
RHLH62.910	6-May-10	6-May-10
RHLH62.910	6-May-10	6-May-10
RHLH62.910	7-May-10	7-May-10
RHLH62.910	11-May-10	11-May-10
RHLH60.910	4-Jun-10	4-Jun-10
RHLH60.910	4-Jun-10	4-Jun-10
RHLH60.011	4-Jun-10	4-Jun-10
RHLH62.910	10-Jun-10	10-Jun-10
RHLH60.011	17-Jun-10	17-Jun-10
RHLH60.011	18-Jun-10	18-Jun-10
RHLH60.910	18-Jun-10	18-Jun-10
RHLH60.910	19-Aug-10	19-Aug-10
RHLH60.910	1-Sep-10	1-Sep-10
RHLH60.910	8-Sep-10	8-Sep-10
RHLH162	8-Sep-10	8-Sep-10
RHLH162	10-Sep-10	10-Sep-10
RHLH162	14-Sep-10	14-Sep-10
RHLH162	21-Sep-10	21-Sep-10

Project Number	Project Name	Total Award	Obligated To-Date (08/08/13)	Accomplishments	Issues/Concerns
N03-FY13Q1-S1-P00414	NP Rural Non-Institutional Care and Respite	$1,995,900		Ninety unique veterans have received non-institutional care in FY 13 to date Services were provided to an average of 60 veterans in contract Homemaker/Home Health Aide (CH/HHA) program, 3 veterans in contract Adult Day Healthcare (CADHC), and 10 contracts Nursing home (CNH) placements. Program added 5 licensed homecare agencies, one Adult Day Healthcare facility and one Nursing facility able to serve rural Long Island • Project team completed outreach monthly at a minimum, increased Caregiver Support (offered two series of 6 presentations related to Bereavement), and increased veteran enrollment in Home Telehealth and Clinical Video Telehealth. • Weekly Huddle to monitor growth of program	• Contracting with additional J.C. approved agencies to supply HHA care specific to eastern Long Island. Actions to analyze Licensed and Accredited JC and CHAP agencies with eastern LI offices. Will also meet with Suffolk County office of the Aging. • Hurricane Sandy affected project growth in first quarter FY 13 and into second quarter (increased utilization of CNH program and reduced utilization of CADHC and CH/HHA programs). • Veterans are found to prefer in-home services through CH/HHA and contract skilled nursing rather than CADHC.
S03-FY12Q1-S2-P00337	NP Satellite HBPC on eastern Long Island	$973,096		• Current Census is 72 pts. • Staffing additions: 2 new RNs and 1 Dietitian. • Team is collaborating regarding assignments, vehicles, orientation for newer staff	• Motor vehicles for current Rural HBPC staff of 8. Working with Facility Motorpool

S03-FY12Q1-S2-P00336	NP Mobile Unit Program and Outreach on eastern Long Island	$513,587		• Long Island State Veterans Home Collaborative Project continues. The Outreach Team goes to the LISVH 1x/week to update eligibility, provide vesting exam or take photo ID. Project started 8/2012. YTD veterans served is 64. • February 18, 2013- Presentation for eastern Long Island Non-VA providers and healthcare professionals regarding referrals to VHA. Attended by 25 participants • March 11, 2013-Presentation to Suffolk County Legislature regarding Rural health program and Riverhead CBOC • YTD- 22 targeted eastern LI events/91 total events: 392 veterans attended, 922 new enrollees, 163 vesting exams, 140 blood pressures • The outreach team has gone to several veterans in the community approximately 7 veterans that are unable to attend events and have been examined and vested and most are determined to be a catastrophic priority group 4. • Participant in Veterans Benefits & Resource Fair- Stony Brook , NY • Participant in 3 Health Fairs • New Program plans- MMU Flu Vaccine Clinic- start date September 2013	• Additional driver needed. Working with HR regarding PD
N03-FY13Q1-S1-P00411	NP Mobile Unit Podiatry Program	$157,376		• April, 2013- successful 3 day OIG Inspection of MU Program with no findings or recommendations • August, 2013- successful 2 day OIG Audit of MU program • YTD veterans served = 361 • Additional location at Southold American Legion Hall (in addition to Riverhead & Patchogue CBOC) • Award of Out of Cycle Funding to support Podiatry Resident educational experience at Danville, Illinois VAMC • Expanded staff- 4 Podiatrist rotate staffing clinics	
03-FY13Q1-S1-P00409	NP Audiology Services at CBOC	$124,050		• Program started March 2013. Part-time program 2 days/week at Riverhead CBOC • YTD veterans serviced =311 • Miles saved= 17,293.09 miles • Plans to expand hours and location	• Awaiting Audiology Tech

Comment	Non- Funded Pilot Project PM&R Walk-In Clinic at Riverhead CBOC			• It is anticipated that implementing an assistive device/walk in clinic in The Riverhead CBOC would achieve the following benefits: • Improved patient access to needed safety devices • Reduced waiting times in completing the referred consult • Improved patient safety having obtained device more quickly • Decreased transportation costs to VA as clinic much closer proximity to their home. • Started April 9, 2013 • Goal is 15-20 veterans/month for 12 hr./week program • 53 veterans seen for 12 weeks	

Month	Maintenance Old MU	Maintenance New MU	Fuel Old/Gallon	Fuel Cost	Fuel New/Gallon	Fuel Cost
FY12				$3.78		$3.78
Oct-11	$0.00	$0.00	0.0	$0.00	n/a	n/a
Nov-11	$0.00	$0.00	0.0	$0.00	n/a	n/a
Dec-11	$0.00	$0.00	0.0	$0.00	n/a	n/a
Jan-12	$0.00	$282.50	0.0	$0.00	n/a	n/a
Feb-12	$214.66	$0.00	0.0	$0.00	n/a	n/a
Mar-12	$2,119.90	$818.35	0.0	$0.00	178.8	$675.86
Apr-12	$0.00	$196.00	90.1	$340.58	90.6	$342.46
May-12	$0.00	$0.00	74.0	$279.72	97.3	$367.79
Jun-12	$398.70	$49.01	90.0	$340.20	57.3	$216.59
Jul-12	$1,225.32	$0.00	144.0	$544.32	54.8	$207.14
Aug-12	$0.00	$163.00	45.0	$170.10	91.2	$344.73
Sep-12	$0.00	$610.00	80.0	$302.40	36.9	$139.48
TOTAL	$3,958.58	$2,118.86	523.1	$1,977.32	606.9	$2,294.05
FY13				$3.78		$3.78
Oct-12	$0.00	$0.00	0.0	$0	32.6	$123.22
Nov-12	$865.00	$98.00	44.0	$166.32	11.9	$449.82
Dec-12	$0.00	$0.00	47.0	$177.66	sandy	sandy
Jan-13	$138.80	$0.00	28.0	$105.84	sandy	sandy
Feb-13	$0.00	$0.00	103.0	$389.34	sandy	sandy
Mar-13	$451.90	$1,048.10	88.0	$332.64	59.1	$223.39
Apr-13	$0.00	$0.00	0.0	$0.00	116.4	$439.99
May-13	$0.00	$58.50	0.0	$0.00	185.6	$701.56
Jun-13	$0.00	$0.00	0.0	$0.00	136.1	$514.45
Jul-13	$0.00	$172.50	0.0	$0.00	105.9	$400.30
Aug-13	$0.00	$105.00	0.0	$0.00	70.3	$265.73
Sep-13						
TOTAL	$1,455.70	$1,482.10	310	$1,171.80	717.90	$3,117.46

Staff NP	Staff RN	Staff Driver	Staff RH Coord
$125,516.51	$122,414.96	$63,218.60	149.485.91
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$10,459.71	$10,201.25	$5,268.22	$12,457.15
$125,516.51	$122,414.96	$63,218.60	149.485.91
$132,118.37	$130,537.18	$72,511.89	$165,272.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$11,009.86	$10,878.10	$6,042.66	$13,772.73
$132,118.37	$130,537.18	$72,511.89	$165,272.73

Production Unit MM - Primary Care

FY12	1081201	1083201	2560201	2587201	3131201
OCT-FY12	$10,664.53	$525.54			
NOV-FY12	$11,470.22	$578.06	$13,522.80	$31,457.93	
DEC-FY12	$11,445.52	$647.03	$9,320.80	$15,728.97	
JAN-FY12	$11,608.30	$651.50	$10,721.47	($31,461.75)	
FEB-FY12	$11,612.18	$649.33	$7,272.33	$10,455.00	
MAR-FY12	$13,207.04	$166.46	$11,702.95	$24,670.90	
APR-FY12	$11,075.96	$0.00	$13,986.45	$13,929.08	
MAY-FY12	$9,354.47		$13,926.36	$14,420.69	
JUN-FY12	$8,867.03		$12,262.97	$14,420.69	
JUL-FY12	$9,127.50		$60,932.26	($580.89)	
AUG-FY12	$9,312.53		($49,224.11)	$74,596.38	
SEP-FY12	$8,183.95		$5,930.76	$34,556.72	
	$125,929.23	$3,217.92	$110,355.04	$202,193.72	$0.00

FY13	1081201	1083201	2560201	2587201	3131201
OCT-FY13	$9,466.09		$4,773.71	($96,844.28)	
NOV-FY13	$9,060.86		$14,866.48	$56,194.12	$1,420.73
DEC-FY13	$55,140.45		$8,804.25	$24,303.09	$154,364.33
JAN-FY13	$87,559.17		$28,141.31	$10,876.00	$25,136.49
FEB-FY13	$62,716.33		$15,597.92	$43,555.55	$2,766.84
MAR-FY13	$77,920.43		$13,652.48	$41,353.83	$20,108.61
APR-FY13	$53,244.22		$27,152.70	$45,870.16	$2,125.52
MAY-FY13	$71,696.95		$4,622.08	$45,842.70	$10,212.55
JUN-FY13	$69,207.36		$4,272.67	$22,432.42	$7,677.77
	$496,011.86	$0.00	$121,883.60	$193,583.59	$223,812.84

1061202	1017203	1081203	1082203	2587203	1031204
		$41,702.35			$2,263.38
		$45,358.79			$2,376.96
		$44,966.29			$2,707.57
		$46,314.19			$2,449.14
		$52,508.41			$2,354.08
		$67,744.40			$2,195.23
		$55,943.47			$2,195.22
		$61,311.99			$0.00
		$55,271.99			
		$62,788.02			
		$53,561.15	$3,325.59		
		$44,201.09	$7,407.47		
$0.00	$0.00	$631,672.14	$10,733.06	$0.00	$16,541.58

1061202	1017203	1081203	1082203	2587203	1031204
$2,803.77		$73,497.45	$8,371.32	($18,308.33)	
		$70,046.65	$8,385.23	$5,932.87	
	$435.64	$66,114.57	$7,995.20	$2,592.19	
	$895.04	$76,901.04	$9,227.26	$427.69	
	$783.21	$66,588.22	$7,995.77	$653.33	
	$955.19	$82,597.23	$11,750.87	$201.88	
	$856.16	$53,874.90	$10,158.91	$707.60	
	$895.24	$57,393.53	$0.00	$707.87	
	$778.01	$49,272.73	$15,305.90	$174.02	
$2,803.77	$5,598.49	$596,286.32	$79,190.46	($6,910.88)	$0.00

1064204	1081204	1084204	2561204	2587204	1031207
$12,948.21	$312,188.66	$19,260.05	$95,328.66		
$13,491.43	$329,653.50	$20,203.30	$109,931.15	$20,000.00	
$12,988.69	$328,935.86	$20,194.43	$97,000.41	$10,000.00	
$13,610.47	$345,363.14	$20,194.70	$110,092.33	($295.97)	
$18,802.74	$346,083.13	$20,194.94	$99,404.02	$7,500.00	
$22,860.74	$405,205.90	$19,273.33	$140,294.85	$21,265.18	
$22,875.16	$331,097.95	$19,276.67	$95,563.93	$9,992.16	
$25,298.93	$362,469.52	$21,113.15	$116,315.83	$10,344.83	
$23,056.94	$331,197.42	$19,276.69	$105,967.98	$10,344.83	
$24,144.91	$346,092.73	$20,194.92	$121,496.49	($1,387.16)	
$25,206.13	$349,173.82	$21,109.85	$169,465.65	$41,764.04	
$22,056.79	$304,174.69	$18,358.42	$150,704.63	$19,583.18	
$237,341.14	$4,091,636.32	$238,650.45	$1,411,565.93	$149,111.09	$0.00

1064204	1081204	1084204	2561204	2587204	1031207
$25,153.95	$395,117.92	$21,113.17	$178,772.11	($53,140.00)	
$24,151.91	$383,636.10	$20,194.91	$158,997.02	$35,087.46	
$22,623.17	$294,256.69	$19,276.69	$168,626.34	$15,210.90	
$25,297.43	$359,329.41	$21,116.57	$179,255.12	$11,562.73	
$21,999.89	$313,851.90	$18,358.44	$145,808.24	$16,488.89	
$8,626.02	$391,712.32	$19,320.20	$244,737.92	$18,844.44	$4,504.58
$10,806.18	$372,772.07	$20,438.17	$180,852.57	$17,858.55	$12,959.58
$11,311.07	$386,717.38	$21,384.40	$172,853.50	$17,865.17	$13,548.86
$10,264.58	$331,474.99	$19,238.43		$12,782.97	$11,781.11
$160,234.20	$3,228,868.78	$180,440.98	$1,429,902.82	$92,561.11	$42,794.13

COSTED ACCOUNT					
1081211	1020221	1024224	2631224	1085227	1028228
$1,821.10		$21,895.14	$614.16	$14,008.78	
$1,907.87		$28,669.46	$248.59	$17,569.12	
$1,903.03		$40,548.11	$344.63	$17,879.79	
$1,910.16		$46,901.00	$234.44	$16,068.70	
$1,910.17		$45,831.78	$234.09	$14,100.90	
$2,285.11		$43,518.73	$254.72	$13,321.70	
$1,823.30		$44,151.50	$531.60	$13,647.83	
$1,997.03		$49,002.67	$257.48	$14,886.49	
$1,823.30		$34,142.51	$125.65	$13,353.29	
$1,910.17		$34,760.77	$317.72	$14,155.74	
$1,996.59		$35,640.03	$301.43	$14,953.79	
$1,736.43		$31,758.59	$282.94	$13,000.91	
$23,024.26	$0.00	$456,820.29	$3,747.45	$176,947.04	$0.00

COSTED ACCOUNT					
1081211	1020221	1024224	2631224	1085227	1028228
$1,997.03		$25,146.76	$326.80	$14,856.55	
$1,910.17		$14,127.69	$284.18	$14,449.25	
$1,823.12		$13,378.28	$282.98	$13,415.74	
$1,998.60	$640.88	$13,842.87	$135.50	$15,512.78	
$1,738.58	$575.23	$10,494.70	$67.09	$13,843.05	
$2,246.33	$599.71	$11,432.35	$43.32	$14,316.68	
$1,912.52	$6,991.75	$11,967.34	$636.78	$17,517.20	$3,944.04
$1,999.49	$6,986.07	$12,478.87	$192.47	$17,785.01	$3,995.09
$1,738.58	$5,766.23	$10,926.66	$92.25	$15,650.99	$3,452.96
$17,364.42	$21,559.87	$123,795.52	$2,061.37	$137,347.25	$11,392.09

1079231	1031241	1061241	1064241	1065241	1015242
	$29,955.28	$174,536.74	$57,879.20	$83,854.55	
	$31,348.48	$192,245.71	$58,256.55	$89,725.86	
	$34,116.47	$192,758.45	$55,481.92	$93,630.68	
	$31,308.36	$205,413.13	$56,326.07	$96,242.34	
	$31,930.99	$202,017.99	$56,045.75	$90,422.95	
	$30,885.75	$192,349.89	$58,576.22	$83,609.05	
$2,481.85	$47,002.69	$226,691.02	$56,281.72	$87,904.34	
$3,435.98	$50,679.65	$268,067.12	$62,226.32	$96,419.75	
$2,341.77	$47,008.04	$246,645.75	$52,418.66	$83,995.54	
$2,849.36	$46,864.86	$262,609.54	$57,713.25	$90,528.64	
$2,999.85	$45,792.86	$286,389.38	$72,254.43	$95,837.88	
$2,974.31	$44,738.52	$245,367.07	$63,238.22	$89,944.51	
$17,083.12	$471,631.95	$2,695,091.79	$706,698.31	$1,082,116.09	$0.00

1079231	1031241	1061241	1064241	1065241	1015242
$3,445.56	$44,613.12	$305,358.76	$81,395.06	$116,113.41	
$2,680.16	$41,999.31	$310,217.43	$94,927.17	$116,467.51	
$3,029.92	$43,211.15	$294,049.69	$90,625.79	$109,501.98	
$2,643.71	$43,272.80	$335,081.46	$105,351.24	$109,533.16	$2,734.37
$2,317.40	$38,037.50	$296,052.11	$96,723.50	$105,672.31	$4,776.83
$3,013.39	$40,893.76	$329,825.09	$113,157.19	$112,939.67	$5,222.87
$2,510.41	$41,570.57	$336,346.32	$103,780.91	$112,801.23	$6,112.20
$2,815.43	$44,147.05	$348,593.05	$105,161.07	$124,413.06	$1,292.45
$2,566.45	$38,500.02	$296,763.21	$90,525.83	$103,264.60	$5,117.07
$25,022.43	$376,245.28	$2,852,287.12	$881,647.76	$1,010,706.93	$25,255.79

1016242	1031250	2632281	1031286	1061409	1081409
		$3,270.36			$3,261.79
		$2,994.46			$2,979.51
		$3,224.40			$3,707.75
		$3,023.77		$4,808.64	$3,446.85
		$2,943.29		($3,834.69)	$3,393.96
		$2,749.18		$9,236.93	$3,984.42
		$3,169.47		$9,251.35	$3,269.63
		$4,190.87		$10,131.03	$3,582.65
		$3,485.87	$3,240.56	$9,252.33	$3,270.43
		$3,973.91	$2,311.64	$9,699.79	$3,251.60
		$3,940.67	$2,404.30	$10,124.50	$3,356.32
		$3,286.75	$2,099.37	$9,109.13	$2,943.96
$0.00	$0.00	$40,253.00	$10,055.87	$67,779.01	$40,448.87

1016242	1031250	2632281	1031286	1061409	1081409
		$4,243.09	$2,880.57	$9,795.73	$3,396.86
		$3,675.13	$2,074.52	$9,717.43	$3,246.91
		$3,734.79	$3,486.90	$9,334.07	$3,323.36
$2,324.94		$3,804.90	$2,787.24	$10,145.87	$3,497.28
$4,002.65		$2,674.20	$2,202.46	$7,419.16	$3,037.57
$4,332.75	$2,852.00	$3,412.17	$1,952.44	$9,894.06	$3,819.14
$4,428.43	$19,689.36	$4,507.65	$2,304.23	$9,685.46	$3,342.00
$4,636.70	$20,765.10	$3,166.95	$2,408.98	$10,442.01	$3,495.75
$4,015.08	$18,040.63	$3,450.29	$2,094.76	$16,676.43	$3,037.57
$23,740.55	$61,347.09	$32,669.17	$22,192.10	$93,110.22	$30,196.44

1031411
$327.44
$327.44

1031411
$0.00

Anderson, Joanne Catherine

From: Fertil, Bertha
Sent: Friday, July 15, 2011 1:18 PM
To: Anderson, Joanne Catherine
Cc: Hessman, Mary Pat
Subject: RE: RH Funding - CORRECTION

RH Project Code: **FY10CBOC-V03-A**
Project Title: **Riverhead CBOC**
Station #: **480**

From: Fertil, Bertha
Sent: Friday, July 15, 2011 1:13 PM
To: Anderson, Joanne Catherine
Cc: Hessman, Mary Pat
Subject: RE: RH Funding

Hi Joanne:

As far as I've checked the Riverhead CBOC doesn't have an original RH Project Code and Project Title that goes back to FY09. Funding for Riverhead was secured in mid-September 2010. The $1,136,693 in funding for Riverhead started in FY10.

Funding Year	Category	MF	MS	MSC	TOTAL
10	CBOC	$374,218	$762,475	$0	$1,136,693

Below are the RH Project Code and Project Title, I've used in the past.

RH Project Code: **V03-A**
Project Title: **Riverhead CBOC**
Station #: **480**

Thanks,
Bertha

From: Anderson, Joanne Catherine
Sent: Friday, July 15, 2011 12:49 PM
To: Fertil, Bertha
Cc: Hessman, Mary Pat
Subject: RH Funding

I need an original RH Project Code and Project Title.
Probably from 09.
Can you send this?

JoAnne

ORH Report- Northport VAMC Milestones/Key Events FY11					
Project Goals	**Objectives**	FY QTR 1	FY QTR 2	FY QTR 3	FY QTR 4
Increase Outreach Efforts to eastern Long Island communities	Broaden understanding of VA benefits, programs and secure enrollment vesting exam appointment. Panel Style Outreach sessions offered at American Legion meetings & Community events. Panel includes program coordinators from Women's Health, Telehealth, HBPC, OEF/OIF, MyHealtheVet	NA	4 sessions completed	10 sessions planned	15 sessions
Increase Outreach Efforts to Native American Veteran population	Broaden Native American Veteran understanding of benefits and healthcare services.	NA	2/25/2011 Facility Director & EEHCP met with Tribal leaders & members at Shinnecock Reservation. Bi-weekly correspondence with Shinnecock Nations veterans Coordinator 5/5/2011- Shinnecock Outreach 4/13/2011 Poospetuck reservation visit	Outreach Events to Wyandanch, Mastic, Setauket	Native American Month-celebration planned with SEPM
Expand Mobile Unit Program	Increase use of Mobile Unit; Hire 1.0 FTE RN and 1.0 FTE NP to provide education and vesting exams. Northport webpage site.	NA	RN/NP interviews and selections	Continued collaboration with Npt. Telehealth lead.	7/2011 Training session at Npt.
Use GIS to support planning and decision making in Rural Health	Determine location of patients to VHA care. Identify geographic access gaps.Collaborate with VISN Strategic Planner. Collaborate with VISN Rural health partners. Geographic/Zip code tracking	VSSC training- Proclarity basics and beyond Basics Use GIS to plan Mobile Unit route according to zip codes, Vet pop density.	3/15/2011 VISN 3 GIS Portal Demo- 1 hr. training.	Correspondence with eastern LI, District 1 & 2. Support Ribbon Cutting ceremony for CBOC.	
Collaborate with ORH	Participate in educational program & identify VA opportunities for increasing care and programs to rural areas of Long Island.	NA	RHPI 1/31-2/4- 4 attendees ORH Systems Redesign project: Increase Teleheatlh referrals by10%		
Pursue partnerships	Library and Community program via	NA	4/1/2011Suffolk County	Continue email and	

with non-VA partners	Medical Library Service Chief.		Office of Aging 3/21/2011Suffolk County Correctional Facility	VANTS call correspondence. Disseminate monthly newsletter.	
Veteran Satisfaction	Maintain and/or improve Westhampton SHEP scores at new location in Riverhead	NA	Receive RHPI satisfaction scores	Decrease to <30 days Increase Open Access to 10% of appts.	Increase by 10%

Email from Joanne Anderson 6/19/2014 @ 1:57PM

Item 6. Explanation

The Mobile Medical Unit is deployed as an asset for Health Screenings for Outreach Events, and for use for the Mobile Unit Podiatry program.

Locations are determined based upon clinic appointments, veteran population and GIS mapping.

Weekly and monthly meetings are held to discuss locations, routes, efficiency of clinics.

GIS mapping is posted on the Northport Data Management Page.

This ORH status report indicates that GIS mapping and veteran demographics have been used to determine locations for use of the MMU.

NORTHPORT VAMC MOBILE MEDICAL UNIT REPORT
OPERATIONAL COSTS FY12 and FY13
September 12, 2013

1. Exactly how NP currently uses (or used) each of the mobile units for RH

MOBILE UNIT & OUTREACH TEAM

- *ORH Mobile Unit Program and Outreach on eastern Long Island- FY10CBOC-V03-A*
- Outreach events to provide vesting exams in one of three exam rooms which offers privacy, in a professional healthcare setting which meets JC standards. Vesting exams include basic physical exam, inclusive of basic fundoscopic eye exam and auditory ear canal. Each exam room is equipped with an exam table, otoscope, weight scale, electrical outlet for laptop connectivity.
- VHA enrollment sessions which includes review of benefits with an eligibility officer, identification card picture, general informational session.
- Seasonal Flu vaccine Program started 9/11/2013.
- Long Island State Veterans Home Collaborative Program- Stony Brook- Weekly enrollment and updating of priority
- Outreach Staff covered by the ORH Mobile Unit/Outreach Funding Proposal include driver, Nurse Practitioner, Registered Nurse and RH Coordinator. Staff are dedicated to the Outreach and Community Relations department. Duties include pre-and post event work. Staff do not "float" to other departments in the medical center.
- FY12 Outreach Events - 20 Rural Outreach events in which the MMU was utilized, 722 veterans attended, 161 new enrollees, 158 vesting exams, 354 BPs
- FY13 YTD Outreach Events- 21 Rural Outreach events, 363 attended, 81 new enrollees, 99 vesting exams, 61 BPs

MOBILE UNIT PODIATRY PROGRAM

- *ORH Proposal Number FY13Q1-S1-P00411- Mobile Unit Podiatry Program*
- Mobile Unit Podiatry program at Riverhead CBOC, Patchogue CBOC, Southold American Legion Hall.
- Mobile Unit Podiatry Program started 3/6/2012 at 2 locations (Riverhead CBOC & Patchogue CBOC)
- Clinic started at 4 hours 8am-12 pm (March –June)
- Clinic hours increased to 5 hours (June-Sept)
- FY12 Q2 & Q3 -554 visits,1746 % increase in visits for eastern Long Island veterans over 6 month period, 185 new referrals to VA podiatry service.
- FY 13 YTD- 790 visits, 210 new referrals to VA podiatry service

2. How much we transferred or expect to transfer to the RH accounts that can be attributable to RH work done using the *Mobile Units (per unit if possible)*

This is the part of the information that was sent to the OIG regarding DSS cost:

A) Total costs associated with departments MM11, AMM3 and AMM5 are listed below by production unit. M1 is the General Medicine clinic where Outreach products are captured and

MM is the Primary Care CBOC's where Podiatry mobile unit products are captured. Costs are extracted monthly and mapped by labor and obligations.

Production Unit	Account	FY12	FY13
(M1) General Medicine/Short Stay Care Unit	1061241	$254,020.29	$216,901.25
(M1) General Medicine/Short Stay Care Unit	1061401	$7,242.25	
(M1) General Medicine/Short Stay Care Unit	1064241	$208,119.63	$125,831.03
(M1) General Medicine/Short Stay Care Unit	1081204	$233,811.80	$149,847.87
(M1) General Medicine/Short Stay Care Unit	2561204		$18,993.40
(MM) Primary Care Clinic	1015242		$25,255.79
(MM) Primary Care Clinic	1016242		$23,740.55
(MM) Primary Care Clinic	1017203		$5,598.49
(MM) Primary Care Clinic	1020221		$21,559.87
(MM) Primary Care Clinic	1024224	$456,820.29	
(MM) Primary Care Clinic	1024224		$123,795.52
(MM) Primary Care Clinic	1028228		$11,392.09
(MM) Primary Care Clinic	1031204	$16,541.58	
(MM) Primary Care Clinic	1031207		$42,794.13
(MM) Primary Care Clinic	1031241	$471,631.95	
(MM) Primary Care Clinic	1031241		$376,245.28
(MM) Primary Care Clinic	1031250		$61,347.09
(MM) Primary Care Clinic	1031286	$10,055.87	
(MM) Primary Care Clinic	1031286		$22,192.10
(MM) Primary Care Clinic	1031411	$327.44	
(MM) Primary Care Clinic	1061202		$2,803.77
(MM) Primary Care Clinic	1061241	$2,695,091.79	
(MM) Primary Care Clinic	1061241		$2,852,287.12
(MM) Primary Care Clinic	1061409	$67,779.01	
(MM) Primary Care Clinic	1061409		$93,110.22
(MM) Primary Care Clinic	1064204	$237,341.14	
(MM) Primary Care Clinic	1064204		$160,234.20
(MM) Primary Care Clinic	1064241	$706,698.31	
(MM) Primary Care Clinic	1064241		$881,647.76
(MM) Primary Care Clinic	1065241	$1,082,116.09	
(MM) Primary Care Clinic	1065241		$1,010,706.93
(MM) Primary Care Clinic	1079231	$17,083.12	
(MM) Primary Care Clinic	1079231		$25,022.43
(MM) Primary Care Clinic	1081201	$125,929.23	

(MM) Primary Care Clinic	1081201		$496,011.86
(MM) Primary Care Clinic	1081203	$631,672.14	
(MM) Primary Care Clinic	1081203		$596,286.32
(MM) Primary Care Clinic	1081204	$4,091,636.32	
(MM) Primary Care Clinic	1081204		$3,228,868.78
(MM) Primary Care Clinic	1081211	$23,024.26	
(MM) Primary Care Clinic	1081211		$17,364.42
(MM) Primary Care Clinic	1081409	$40,448.87	
(MM) Primary Care Clinic	1081409		$30,196.44
(MM) Primary Care Clinic	1082203	$10,733.06	
(MM) Primary Care Clinic	1082203		$79,190.46
(MM) Primary Care Clinic	1083201	$3,217.92	
(MM) Primary Care Clinic	1084204	$238,650.45	
(MM) Primary Care Clinic	1084204		$180,440.98
(MM) Primary Care Clinic	1085227	$176,947.04	
(MM) Primary Care Clinic	1085227		$137,347.25
(MM) Primary Care Clinic	2560201	$110,355.04	
(MM) Primary Care Clinic	2560201		$121,883.60
(MM) Primary Care Clinic	2561204	$1,411,565.93	
(MM) Primary Care Clinic	2561204		$1,429,902.82
(MM) Primary Care Clinic	2587201	$202,193.72	
(MM) Primary Care Clinic	2587201		$193,583.59
(MM) Primary Care Clinic	2587203		($6,910.88)
(MM) Primary Care Clinic	2587204	$149,111.09	
(MM) Primary Care Clinic	2587204		$92,561.11
(MM) Primary Care Clinic	2631224	$3,747.45	
(MM) Primary Care Clinic	2631224		$2,061.37
(MM) Primary Care Clinic	2632281	$40,253.00	
(MM) Primary Care Clinic	2632281		$32,669.17
(MM) Primary Care Clinic	3131201		$223,812.84

Rural Health Podiatry mobile supplies were budgeted at $15,000 for FY12 and FY13.

B) **Costs associated with Fuel and Maintenance:**

Month	Maintenance Old MU	Maintenance New MU	Fuel Old/Gallon	Fuel Cost	Fuel New/Gallon	Fuel Cost	Staff NP	Staff RN	Staff Driver	Staff RH Coord
FY12				$3.78		$3.78	$125,516.51	$122,414.96	$63,218.60	149.485.91
Oct-11	$0.00	$0.00	0.0	$0.00	n/a	n/a	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Nov-11	$0.00	$0.00	0.0	$0.00	n/a	n/a	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Dec-11	$0.00	$0.00	0.0	$0.00	n/a	n/a	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Jan-12	$0.00	$282.50	0.0	$0.00	n/a	n/a	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Feb-12	$214.66	$0.00	0.0	$0.00	n/a	n/a	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Mar-12	$2,119.90	$818.35	0.0	$0.00	178.8	$675.86	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Apr-12	$0.00	$196.00	90.1	$340.58	90.6	$342.46	$10,459.71	$10,201.25	$5,268.22	$12,457.15
May-12	$0.00	$0.00	74.0	$279.72	97.3	$367.79	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Jun-12	$398.70	$49.01	90.0	$340.20	57.3	$216.59	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Jul-12	$1,225.32	$0.00	144.0	$544.32	54.8	$207.14	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Aug-12	$0.00	$163.00	45.0	$170.10	91.2	$344.73	$10,459.71	$10,201.25	$5,268.22	$12,457.15
Sep-12	$0.00	$610.00	80.0	$302.40	36.9	$139.48	$10,459.71	$10,201.25	$5,268.22	$12,457.15
TOTAL	$3,958.58	$2,118.86	523.1	$1,977.32	606.9	$2,294.05	$125,516.51	$122,414.96	$63,218.60	149.485.91
FY13				$3.78		$3.78	$132,118.37	$130,537.18	$72,511.89	$165,272.73
Oct-12	$0.00	$0.00	0.0	$0	32.6	$123.22	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Nov-12	$865.00	$98.00	44.0	$166.32	11.9	$449.82	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Dec-12	$0.00	$0.00	47.0	$177.66	sandy	sandy	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Jan-13	$138.80	$0.00	28.0	$105.84	sandy	sandy	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Feb-13	$0.00	$0.00	103.0	$389.34	sandy	sandy	$11,009.86	$10,878.10	$6,042.66	$13,772.73

Mar -13	$451.90	$1,048.10	88.0	$332.64	59.1	$223.39	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Apr-13	$0.00	$0.00	0.0	$0.00	116.4	$439.99	$11,009.86	$10,878.10	$6,042.66	$13,772.73
May -13	$0.00	$58.50	0.0	$0.00	185.6	$701.56	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Jun-13	$0.00	$0.00	0.0	$0.00	136.1	$514.45	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Jul-13	$0.00	$172.50	0.0	$0.00	105.9	$400.30	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Aug-13	$0.00	$105.00	0.0	$0.00	70.3	$265.73	$11,009.86	$10,878.10	$6,042.66	$13,772.73
Sep-13							$11,009.86	$10,878.10	$6,042.66	$13,772.73
TOTAL	$1,455.70	$1,482.10	310	$1,171.80	717.90	$3,117.46	$132,118.37	$130,537.18	$72,511.89	$165,272.73

Northport expenses for Staff Podiatrist = $30,000 in 2012 and 142,376 in FY13

3. **Can we get this breakout for FY 12/13 respectively?** See above
   Northport did not have a separate DSS department for Rural Health and workload was entered in primary care and Podiatry. A new Rural Health department will be created for FY14.

RH MMU Staffing

Email sent by Joanne Anderson 6/19/2014 @ 3:45PM

Staffing used for Outreach Events and the Mobile Unit Podiatry Program is noted below. Clinical care includes: Hypertension Screening, Vesting Physical Exams, Non-complex podiatric care.

Staffing for the MMU for the period FY 11- 12:

1. Outreach Nurse Practitioner- 1 FTE
2. Outreach Registered Nurse- 1 FTE
3. Mobile Medical Unit Driver/medical Support Assistant- 1 FTE

Additional staff are scheduled depending on the number of anticipated attendees. Attendees are estimated based upon a pre-event call to the Community Relations Office and/or completion of a pre-event registration form by the veteran. Events are customized so that a positive enrollment or clinical experience is provided. Additional staff for enrollment events include:

4. Eligibility Officer
5. Community Relations Supervisor
6. RH Coordinator
7. Medical Support Assistant

The Mobile Unit Podiatry program is scheduled as a 4 hour clinic and patients are given an appointment time. Podiatrists are scheduled weekly. A consistent pool of 5 Podiatrist provide staffing for the MU Podiatry Program.

JoAnne Anderson RN MSN

Executive Assistant to Director

Northport VAMC

79 Middleville Road, Northport, NY 11768

Office: 631-261-4400 ext 5943

Fax: 631-754-7933

Joanne.anderson2@va.gov

UNIQUE TREND REPORT VSSC 1 AND 5 YEAR COMPARISON

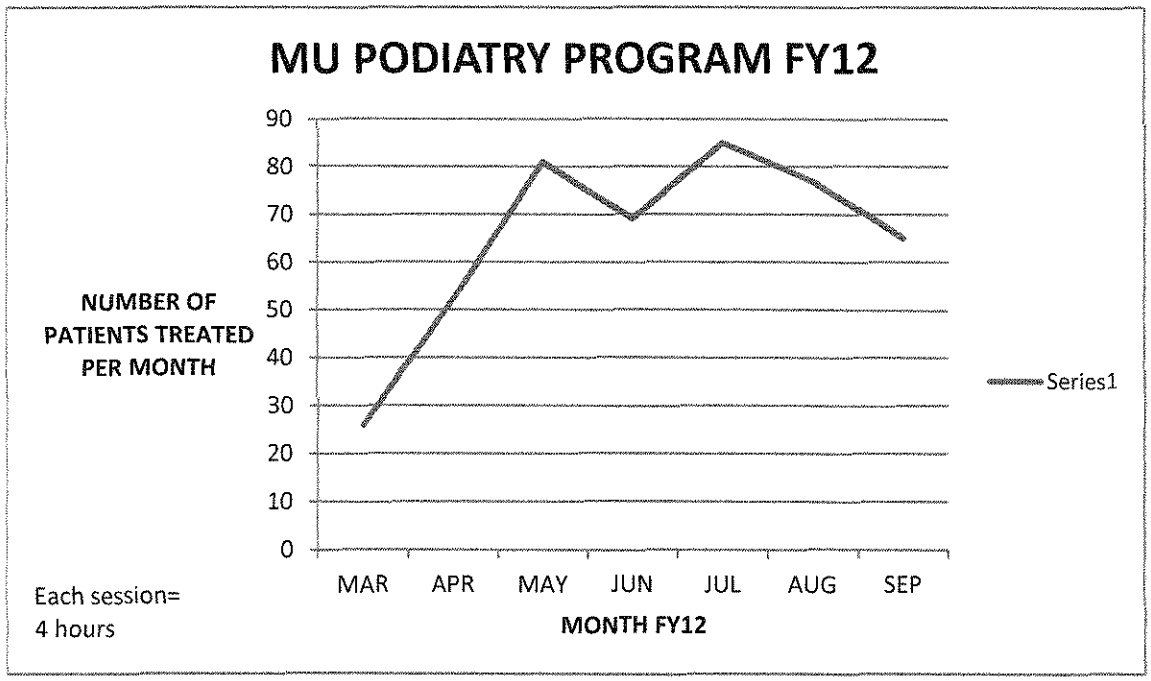
VISN/Parent Station	Data displayed for: S	0	0	0	0	0	0	0	0	0
(V03) (526) Bronx, NY	Priority Group	FY09	FY10	FY11	FY12	FY13	1YR Diff	1YR Change	5YR Diff	5YR Change
0	Priority 1-6	17427	17631	17340	17871	20340	2469	0.138	2913	0.167
0	Priority 7-8	6435	5745	5500	5395	5836	441	0.082	-599	-0.093
0	Not Enrolled	2145	1922	1454	1531	1566	35	0.023	-579	-0.27
0	Unknown	0	0	125	299	261	-38	-0.127	0	0
0	All Priorities	26007	25298	24419	25096	28003	2907	0.1158	1996	0.0767
(V03) (561) New Jersey HCS,	Priority Group	FY09	FY10	FY11	FY12	FY13	1YR Diff	1YR Change	5YR Diff	5YR Change
0	Priority 1-6	35626	37568	37500	38020	37999	-21	-0.001	2373	0.067
0	Priority 7-8	19270	18585	17470	16894	16159	-735	-0.044	-3111	-0.161
0	Not Enrolled	3710	3243	3210	3375	3256	-119	-0.035	-454	-0.122
0	Unknown	0	0	306	626	454	-172	-0.275	0	0
0	All Priorities	58606	59396	58486	58915	57868	-1047	-0.0178	-738	-0.0126
(V03) (620) VA Hudson Valle	Priority Group	FY09	FY10	FY11	FY12	FY13	1YR Diff	1YR Change	5YR Diff	5YR Change
0	Priority 1-6	13719	14118	14565	15013	15338	325	0.022	1619	0.118
0	Priority 7-8	9431	9111	8883	8360	8061	-299	-0.036	-1370	-0.145
0	Not Enrolled	1658	1687	1566	1384	1406	22	0.016	-252	-0.152
0	Unknown	2	2	86	240	208	-32	-0.133	206	103
0	All Priorities	24810	24918	25100	24997	25013	16	0.0006	203	0.0082
(V03) (630) New York Harbor	Priority Group	FY09	FY10	FY11	FY12	FY13	1YR Diff	1YR Change	5YR Diff	5YR Change
0	Priority 1-6	35516	35971	36162	36227	33942	-2285	-0.063	-1574	-0.044
0	Priority 7-8	9832	9633	9394	9242	8736	-506	-0.055	-1096	-0.111
0	Not Enrolled	5976	5100	4923	3948	3572	-376	-0.095	-2404	-0.402
0	Unknown	0	1	298	698	593	-105	-0.15	1	1
0	All Priorities	51324	50705	50777	50115	46843	-3272	-0.0653	-4481	-0.0873
(V03) (632) Northport, NY	Priority Group	FY09	FY10	FY11	FY12	FY13	1YR Diff	1YR Change	5YR Diff	5YR Change
0	Priority 1-6	18699	19550	19786	19792	19924	132	0.007	1225	0.066
0	Priority 7-8	13177	13138	13142	12710	11833	-877	-0.069	-1344	-0.102
0	Not Enrolled	1295	1044	1159	1262	1263	1	0.001	-32	-0.025
0	Unknown	1	0	109	509	307	-202	-0.397	306	306
0	All Priorities	33172	33732	34196	34273	33327	-946	-0.0276	155	0.0047
V03	Priority Group	FY09	FY10	FY11	FY12	FY13	1YR Diff	1YR Change	5YR Diff	5YR Change
0	Priority 1-6	111669	115238	115770	116810	115899	-911	-0.008	4230	0.038
0	Priority 7-8	55958	54562	52772	50940	48723	-2217	-0.044	-7235	-0.129

UNIQUE TREND REPORT VSSC 1 AND 5 YEAR COMPARISON

0	Not Enrolled	14573	12701	12020	11241	10891	-350	-0.031	-3682	-0.253	
0	Unknown	3	3	921	2354	1815	-539	-0.229	1812	604	
0	All Priorities	182203	182504	181483	181345	177328	-4017	-0.0222	-4875	-0.0268	
Link to Unique Patients Cube	0	0	0	0	0	0	0	0	0	0	

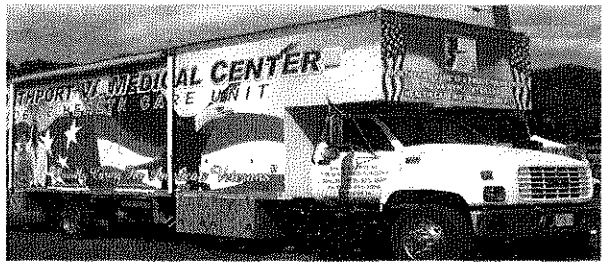
NORTHPORT VAMC MOBILE UNIT PODIATRY PROGRAM
MARCH 6, 2012 THRU SPTEMBER 30, 2012

Month	Attended
MAR	26
APR	52
MAY	81
JUN	69
JUL	85
AUG	77
SEP	65
	455



Department of Veterans Affairs Medical Center

79 Middleville Road, Northport, NY 11768
Mobile Unit Request Form 2012



Northport VA Medical Center has established the Mobile Unit Program to provide health education and screenings for Veterans in the community setting. The Mobile Unit Program operates at designated sites and at special community events and should be scheduled 2 to 3 weeks in advance. Confirmation of Northport VAMCs attendance at the event will be given based on our availability. The requesting organization will provide coordination of 6 parking spaces for the mobile unit. If the event is not held at your location, you will need to ensure the logistical needs are met and communicated within 2 weeks prior to the event.

To request the Northport VAMC Mobile Unit, please complete and email or fax to JoAnne Anderson.

JoAnne Anderson RN MSN FNPc Rural Health Coordinator
Northport VAMC, 79 Middleville Road, Northport, NY 11768
Ph: 631-261-4400 ext 4590 Fax: 631- 486-6135 Email: joanne.anderson2@va.gov

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Organization Contact: _____ _____
(Name) Phone/Email Address
Date mobile van is requested: _____ **Time of Event:** _____
Description of event: _____ _____
_____

Address of event (including zip code):_____ _____

Estimated Number of Participants: _____

Specific Programs Requested: (please check or write in specific request)

- **My HealtheVet** _____ **Enrollment** _____
- **ID card** _____ **Hypertensive Screening** _____

Office Use: Approved Date_____ Signature_____

Email from Joanne Anderson explanation of request for mobile unit form

Item 9. Explanation

Organizations can request the Community Relations Team to organize an event.

Events can be augmented by using the Mobile Medical Unit to complete vesting exams in on of the examination rooms.

Requesting the Mobile Medical Unit can be accomplished by completing this form.

Northport VA Medical Center

Timeline in CLC4 Case

	Date	Action	Origin	Comments	Documents
1	12/01/04	Adm Investigations: Do it Right the First Time	Department of Veterans Affairs	Administrative Investigation Training & Guidebook	Adm Investigations - Guidebook - Training.pdf
2	07/20/06	Employee-To-Employee WPV	Northport VAMC	Policy to effectively maintain a safe working environment	Employee to Employee Workplace Violence.pdf
3	12/21/09	Patient Abuse CM 05-46	Northport VAMC	Policy to establish conduct expectations of employees in regard to their interactions with patients.	Patient Abuse CM 05-46 9-21-09.pdf
4	01/13/10	Under Secretary of Health Information Letter (IL 10-2010-002	Gerald M. Cross, MD, FAAFP - Acting Under Secretary of Health	Information Letter regarding Intimidating and Disruptive Behaviors that Undermine a Culture of Patient Safety	Patient Safety IL 10-2010-002.pdf
5	11/01/10	Extended Care Procedural Memo EC-6	Northport VAMC	Interdisciplinary approach to patient care for Extended Care residents	Extended Care Procedural Memo EC-6 11-2010.pdf
6	08/20/12	Patient Safety Improvement Plan CM 00-134	Northport VAMC	Policy to prevent inadvertent harm to patient	Patient Safety Improvement Program 8-20-12.pdf
7	12/30/12	Patient Complaint Letter	Linda Burke-Scott, MD	Pt's sister complained of poor treatment of brother	Patient Complaint Burke 12-30-12.pdf

All information in this document is highly confidential

Northport VA Medical Center

8	01/07/13	Patient Complaint Letter	Grace & Michael Brusca	Family's request to reassign pt to a General Practitioner and not a Nurse Practitioner.	Patient Complaint Brusca 1-7-13.pdf
9	01/10/13	Patient Complaint Letter	Jennifer DeVaul	Pt found by family incoherent feverish, shaking, and could not walk or stand. No nurse was available. Pt was subsequently discharged with care plan, rudely spoken to and given no info on discharge, etc.	Patient Complaint DeVaul 1-10-13.pdf
10	02/11/13	Letter in Response to Pt Complaint	Philip C. Moschitta, MCD	Response to family member on Pt complaint (DeVaul).	Response to PT Complaint - DeVaul.pdf
11	02/27/13	Patient Complaint Letter	Roxanne Christian	Pt crying because accused of taking illegal drugs.	Pt Crying Accused of taking Illegal Drugs.pdf
12	03/06/13	ROC - Patient Complaint	Delores Carucci & Ed Bolitho, DAV Volunteer	Pts electric wheelchair was removed, etc.	Patient Complaint Carucci 3-6-13.pdf
13	04/08/13	Memo - Concerns CLC 4	Younghee Limb, MD Associate Chief of Staff Extended Care	Brief description of issues in CLC 4	Memo-Concerns CLC 4.pdf
14	04/18/13	Report of Contact (ROC)	Frances Ciorra, LMSW	JF stated about a "If I had a rope, I would tie it around this guys neck and pull."	ROC Ciorra 4-18-13.pdf
15	05/09/13	Report of Contact (ROC)	Matthew Bessell, LSCW Social Worker Extended Care	MB incident with JF	ROC Matthew Bessell 5-09-13.pdf
16	05/10/13	Report of Contact (ROC)	Melanie Brodsky, LCSW Social Work Section Chief	JF's incident with MB, etc.	ROC Melanie Brodsky 5-10 and 5-20-13.pdf
17	05/20/13	Report of Contact (ROC)	Maryann Tierney, LCSW	JFs alleged opinion of pt TP at meeting etc.	ROC Maryann Tierney 5-20-13.pdf
18	05/21/13	Report of Contact (ROC)	Frances Ciorra, LMSW	JF allegedly stated Maryann is unstable, she is calling us the lynch mob, etc.	ROC Frances Ciorra 5-21-13.pdf

All information in this document is highly confidential

Northport VA Medical Center

19	05/22/13	WPV Report	Maryann Tierney, LCSW	JF allegedly stated pt's son was violent w/o cause. Left MT out of treatment team meetings, when attended JF told her she lost her right to speak. JF, CF, & EM were overheard calling MT a part of the woman's anatomy.	WPV Maryanne Tierney 5-22-13.pdf
20	05/22/13	Report of Contact (ROC)	Jacqueline Berkman	JF allegedly threatens JB to keep her mouth shut regarding a conversation she just heart about MT.	ROC Jacquelyn Berkman 5-22-13.pdf
21	05/22/13	Report of Contact (ROC)	Maryann Tierney, LCSW	JF, CF, & EM were overheard calling MT a part of the woman's anatomy.	ROC Maryann Tierney 5-22-13.pdf
22	05/24/13	Report of Contact (ROC)	Charnette Simpson	CF reported that she is fearful of JF, he is loud, exhibits aggressive behavior and makes her feel uncomfortable in the workplace.	ROC Charnette Simpson 5-24-13.pdf
23	05/25/13	WPV Report	Catherine Fasano	CF complains that JF has a conduct of verbal anger, threats, name calling lying, going to the IG to make anonymous complaints, etc.	WPV Catherine Fasano 5-25-13.pdf

All information in this document is highly confidential

Northport VA Medical Center

24	05/28/13	WPV Team Meeting	WPV Team	Meeting regarding allegations raised of workplace violence and alleged pt abuse in CLC 4. WPV complaints from CF and MT regarding JF. All in attendance recommended AIB & Paid Non-duty Status to protect the integrity of the investigation.	In attendance: Dr. Michael Marino, WPV Chair, Heidi Vandewinckel. WPV Co-Chair, Nick Squicciarini, Chief of Police, Cheryl Carrington, HR, Melanie Brodsky, Social Work, Dr. Limb CLC 4, Judy Ingrassia ACNS, & Bill Burton, EEO
25	05/28/13	Paid Non-Duty Status Letter	Younghee Limb, MD Associate Chief of Staff Extended Care	Placed on Paid Non-Duty status Pending investigation by supervisor, Younghee Limb, MD w/Policy w/guidance of AA due to investigation of an incident of alleged misconduct where it is determined that employee's presence in the work place may pose a threat to the employee, co-workers & patients.	Paid Non-Duty Status 5-28-13.pdf
26	05/29/13	Congressional	Congressman Steve Israel Third District, NY	JF's complain of being put in a PAID Non-Duty status with police escort	Congressional - Israel 5-29-13.pdf
27	05/29/13	WPV Committee Letter	NFFE/Joseph Fasano	Complaint submitted to WPV team by NFFE on behalf of JF regarding a WPV report submitted by Maryanne Tierney	WPV Complaint JF 5-29-13.pdf
28	05/30/13	Report of Contact (ROC)	Judy Ingrassia, ACNS Extended Care	CF fearful of JF because he has all of her personal medical information.	ROC Judy Ingrassia 5-30-13.pdf

Northport VA Medical Center

29	06/03/13	AIB Charge Letter	Philip C. Moschitta, MCD	Appointment of Administrative Investigation Board by the MCD	AIB Charge Letter dated 6-3-13.pdf
30	06/04/13	Letter to JF	Younghee Limb, MD Associate Chief of Staff Extended Care	Acknowledgment of request for written communication; and VA Chain of Command	Letter Chain of Command 6-4-13.pdf
31	06/07/13	Step 1 Grievance NFFE	Richard Thomesen President NFFE/IAM FL 387	NFFE filed grievance on behalf of JF regarding WPV that occurred from 5-16-5-28-13 by MT.	NFFE Step 1 Grievance John Sperandeo.pdf
32	06/07/13	Information Request to HR from NFFE regarding AA Policy	Richard Thomesen President NFFE/IAM FL 387	NFFE requests information regarding JF being put on AA w/Police escort. Demands to know the charges of the AIB	NFFE Info Request JF AA and AIB Charges 6-7-13.pdf
33	06/10/13	Step 1 Grievance NFFE	John Sperandeo, LCSW Chief Social Work	Response to NFFE Step 1 Grievance dated 6-7-10	Step 1 Grievance - Agency Response 6-10-13.pdf
34	06/13/13	Congressional	Senator Kirsten E. Gillibrand	JF sent letter to Senator Gillibrand dated 5/31/13 regarding, police escort requirement @ VA, discrimination due to PTSD of an alleged 220% service connected disabled Veteran.	Congressional - Gillibrand 6-13-13.pdf
35	06/14/13	WPV Complaint	Joseph Fasano/NFFE	MT opening boasting about performing background checks on Veterans, Etc.	WPV Complaint JF Through NFFE 6-14-13.pdf

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Northport VA Medical Center

36	06/17/13	WPV Complaint	Joseph Fasano/NFFE	WPV that occurred 5-16-13 -5-28-13 against JF by Maryanne Tierney, SW	WPV Complaint JF Through NFFE 6-17-13.pdf
37	06/18/13	WPV Complaint	Joseph Fasano/NFFE	WPV complaint that MT allegedly threatened JF for several months boasting that her husband is a retired cop with an extensive firearm collection, as well as Dr. Calandrino.	WPV Complaint JF Through NFFE 6-18-13 p7 of FAX.pdf
38	06/18/13	WPV Complaint	Joseph Fasano/NFFE	WPV complaint Patient P's son is violent, unstable and volatile. MT is volatile, erratic, toxic, hostile, aggressive, threatening and unprofessional.	WPV Complaint JF Through NFFE 6-18-13.pdf
39	06/19/13	WPV Complaint	Joseph Fasano/NFFE	WPV complaint that CF demonstrated by her actions that she is not the same skin color as Rosie Chatman, black. Charnette Simpson is black and part of the ghetto crew, etc.	WPV Complaint JF Through NFFE 6-19-13.pdf
40	06/19/13	WPV Complaint	Joseph Fasano/NFFE	JF complains that he has been sexually harassed by MT for a period of 7 months	WPV Complaint JF Through NFFE Sexual Harassment 6-19-13.pdf

Northport VA Medical Center

41	06/19/13	WPV Complaint	Joseph Fasano/NFFE	JF complains that CF humiliated him when she stated his mother had an affair with a Catholic priest and his father was a pedophile.	WPV Complaint JF Through NFFE CF 6-19-13.pdf
42	06/20/13	WPV Complaint	Joseph Fasano/NFFE	Complaint regarding Cathy Fasano divulging personal and sensitive employee info while speaking with Maryann Tierney SW on CLC 4 etc.	WPV Complaint JF Through NFFE 6-20-13.pdf
43	06/25/13	Complaint about Maryanne Tierney	NFFE faxed on 7/25/13 to X6089	Letter written in 3rd person regarding MT allegedly yelling at and threatening JF. (no date on letter and no salutation)	Complaint MT Threatening JF.pdf
44	06/25/13	Issue Brief	Younghee Limb, MD Associate Chief of Staff Extended Care & Paul Donat, RN Health Systems Specialist	IB prepared in response to JFs email to Secretary, Eric Shinseki. Original date 6-25 follow-up 7-3	Issue Brief 6-25 and 7-3-13.pdf
45	06/27/13	AIB Extension Request	Paul Haberman, RN Chair of AIB	AIB requesting an extension until 8/1/13.	AIB Extension Request.pdf
46	06/28/13	AIB Extension Request Approval	Philip C. Moschitta, MCD	AIB extension Approved by MCD	AIB Extension Request Approved.pdf

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Northport VA Medical Center

47	07/02/13	Letter from Honorable Secretary Shinseki's Office	Joseph A. Fasano	Front page: URGENT VETERAN CRISIS (no date) Letter to Secretary faxed from JF (631-239-1975)dated 6/1/13. Rcvd by Secretary on 7/2/13.	Urgent Veteran Crisis Letter faxed to Shinseki by JF.pdf
48	07/03/13	Letter from Honorable Secretary Shinseki's Office	Joseph A. Fasano	Letter forwarded to NPVAMC Attn: MCD & Patient Advocate. Memo from Secretary's office is dated 7/3/13. Letter to Secretary from JF dated 6/1/13. Rcvd by Secretary on 7/7/13.	Letter from Honorable Secretary Shinseki Memo date 7-3-13.pdf
49		Letters to President Obama	Joseph A. Fasano	Letters forwarded from the White House to Northport VA of Complaints against the medical center. VACO instructed MCD to respond to Mr. Fasano acknowledging the President's receipt of the letters & respond to the allegations.	White House Correspondence regarding JF Complaints 7-4-13 and 7-10-13.pdf
50	07/08/13	Letter to JF regarding his correspondence to Shinseki	Younghee Limb, MD Associate Chief of Staff Extended Care	EAP & EEO referrals, AIB extension info, and contact info for any further questions	Letter to JF regarding Shinseki 7-8-13.pdf
51	07/11/13	Congressional	Senator Kirsten E. Gillibrand	Complaint from JF	Congressional Gillibrand 7-11-13.pdf
52	07/16/13	Letter from NY Office of the Attorney General	Alexander Bochstein Health Care Bureau	Letter dated 7/16 sent to JF regarding his letters sent to the Attorney General regarding HiPAA Violations at Northport VAMC & AIB Discrimination and ADA Violations	Attorney General Letter to JF 7-16-13.pdf

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Northport VA Medical Center

53	07/17/13	Congressional	Senator Kirsten E. Gillibrand	Complaint from JF	Congressional Gillibrand 7-17-13.pdf
54	07/19/13	Letter from Governor Andrew M. Cuomo	Samuel I. Spitzberg General Counsel	Letter to JF regarding a letter sent to Attorney General's Office, indicating that NYS division of Veterans' Affairs does not oversee Northport VAMC.	Letter from Governor Cuomo to JF.pdf
55	07/29/13	Catherine Fasano Transferred	Rosie Chatman, Nurse Executive, Northport VAMC	Catherine Fasano transferred from T&L 309 (Nursing Svc) to T&L 110 (Quality Mgmt.) effective 7/29/13, by Rosie Chatman.	CF transferred from NS to QM 7-29-13.pdf
56	08/02/13	AIB Report Complete	Paul Haberman, RN Barbara Albanese, MSW Steven Wintch, MHA	Investigation convened to inquire into the facts and circumstances surrounding several allegation of Patient Abuse and Professional Misconduct on CLC4.	AIB Report 8-2-13.pdf
57	08/09/13	NFFE Complains about FOIA requests for HR	Richard Thomesen President NFFE/IAM FL 387	NFFE sent an email to HR inquiring about FOIA request, threating to contact media	NFFE email demanding info or will contact media.pdf
58	08/29/13	Congressional Response	Maria Favale, Associate Director on behalf of Mr. Philip C. Moschitta, MCD	Employee put on a PAID Non-Duty Status, police escort is required to protect all parties involved.	Congressional Response - Gillibrand 8-29-13.pdf
59	09/13/13	Investigation resulting from WPV Complaint Rcvd 8/10/13	John Sperandeo, LCSW Chief Social Work	Investigation was conducted by Chief of Social Work regarding WPV allegation by JF and concluded unfounded.	WPV Investigation by Chief of SW 9-13-13.pdf

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Northport VA Medical Center

60	10/30/13	Return to Duty Letter	Edward Mack, MD Chief of Staff, Northport VAMC	RTD letter effective 11/1/13, Police escort no longer needed.	RTD Letter 10-30-13.pdf
61	11/01/13	Reassignment Letter	Philip C. Moschitta, MCD	JF Reassignment to Business Office	Reassignment Letter 11-1-13.pdf
62	11/15/13	Welcome to Business Office	April Esposito, Assistant Chief Business Office	Clarification of Tour of Duty, training information, Supv info dated 11/15/13.	Welcome to the Business Office.pdf
63	12/18/13	EEOC Fully Executed Settlement Agreement	Honorable Eric K. Shinseki, Secretary, Department of Veterans Affairs	EEO Settlement between JF and Secretary of Department of Veterans Affairs, dated 12/18/13.	EEO Fully Executed Agreement.pdf
64	12/19/13	EEOC Order of Dismissal	Honorable Eric K. Shinseki, Secretary, Department of Veterans Affairs	US Equal Employment Opportunity Commission (EEOC) Order of Dismissal dated 12/19/13.	EEO Order of dismissal.pdf
65	01/12/14	SF-52 Reassignment to PM & RS	Wilmino Sainbert, HRO	In accordance with EEO settlement JF was reassigned to PM & RS effective 1-12-14 eOPF was down at the time. HR was not able to pull up SF-50 but forwarded SF-52 to JF to show the processing for the reassignment was processed and approved.	EEO JF SF-52 .pdf
66	02/10/14	Sick Leave Restoration Letter	Wilmino Sainbert, HRO	SL Restoration Letter dated 2/10/14 informing JF that is SL has been restored as per EEO settlement agreement.	SL Restoration Letter 2-10-14.doc
67	02/14/14	Agency Response to Presidential Complaint	Philip C. Moschitta, MCD	Agency's response to White House Correspondence sent by JF addressing allegations.	Presidential Response to JF 2-14-14.pdf

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Northport VA Medical Center

68	03/20/14	Outlook email of Confirmation of EEO Settlement Compliance	Mary Pat Hessman, Chief of Fiscal	EEO manager, William Burton requested confirmation of compliance of elements in EEO Settlement Agreement. Mary Pat responded that JF received $ Settlement, attorney fees were paid, and SL was restored	EEO Confirmation of Settlement Compliance 3-20-14.pdf
69	NO DATE	Functional Statement for Nurse Practitioner (General)	Human Resources	General Functional Statement for Nurse Practitioner	Functional Statement NP.pdf
70	NO DATE	VA Handbook 0700 Administrative Investigations	Department of Veterans Affairs	VA Handbook Guidance and Instruction regarding Adm Investigations	Administrative Investigation VA Handbook 0700.pdf
71	NO DATE	Adm Investigations: Glossary	Office Human Resources Management (OHRM)	Glossary of Terms used in Investigations	Adm Investigation - Glossary.pdf

Cheryl L. Carrington

Labor Relations Specialist

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
79 Middleville Rd
Northport, NY 11768

May 28, 2013

Mr. Joseph A. Fasano
Nurse Practitioner
Extended Care Service
Northport VA Medical Center
79 Middleville Road
Northport, NY 11768-2290

Subject: Paid Non-Duty Status

At this time you are the subject of an investigation.

Please be advised that effective today, May 28, 2013, you will be placed in a non-duty status. During this period you will be carried in a pay status (Authorized Absence) without charge to leave. This status is subject to being terminated at the agency's discretion and you may be ordered to return to duty at any time.

You will need to remain available during your regular work hours. Please ensure that you provide me with a current phone number so that you can be reached during your work hours. In addition, you should anticipate receiving additional correspondence about this in the near future.

During the time of this investigation please refrain from contact with any member of the Community Living Center 4 (CLC4) clinical team or any member that supports this unit verbally, by telephone or by email. Furthermore, during this time period you may visit the VA Medical Center, Northport to meet with a union representative, attend to personal business such as banking, and based upon your Veteran's status, seek medical treatment. However, if it is necessary for you to visit the VA Medical Center or worksite, you must contact Police Service (24 hours) in advance so that arrangements can be made for an escort. The police may be contacted at (631) 261-4400 ext. 7151 to make escort arrangements.

If you have any questions, please do not hesitate to contact me at 631-261-4400 ext. 5075.

Younghee Limb, MD
Associate Chief of Staff
Extended Care

He received it but did not wish to sign — 5/28/13

Employee signature for receipt of letter — Date

taking the examination and for travel to and from the place of examination. Any additional absence will be charged to annual leave, or LWOP if annual leave is not available.

m. **Pending Emergency Suspension.** Ordinarily, employees will be retained in a pay and active duty status during an inquiry or investigation into an incident of misconduct or pending a decision on a proposed discharge. In instances where it is determined that an employee's continued presence at work might reasonably pose a threat to the employee or others, result in loss of or damage to Government property, or otherwise jeopardize legitimate Government interests, the employee may be placed in a paid non-duty status (i.e., authorized absence for timekeeping purposes) for a brief but reasonable period of time. The facility Director may approve such authorized absence in order to conduct an investigation into the situation and/or to obtain the Under Secretary for Health's decision on a request to effect a suspension (see VA Handbook 5021).

n. **Bone-Marrow and Organ Donor Leave.** An employee is entitled to 7 days of paid time off in a leave year to serve as a bone-marrow donor, and 30 days of paid time off in a leave year to serve as an organ donor. Employees may take this leave without charge to other types of leave or reduction in pay. This leave is in addition to other types of leave and is creditable as regular duty for all purposes, such as leave accrual, retirement, and proficiency rating.

o. **VA Policy.** The authorized absence policy, contained in chapter 2 of this part, for title 5 employees is also applicable to employees under this chapter for the following types of absences:

(1) Absence for Congressional Medal of Honor holders.

(2) Duty connected injury or illness.

(3) Change in facility.

(4) Civil Defense and disaster activities.

(5) Funerals.

(6) Meetings with labor organizations and other groups.

(7) Parades, ceremonies, and civic activities.

(8) Participation in civic organizations.

(9) Participation in military funerals.

(10) Representing labor organizations.

(11) Voting and registration.

(12) Weather and emergency situations.

without charge to leave when their personal religious beliefs require that they abstain from work during certain periods of the workday or workweek, thereby avoiding an annual leave or leave without pay charge.

b. **State and Local Holidays.** If a facility is closed on a State or local holiday because it is determined that Federal work may not be properly performed as provided in paragraph 5d of chapter 2, this part, absence on such day is not chargeable to leave for an employee of the facility. Such approved time off is considered authorized absence without charge to leave.

9. AUTHORIZED ABSENCE. An authorized absence is an absence administratively approved, which does not result in a charge to leave of any kind, or in loss of basic salary. The following will be used as the *guide* in determining the types of absences from duty which may be authorized without charge to leave.

a. **Rest and Relaxation.** The Under Secretary for Health and facility directors or the professional person acting for them are authorized to approve absence for not to exceed 24 consecutive hours for rest and relaxation for full-time physicians, dentists, podiatrists, chiropractors, and optometrists who have been required to serve long hours in the care and treatment of patients.

b. **Tardiness or Absence for Part of a Day**

(1) A full-time physician, dentist, podiatrist, chiropractor, or optometrist will be charged a full day's leave for absence for a part of a day, unless the absence is excused by officials authorized to approve leave. This authority to approve absence for tardiness and absence for portions of a day will be exercised only when such absence from duty is of short duration and will not be interpreted to cover absences of a major portion of the day wherein annual or sick leave should be properly charged.

(2) It is incumbent upon supervisory officials to ensure that full-time nurses, nurse anesthetists, PAs, and EFDAs and part-time employees discharge their obligation to VA in terms of the number of hours for which payment is made and the number of hours actually worked in accordance with the pre-established tour of duty. An unavoidable or necessary absence from duty and tardiness of less than 1 hour may be excused. In other instances, absences or tardiness will be charged to annual leave or LWOP (with the employee's consent), or absence without leave, as appropriate. The charges to leave will come as a result of appropriate reporting in the ETA system.

(3) Repeated instances of tardiness or unexcused absences during scheduled working hours will be considered a disciplinary matter under the provisions of VA Handbook 5021 or as a matter for appropriate action with regard to probationary employees and temporary full- and part-time employees under the applicable provisions of VA Handbook 5021.

c. **Hearings Before Federal Boards, VA Boards and Committees.** Absence of employees required to appear before Federal boards, before VHA boards, or before other VA boards or committees as witnesses or as participants in the matter under consideration will be approved without charge against leave.