US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan

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Executive Summary

The Office of Inspector General (OIG) Care in the Community program evaluates selected performance elements of the Veterans Health Administration (VHA) Veterans Community Care Program. The resulting report describes selected care coordination activities required to initiate and process referrals for non-VA care (community care). Using interview results and analysis of relevant data, the report also highlights opportunities and challenges for Veterans Integrated Service Network (VISN) and facility staff as they navigate current community care referral processes.[1]

Inspection Summary

The OIG reviewed community care processes at eight medical facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan with a community care program from June 24 through July 5, 2024. The OIG evaluated facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Community Urgent Care Coordination and Management. The OIG issued 16 recommendations across these five domains. The intent is for leaders to use recommendations as a road map to improve processes that support efficient delivery and coordination of community care going forward. The elements evaluated and OIG findings are summarized below.

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

Leadership and Administration of Community Care 	To determine how VISN and facility leaders supported community care services, the OIG evaluated the following elements: • Community care oversight councils • Resource utilization • Staffing and operations • Third-party administrator interactions • Patient safety event reporting • Medical documentation importing performance • Community care concerns expressed by facility and VISN leaders • Primary care provider survey responses The OIG issued **five recommendations:** community care oversight councils function according to their charters and meet the required number of times per fiscal year (recommendation 1); facility directors confirm community care clinical staffing needs and take action as necessary (recommendation 2); staff enter patient safety events into the Joint Patient Safety Reporting system (recommendation 3); patient safety managers or designees brief patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings (recommendation 4); and staff import all community care documents into patients' electronic health records within five business days of receipt (recommendation 5).
Administratively Closed Community Care Consults 	To evaluate whether facility community care staff followed VHA processes for administratively closed community care consults, the OIG determined whether they • contacted patients to confirm if they attended their appointments, • attempted to obtain the medical documents, and • administratively closed the consult if they did not receive the documents and made additional attempts to obtain them. The OIG issued **two recommendations:** staff confirm patients attended their appointments and attempt to obtain community providers' medical documents prior to administratively closing consults (recommendation 6) and make two additional attempts to obtain medical documents within 90 days of the appointment following administrative closure of non-low-risk consults (recommendation 7).

Community Care Provider Requests for Additional Services 	To assess how facility staff coordinated community providers' requests for additional services not covered by the initial referral, the OIG determined whether facility staff met requirements for • processing requests for additional services, • incorporating the requests and medical documents in electronic health records, • verifying community providers' signatures on requests for additional services forms, and • notifying community providers and patients of the requests for additional services approvals. The OIG issued **five recommendations:** staff process community providers' requests for additional services within three business days of receipt (recommendation 8), incorporate supporting medical documents with the requests for additional services forms into patients' electronic health records (recommendation 9), confirm community providers signed the requests for additional services forms (recommendation 10), and send letters to community providers and patients when they approve the requests (recommendations 11 and 12).
Care Coordination Activities for Patients Referred for Community Care 	To evaluate how effectively facility community care staff coordinated care for patients referred for community care, the OIG determined whether they • contacted patients based on VHA's recommended frequencies, • documented care coordination as required, and • confirmed patients attended their appointments. The OIG issued **two recommendations:** staff create and use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care coordination other than basic (recommendation 13), and confirm patients attended their scheduled community care appointments and received care (recommendation 14).
Community Urgent Care Coordination and Management 	To determine how facility providers and community care staff coordinated and managed care for patients who received community urgent care services, the OIG evaluated whether community care staff were notified of patients who received urgent care in the community and created the Community Care–Urgent Care Record note in the patient's electronic health record and attached the medical documents. The OIG issued **two recommendations:** Veterans Health Administration creates a process for facility staff notification of patients' urgent care visits in the community (recommendation 15), and staff create the Community Care–Urgent Care Record note in electronic health records when they receive urgent care documents (recommendation 16).

VA Comments and OIG Response

The Under Secretary for Health and Acting Veterans Integrated Service Network Director concurred with the inspection findings and recommendations 1 through 14 and 16, concurred in principle with recommendation 15, and provided acceptable improvement plans (see appendix F for the full text of the directors' comments). Based on information provided, the OIG considers recommendations 2, 5, and 16 closed. The OIG will follow up on the planned actions for the remaining open recommendations until they are completed.

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Contents

Abbreviations

IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Office of Inspector General (OIG) Care in the Community program routinely evaluates Veterans Health Administration (VHA) and Veterans Integrated Service Network (VISN) facilities' processes for coordinating community care and providing leadership and administrative oversight of VHA's Veterans Community Care Program.[1] The OIG's program also surveys facility primary care providers about their experiences with community care and assesses the feedback.

Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act, VHA's Veterans Community Care Program simplifies the process for veterans to receive non-VA care (community care) by expanding eligibility criteria.[2] VHA's Office of Integrated Veteran Care (IVC) aims to provide veterans referred to community care timely access to high quality care through the Veterans Community Care Program in a way "that is easy to understand [and] simple to administer."[3] According to IVC leaders, the field guidebook outlines the program's requirements, "processes and tools related to eligibility, referral and care coordination."[4]

[1] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[2] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101, https://www.congress.gov/115/plaws/publ182/PLAW-115publ182.pdf; US Senate Committee on Veterans' Affairs, "The VA MISSION Act of 2018: The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act," accessed July 8, 2021; VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

[3] VHA IVC, chap. 1 in *Community Care Field Guidebook,* November 21, 2022.

[4] Department of Veterans Affairs "Office of Integrated Veteran Care (IVC) Community Care Field Guidebook," accessed July 1, 2024, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. (This website is not publicly accessible.)

VA Healthcare System Serving Ohio, Indiana, and Michigan

VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan includes 10 medical facilities located in Indiana, Ohio, and the lower peninsula of Michigan, and 63 outpatient centers.[5]

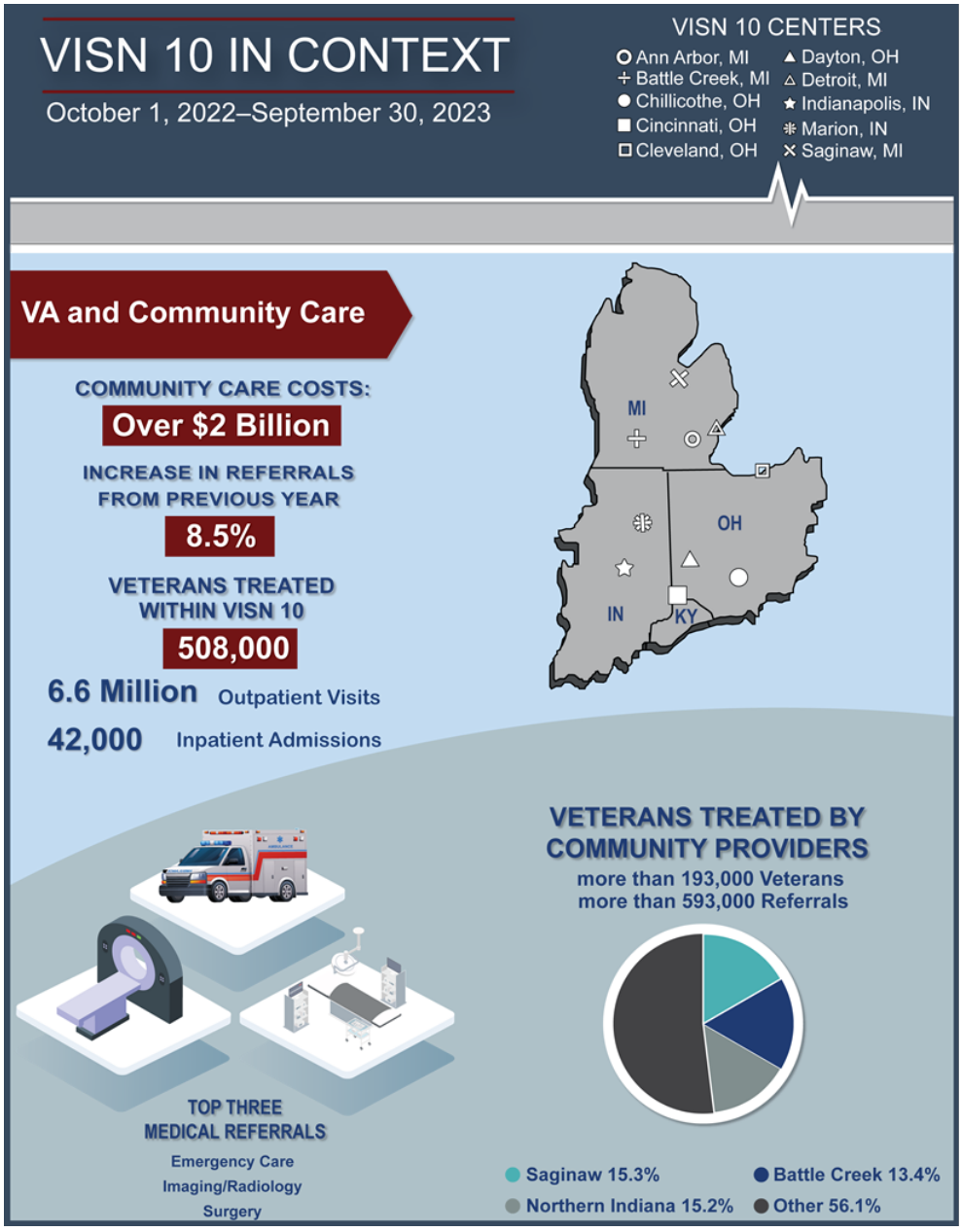

Figure 1. *Community care referral data for VISN 10.*
Source: OIG analysis of VHA data. The OIG did not verify the accuracy.

[5] "Veterans Health Administration VISN 10," Department of Veterans Affairs, accessed October 22, 2024, https://department.va.gov/integrated-service-networks/visn-10/.

Community Care Consult Management

In general, to refer a patient to a community provider for care, a VHA provider enters a consult (an order) in the patient's electronic health record. Facility community care staff receive the consult and schedule the appointment. After the appointment, staff request the community provider's medical documentation if the provider did not send it promptly. Facility community care staff complete the process by closing the consult, which may occur with or without receipt of the associated medical documentation from the community care provider. While facility community care staff work on the consult, they also coordinate care for the patient, which may include processing requests for services not preapproved in the consult or incorporating test results into the patient's electronic health record.

Inspection Elements

The OIG evaluated selected VISN 10 facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Community Urgent Care Coordination and Management. The inspection results describe the OIG's findings related to care coordination activities for patients referred for community care. The report highlights opportunities and challenges for VISN and facility staff as they navigate current community care referral processes (see appendix A for a list of all report recommendations).

Inspection Results

Leadership and Administration of Community Care

Effective leaders make decisions that directly or indirectly have an impact on every aspect of operations.[6] In health care, leaders create "policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services."[7] Leaders should ensure patients receive the same level of care whether it is delivered through the medical facility or care in the community.[8]

To determine how VISN 10 and its facility leaders supported community care services, the OIG evaluated requirements established by VHA in the field guidebook. The OIG team discussed required program elements with facility community care and executive leaders, as well as VISN leaders, and elicited reasons when the OIG found noncompliance with requirements. The team also sought input from the leaders and primary care providers about the effectiveness of the community care program based on their experiences.

Community Care Oversight Councils

VHA requires VISN directors to ensure that all medical facilities with community care programs within their network establish a local community care oversight council. These councils consist of clinical and nonclinical staff working together to equitably allocate resources, so all patients receive quality care in the community.[9] The OIG examined the council charters and meeting minutes for fiscal year 2023 and determined that all the reviewed VISN 10 facilities had community care oversight councils that reviewed relevant issues, such as community care utilization. However, the OIG also determined that Battle Creek, Cincinnati, and Indianapolis councils did not meet at the frequency required by their charters. For instance, the council at Cincinnati only met 3 of the required 12 times. Facilities without a consistently functioning oversight council may be unable to ensure patients receive quality care. The OIG made one recommendation in this area.

[6] The Joint Commission, *Standards Manual*, E-dition, LD.04.01.05, July 2021.

[7] The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[8] The Joint Commission, *Standards Manual*, E-dition, LD.04.03.09.

[9] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum to Network Directors (10N1-23), October 17, 2017.

Recommendation 1

1. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures community care oversight councils function according to their charters and meet the required number of times per fiscal year.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

Resource Utilization

When analyzing ongoing community care decisions, "VA Medical Center leadership must consider the ability to provide higher quality care, community capabilities, projected demand, current in-house and community access, costs, space constraints, impact on VA's education and research mission, sustainability, and the Veteran experience."[10]

Leaders at all eight facilities said they evaluated whether to continue purchasing specific types of care in the community or to provide the care internally and took actions accordingly. For example, leaders at Indianapolis reported concerns about access to community care residential rehabilitation services. When beds are not available at their facility, patients often receive treatment at community facilities outside the VISN instead of at a VHA facility within the VISN. Consequently, they are working to convert some domiciliary beds into beds for patients needing treatment for substance abuse to decrease the need for community residential rehabilitation services.[11]

Detroit leaders said they evaluated emergency room visits at their facility that resulted in community hospital admissions. The leaders explained that when patients need hospital admission, but the facility has no available inpatient beds, staff transfer them to a community hospital. To reduce these transfers, the leaders increased the number of inpatient beds. Additionally, VISN leaders described creating a tele-emergency care department in March 2024; the department's staff resolved 62 percent of patients' problems and therefore reduced VA or community emergency department visits.[12]

[10] VHA IVC, "RCI [Referral Coordination Initiative] Resource Analysis Assessment Guidance Document," updated January 26, 2022, https://dvagov.sharepoint.com/ReferralCoordination. (This website is not publicly accessible.)

[11] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed February 18, 2025, https://www.va.gov/homeless/dchv.

[12] Tele-emergency care providers evaluate patients "over the phone or on video" for non-life-threatening care "and recommend treatment or follow-up," "VA News, VA Makes Tele-Emergency Care Available Nationwide, Offering Veterans More Virtual Care Options," Department of Veterans Affairs, September 26, 2024, https://news.va.gov/va-makes-tele-emergency-care-available-nationwide.

Staffing and Operations

The OIG found that leaders at all facilities reassessed staffing at the required intervals. VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[13] The model includes a staffing tool designed to provide leaders a method to quantify the numbers of administrative and clinical personnel necessary to successfully operate their community care programs.[14] All facility community care leaders, except those at Dayton, reported the staffing tool did not accurately assess their staffing needs. For example, a Marion leader explained that the results of the tool indicated they were overstaffed administratively and understaffed clinically; however, they were not as overstaffed as the tool indicated.

VHA requires facility leaders to assess staffing using the tool, then reassess staffing every 90 days.[15] When facility leaders do not reassess staffing at the required intervals, they may fail to meet workload demands, which could negatively affect community care program operations and patient care. During interviews, facility community care program leaders shared their staffing needs and the associated effects on community care services.

Battle Creek, Cincinnati, Indianapolis, Marion, and Saginaw leaders discussed their need for additional administrative staff, such as medical or program support assistants. Community care leaders at Chillicothe, Dayton, Detroit, and Indianapolis said they need additional nursing staff to coordinate care for patients referred to the community.[16] Additionally, Chillicothe and Dayton community care leaders said they could not hire additional nurses because of budget constraints. As a result, Dayton leaders said nurses prioritized reviewing the most urgent consults and those that required more complicated types of care over reviewing community providers' medical documentation. A Detroit community care leader described working to quantify their nursing staff needs, while an Indianapolis leader reported hiring additional nursing staff but still needing two more.

[13] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #783114)," memorandum; VA Community Care, "VA Community Care Operating Model" (fact sheet), May 12, 2017.

[14] The tool uses average task times, workload data, types of staff (administrative or clinical), other nonclinical tasks (work that does not involve processing consults or coordinating care), and staff's projected time off to calculate program needs. Laura Osborne and John Leskovich, VHA OCC, "Office of Community Care (OCC): Staffing Tool Training" (PowerPoint presentation), February 2022.

[15] Assistant Under Secretary for Health for Operations (15), "National Implementation of the Community Care Operating Model Staffing Tool," memorandum to Veterans Integrated Service Network Directors (10N1-23), March 1, 2021.

[16] Examples of care coordination include appointment confirmation, follow-up, communication with the patient and community providers, and transition back to VHA medical care. VHA IVC, "Community Care–Care Coordination Plan (CC-CCP) Note Standard Operating Procedure," June 2022.

The OIG reviewed the community care staffing tool results for the second quarter of fiscal year 2024 and determined that Ann Arbor, Chillicothe, Dayton, and Indianapolis were clinically understaffed. The staffing tool results for Dayton identified they needed eight additional clinical staff, which was the highest number needed for the facilities. Further, the tool showed that Ann Arbor needed three more clinical staff, Chillicothe needed two, and Indianapolis needed one.[17] The OIG is concerned that facility community care departments may not be able to provide necessary services to patients without hiring additional clinical staff. The OIG made one recommendation.

Recommendation 2

2. The Veterans Integrated Service Network Director, in conjunction with facility directors, confirms community care clinical staffing needs and takes action as necessary.

The VISN Director concurred and provided an action plan with a completion date of March 2025.[18]

Third-Party Administrator Interactions

VHA established contracts with third-party administrators to create regional networks of community providers able to provide care to veterans. Third-party administrators are responsible for ensuring safe medical care by network providers and for investigating potential quality issues that may affect the safety or quality of care provided in the community to ensure that, if needed, appropriate follow-up actions are taken.[19]

Facility patient safety managers and VISN patient safety officers may request updates regarding potential quality issues from third-party administrators. Patient safety managers and patient safety officers may provide respective updates to their facility community care program team. Most facility community care leaders shared concerns about the third-party administrators' lack of response to issues submitted. A VISN leader explained that leaders do not have a way to monitor actions the administrator takes when they report quality events or to ensure the events do not reoccur.

The OIG is concerned that the limited information VHA leaders receive regarding potential quality issues negatively affects their oversight ability and efforts to ensure patients receive

[17] The OIG calculated clinical staff needed as the difference between the number of clinical staff authorized to the facility's community care program and the number recommended by the staffing tool.

[18] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

[19] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

quality care. The OIG made no recommendations in this area but suggests VHA leaders discuss these concerns with the third-party administrators.

Patient Safety Event Reporting

VISN and facility community care leaders shared specific instances of community care patient safety concerns with the OIG. For example, Saginaw community care leaders said a national shortage of radiologists delayed VHA providers in receiving imaging reports.[20] In response, the leaders trained VHA ordering providers to indicate on imaging consults when they needed the results urgently.[21]

Further, community care leaders at Indianapolis shared recent safety concerns involving heart transplant patients. According to the leaders, they received notification from the third-party administrator on a Friday afternoon at 4 p.m. that the main hospital for treating heart transplant patients was no longer approved within the third-party administrator's provider network. Indianapolis leaders said staff had to transfer a patient at that hospital to another facility, which posed a significant safety concern because of the patient's fragile condition.

Additionally, the OIG found that staff at two facilities did not enter some patient safety events into the Joint Patient Safety Reporting system.[22] Community care staff at all the inspected facilities, except Battle Creek and Marion, provided the OIG with lists of potential patient safety issues they submitted to the administrator.[23] The OIG compared the lists with events entered into the system and found two potential patient safety issues that Detroit community care staff submitted to the third-party administrator but did not enter into the system. Similarly, Dayton submitted two potential quality issues to the third-party administrator but only entered one into the system.

Facility staff should refer all patient safety events involving community care providers to the third-party administrator for investigation.[24] In addition, VHA requires staff to enter these events into its Joint Patient Safety Reporting system, and facility patient safety managers to review the

[20] A radiologist is a physician who specializes in "diagnosing and treating injuries and diseases using medical imaging and procedures." "What Is a Radiologist," American College of Radiology, accessed March 2, 2025, https://www.acr.org/about/radiology-overview.

[21] Imaging refers to processes that use specialized medical techniques to produce images of organs or structures not visible to the naked eye. *Merriam-Webster,* "Imaging," accessed January 28, 2025, https://www.merriam-webster.com/dictionary/imaging.

[22] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[23] A Battle Creek community care leader said they did not keep a list of potential quality issues submitted to the third-party administrator, while a Marion community care leader reported that no potential quality issues were submitted to the third-party administrator for fiscal year 2023.

[24] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

events to determine the need for any immediate actions.[25] If staff do not enter the events, patient safety managers may miss opportunities to address patient safety risks.

The OIG also found that none of the facilities' community care oversight council meeting minutes included discussions of patient safety event information. VHA requires facility patient safety managers or designees to brief the community care oversight council on patient safety event trends, lessons learned, and corrective actions.[26] Failure to brief community care patient safety events could jeopardize safe, high quality care. Community care leaders at some facilities said patient safety managers did not discuss the events at the council meetings because they reported them in other meetings, or council members did not tell them they had to attend. The OIG made two recommendations.

Recommendation 3

3. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system.

The VISN Director concurred and provided an action plan with a completion date of January 2026.

Recommendation 4

4. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings.

The VISN Director concurred and provided an action plan with a completion date of January 2026.

Medical Documentation Importing Performance

VHA requires staff to import all community care documents into patients' electronic health records within five business days of receipt.[27] All facility community care leaders said they track the medical documents; and Chillicothe, Dayton, Marion, and Saginaw leaders said they had backlogs with staff importing them into the records. Dayton community care leaders said their backlog of 8,440 documents happened after three of five staff contracted to help import documents left at the same time the previous year. The leaders paid staff overtime and will add

[25] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

[26] VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.

[27] VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirements," March 2021.

five new contract staff to resolve the backlog. Additionally, Saginaw leaders said staff discovered a folder that contained 800 documents they needed to import into electronic health records. These leaders also paid staff overtime and reassigned staff from other departments to assist with the backlog.[28]

Facility community care leaders shared barriers experienced with the process used to obtain medical documents from community providers. Battle Creek, Dayton, Detroit, and Indianapolis leaders reported barriers, such as

- some medical documents lack community providers' signatures, causing extra work for staff to obtain them;
- the third-party administrator contract allows 30 days for community providers to submit the medical documents, but community care staff sometimes need them sooner;
- medical documents do not have patient identifiers;
- there is no incentive for community providers to send medical documents because they receive payment without it; and
- community providers' offices lack administrative staff.

Facility community care leaders shared numerous actions they took to address these barriers. For example, after noticing that some community facilities did not provide medical documents even after multiple requests, Chillicothe community care leaders routinely reported the providers to the third-party administrator, which resulted in some improvement. Leaders at Cincinnati and Dayton said that securing community care staff access to the EPIC electronic health record system has enabled them to retrieve medical documents directly from community providers' patient records.[29] Similarly, Battle Creek and Saginaw leaders stated that using the VHA HealthShare Referral Manager system to obtain medical documents from community providers was helpful, and they encouraged more community providers to enroll.[30]

Failing to promptly import incoming medical documents from community providers could negatively affect care coordination and quality of care. Therefore, it is critical that staff import these documents into patients' electronic health records timely. The OIG made one recommendation.

[28] Chillicothe and Marion leaders reported backlogs of 134 and 12 documents, respectively.

[29] EPIC is an electronic health record system used by healthcare providers. "EPIC EHR Overview," EHR Guide, accessed August 21, 2024, https://ehrguide.org/top-ehr-software/epic-ehr-software/.

[30] VHA and community providers can use the HealthShare Referral Manager system to upload and share medical documentation. VHA IVC, chap. 4 in *Community Care Field Guidebook*, August 2024.

Recommendation 5

5. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures staff import all community care documents into patients' electronic health records within five business days of receipt.

The VISN Director concurred and provided an action plan with a completion date of March 2025.[31]

Community Care Concerns Expressed by Facility and VISN Leaders

During interviews, the OIG asked VISN and facility leaders to share top concerns about their community care programs overall. Their top concerns included increased community care spending and wait time eligibility referrals.

Increased community care spending. VISN leaders and leaders at all facilities, except Detroit, expressed concerns with the increase in community care spending. Leaders from Marion and Saginaw explained that 40 and 50 percent of their budgets, respectively, were going to community care, and the Marion leader said this was not sustainable. However, a Saginaw leader said they expected a 24 percent increase in consult volume this year but had only seen a 12 percent increase.

Wait time eligibility referrals.[32] Facility leaders from Battle Creek, Cincinnati, and Saginaw shared concerns about patients referred to community care due to wait time eligibility, but wait times were longer for an appointment in the community than at the VHA facility. A leader at Cincinnati explained that wait time eligibility for specialty community care was 28 days, with no consideration of the community appointment wait time. For example, if staff refer a patient to a dermatologist in the community, the patient may wait six months for an appointment, but a VHA provider could have an available appointment in 29 days. A leader from Saginaw shared a similar example and said VHA needed to do a better job of informing patients about the wait times for community care appointments so they can make informed decisions about where to obtain care.

[31] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

[32] A patient meets community care wait time eligibility when appointment wait time at a specific VA medical facility is 20 days for primary and mental health care and "28 days for specialty care from the date of request, unless the Veteran agrees to a later date." VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

Leaders shared concerns that provide insight into potential community care vulnerabilities and challenges that IVC leaders could consider for program improvements at these facilities.

Primary Care Provider Survey Responses

VHA primary care providers address patients' healthcare needs by diagnosing and managing conditions and coordinating their overall care and may initiate referrals to community care providers.[33] The OIG surveyed VISN 10 primary care providers anonymously for feedback about issues they encountered with the community care program, including questions about community care referrals (see appendix B for detailed survey information). The feedback could lead to process improvements at both the local and national levels.[34] Table 1 lists selected survey results.

Table 1. Survey Respondents' Reported Issues

Reported Issues	Percent*
Delays receiving community specialty provider medical documents	78
No call when results had a significant finding or required immediate attention for patients referred to community care for diagnostic testing	72
Appointment scheduling delays	60
Document receipt delays from specialists negatively affecting patient outcomes	56
Appointment scheduling delays negatively affecting patient outcomes	48
Quality of care concerns when referring patients to community specialty care	31

Source: VA OIG survey of VISN 10 primary care providers' experience with community care.

**Some respondents did not answer every survey question; percentages are reported based on the number of responses for the relevant question.*

Some providers who reported concerns about the quality of community care submitted additional comments. The OIG identified the following recurring themes:

- Lack of community provider medical documents, which could delay appointments for follow-up care
- Lack of communication between facility community care and community providers

[33] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[34] Community Care Survey of primary care providers' experience. Survey responses may not be representative of all primary care providers in VISN 10 due to the low response rate.

Administratively Closed Community Care Consults

Documentation of health care from community providers conveys treatment decisions to VHA providers and is important in the patient's care. Delays in the return of medical documents may affect continuity of care, and VHA staff must take steps to obtain the medical documents and notify the referring provider if the consult is closed without them.

The OIG reviewed five facilities to determine whether community care staff followed VHA processes for administratively closed community care consults.[35] VHA established a process for community care staff to administratively close consults if they do not get the medical documents following their first attempt. After the date of the community care appointment, facility community care staff

- contact the patient to confirm appointment attendance,
- attempt to obtain the community care provider's documents and record the effort in the electronic health record if they have not received it within 14 days of the scheduled appointment, and
- close the consult administratively and make two additional attempts to obtain the documents within 90 days of the appointment.[36]

Confirmation of Appointment Attendance and Attempts to Obtain Medical Documents

The OIG estimated that Marion community care staff failed to consistently confirm patients attended their appointments and attempt to obtain community providers' medical documents prior to administratively closing 37 percent (95% CI: 23 to 52) of consults.[37]

One of the community care assistant nurse managers said staff confirmed patients attended their appointments and attempted to obtain the documents but did not consistently record these efforts. Failure by community care staff to complete required tasks prior to administratively closing the consults could delay follow-up. The OIG made one recommendation.

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[35] The OIG assessed performance in three domains for each facility and selected the two poorest performing domains to review. Based on those criteria, the OIG reviewed Administratively Closed Community Care Consults at Battle Creek, Cincinnati, Detroit, Indianapolis, and Marion.

[36] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. VHA rescinded and replaced this directive with VHA Directive 1232, *Consult Management*, November 22, 2024.

[37] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time. Statistical analysis for facility noncompliance appears in appendix C.

Recommendation 6

6. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended their appointments and attempt to obtain community providers' medical documents prior to administratively closing consults.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

Additional Attempts to Obtain Medical Documentation After Administrative Closure

The OIG found that Battle Creek, Cincinnati, Detroit, Indianapolis, and Marion community care staff failed to consistently make two attempts to obtain community providers' medical documents within 90 days of the appointment after administratively closing consults.[38]

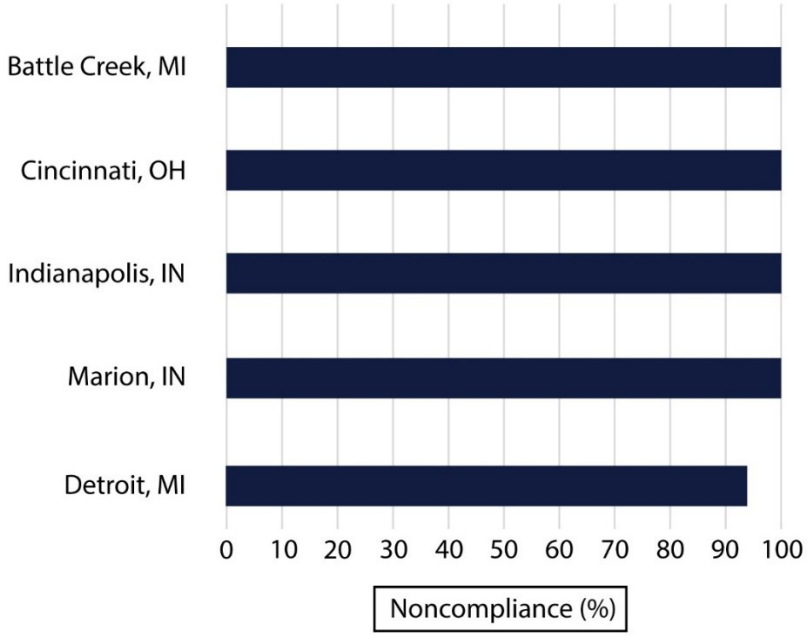

Figure 2. *Additional attempts to obtain community providers' medical documents after administrative consult closure.*

Source: OIG analysis of VHA data.

Community care leaders and staff in Cincinnati, Detroit, Indianapolis, and Marion facilities explained that staff made all three attempts to obtain community providers' medical documents

[38] Statistical analysis for facility noncompliance appears in appendix C.

prior to administratively closing the consult. Cincinnati and Indianapolis community care leaders said open consults are easier to track for follow-up.

If staff do not administratively close the consult after making the first attempt to obtain medical documents, the consult remains in an open status and staff cannot track it using VHA's administrative closure report, which was created to monitor their continued efforts to obtain the documents.[39] The OIG made one recommendation.

Recommendation 7

7. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make two attempts to obtain community providers' medical documents within 90 days of the appointment following administrative closure of non-low-risk consults.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

Community Care Provider Requests for Additional Services

Community providers may submit requests for additional services in circumstances when they determine the need for continued care under an expiring VHA authorization, a new specialty referral, or a procedure that was not previously authorized by VHA. VHA staff review and make timely decisions on the requests.[40]

The OIG determined that facility community care staff did not consistently

- process community providers' requests for additional services in a timely manner;
- incorporate community providers' supporting medical documents and requests for additional services into patients' electronic health records;
- ensure requests for additional services included the community provider's signature; and
- send approval letters to community providers and patients, as detailed below.[41]

[39] VHA IVC, chap. 4 in *Community Care Field Guidebook.*

[40] Tamika Taylor, VHA IVC, "Requests for Services (RFS) Form 10-10172 Training" (PowerPoint presentation), September 2023; VHA IVC, chap. 3 in *Community Care Field Guidebook*, June 2022.

[41] The OIG assessed performance in three domains for each facility and selected the two poorest performing domains to review. Based on those criteria, the OIG reviewed Community Care Provider Requests for Additional Services at Chillicothe, Cincinnati, Dayton, Detroit, and Saginaw.

VHA has established a process for community providers' requests for additional services not already approved under the VHA referral.[42] The process requires community providers to submit the request and supporting medical documents on a VHA-provided form. Then, facility community care staff must

- review the request for the provider's signature and supporting documents,
- approve or deny the request within three business days of receipt,
- incorporate the request and supporting medical documents into the electronic health record, and
- send a letter to the community provider and patient to inform them of the decision and explain the reasons for a denied request.[43]

Requests for Additional Services Decisions

The OIG found that only community care staff at Cincinnati consistently processed requests for additional services within three business days of receipt.[44]

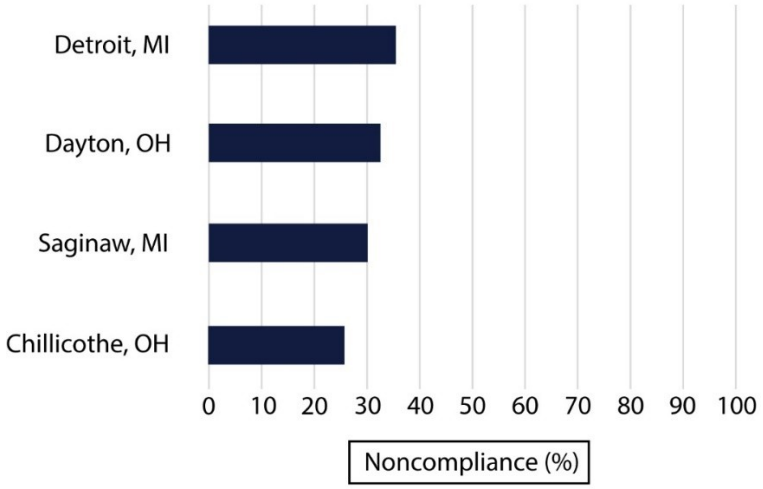

Figure 3. *Requests for additional services processed within three business days of receipt.*

Source: OIG analysis of VHA data.

When staff do not process requests for additional services within three business days, it may delay needed care and negatively affect patient outcomes. Chillicothe, Dayton, and Detroit

[42] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[43] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[44] Statistical analysis for facility noncompliance appears in appendix C.

community care staff shared several reasons they did not process the requests within three business days, such as

- VHA providers not approving requests timely,
- taking additional time to determine whether VHA can provide the care instead of referring the patient to the community, and
- managing numerous and complex requests.[45]

The OIG made one recommendation.

Recommendation 8

8. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff process community providers' requests for additional services within three business days of receipt.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

Requests for Additional Services Forms and Medical Documents Incorporated into Electronic Health Records

The OIG estimated that Saginaw community care staff did not incorporate 28 percent (95% CI: 15 to 41) of requests for additional services forms into the electronic health records.[46] If community care staff do not incorporate the forms, it may delay subsequent needed patient care. Saginaw community care leaders said staff never received the request for additional services forms; instead, they received the requests by phone or on a fax cover sheet.

The OIG also estimated that Cincinnati community care staff did not incorporate supporting medical documents into patients' electronic health records for 48 percent (95% CI: 33 to 62) of requests for additional services.[47] Without the supporting documents, community care staff and VHA providers may not have the information necessary to make timely and appropriate healthcare decisions. The Cincinnati Nurse Manager reported being new to the position and unaware of the reasons for noncompliance but taking actions, like getting a dedicated fax line, to

[45] The referral coordination initiative is VHA's revised referral process for internal or direct VHA and community care. The change involves reviewing the care options and community care eligibility for patients before scheduling appointments. Department of Veterans Affairs, Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*, November 2023.

[46] Statistical analysis for facility noncompliance appears in appendix C.

[47] Statistical analysis for facility noncompliance appears in appendix C.

ensure community care staff receive supporting documents. The OIG made one recommendation.

Recommendation 9

9. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff incorporate supporting medical documents with requests for additional services forms into patients' electronic health records.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

Community Care Providers' Signatures on Requests for Additional Services Forms

The OIG determined that at Detroit, requests for additional services forms in patients' electronic health records did not include the community care provider's signature 27 percent of the time.[48] As part of its commitment to patient safety and prevention of adverse outcomes, VHA requires the community provider's signature to authenticate the request and ensure it is correct.[49] The OIG made one recommendation.

Recommendation 10

10. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm community providers signed the requests for additional services forms.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

[48] A confidence interval is not included for a census review because the data represents every patient in the study population. Statistical estimates for facility noncompliance appears in appendix C.

[49] Tamika Taylor, VHA IVC – Integrated Access, "RFS [Request for Services]/CPO [Community Provider Orders]" (PowerPoint presentation), August 2022.

Community Provider Notification of Requests for Additional Services Decisions

The OIG found that community care staff at Chillicothe, Cincinnati, Dayton, Detroit, and Saginaw did not consistently send community providers approval letters for requests for additional services.[50]

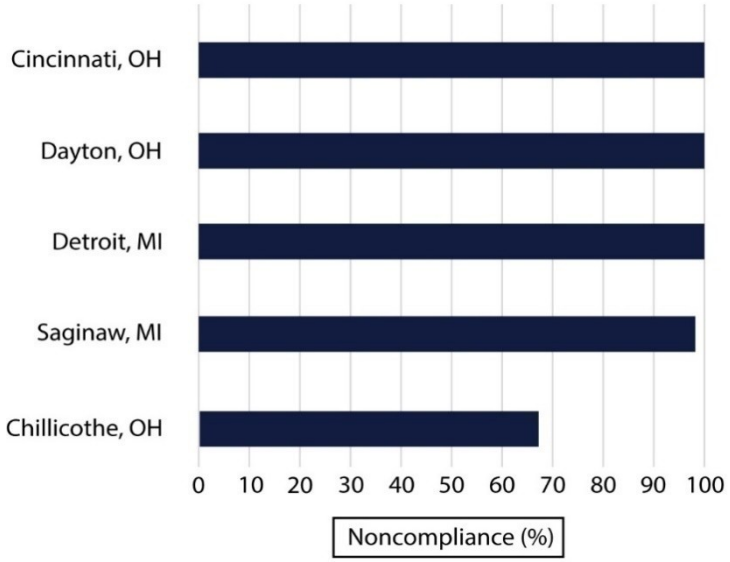

Figure 4. *Community provider notification of requests for additional services approvals.*

Source: OIG analysis of VHA data.

Failure to send approval letters may delay patient care because community providers could be unaware requests were received and approved. Community care leaders at Dayton said staff sent community providers a new authorization when they approved requests instead of a letter. Leaders at Chillicothe and Detroit gave additional reasons, such as they were unaware of the requirement, and community providers asked not to receive more paperwork. The OIG made one recommendation.

Recommendation 11

11. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval letters to community providers for requests for additional services.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

[50] Statistical analysis for facility noncompliance appears in appendix C.

Patient Notification of Requests for Additional Services Decisions

Additionally, the OIG found that Chillicothe, Cincinnati, Dayton, Detroit, and Saginaw community care staff did not consistently send approval letters to patients for requests for additional services.[51]

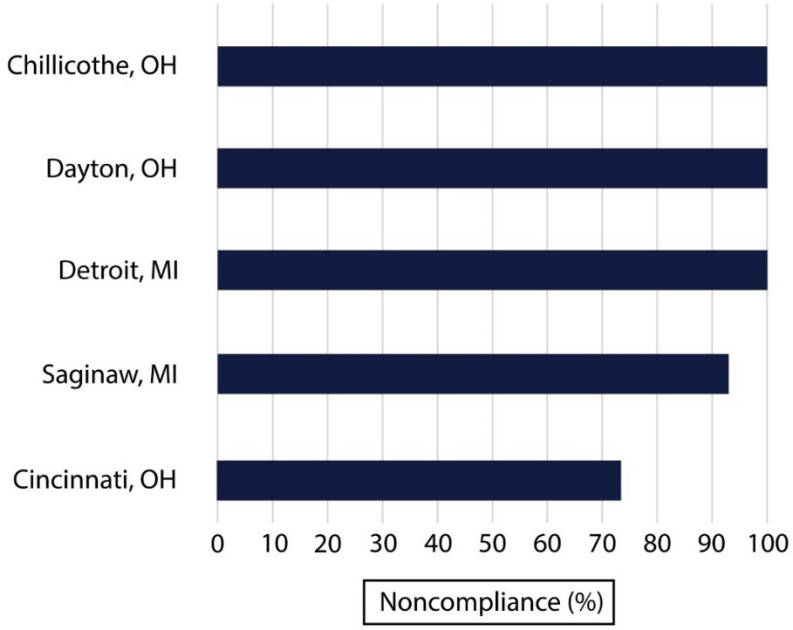

Figure 5. *Patient notification of requests for additional services approvals.*

Source: OIG analysis of VHA data.

Community care staffs' failure to send approval letters to patients may cause them to be uninformed of the decision in a timely manner. Community care leaders and staff at the five facilities reported being unaware of the requirement to send the letters and not having enough staff. The OIG made one recommendation.

Recommendation 12

12. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval letters to patients for requests for additional services.

The VISN Director concurred and provided an action plan with a completion date of September 2025.

[51] Statistical analysis for facility noncompliance appears in appendix C.

Care Coordination Activities for Patients Referred for Community Care

Facility community care staff use care coordination to organize services and resources with patients and community providers based on an individual patient's needs. A VHA care coordination plan addresses activities, such as appointment scheduling, follow-up, communication with the patient and community providers, and transition back to VHA medical care.[52]

The OIG found that facility community care staff at the facilities reviewed did not contact patients according to VHA's recommended frequency, consistently create and use the Community Care–Care Coordination Plan note to document care coordination activities, or confirm patients attended their appointments, as detailed below.[53] VHA has established a care coordination model as a framework for overseeing care and aligning resources based on the individual patient's needs. The model details the principles of care coordination, defines staff roles and responsibilities, and describes specific ways to accomplish goals, such as improved care transitions between VHA and community providers.[54]

Facility community care staff use an automated algorithm called the Screening Triage Tool to determine the appropriate level of care coordination for each consult.[55] Levels are based on the intensity, frequency, duration, and type of care coordination each patient needs. As care complexity increases, so does the type and frequency of care coordination services, including contact with the patient.[56] Table 2 lists the levels of care coordination and corresponding recommended frequency of patient contact.[57]

[52] VHA IVC, "Community Care–Care Coordination Plan (CC-CCP) Note Standard Operating Procedure."

[53] The OIG assessed performance in three domains for each facility and selected the two poorest performing domains to review. Based on those criteria, the OIG selected the Community Care Provider Requests for Additional Services domain for Battle Creek, Marion, and Indianapolis. However, after selecting patients' electronic health records, the OIG determined there was an insufficient number of requests for additional services to statistically analyze. The OIG then selected the Care Coordination Activities for Patients Referred to Community Care domain for Battle Creek, Marion, and Indianapolis.

[54] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[55] The Screening Triage Tool "is a component of the end-to-end care coordination process for Veterans receiving care in the community." VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure," July 2, 2019.

[56] VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure."

[57] VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure."

Table 2. Levels of Care Coordination and Recommended Frequency of Patient Contact

Level of Care	Frequency of Patient Contact
Basic	As needed
Moderate	Monthly to quarterly
Complex/chronic	Weekly to monthly
Urgent	Hourly to daily

Source: VHA, "Screening Triage Tool Standard Operating Procedure."

VHA also developed a standardized progress note called the Community Care–Care Coordination Plan that facility community care staff use to document aspects of care coordination, such as clinically indicated services and patients' psychosocial needs, preferences, and goals. VHA requires staff to document all care coordination activities in the note, except for consults with a basic level.[58]

Patient Contacts According to Recommended Frequencies

The OIG estimated that community care staff at Battle Creek, Indianapolis, and Marion did not consistently contact 98 percent (95% CI: 94 to 100), 77 percent (95% CI: 64 to 88), and 96 percent (95% CI: 90 to 100), respectively, of patients according to the recommended frequency for consults requiring complex/chronic levels of care.[59] Indianapolis and Marion community care leaders said staff did not contact patients at the recommended frequency because of a community care staffing shortage and a lack of awareness that they needed to contact the patients. Because the guidebook recommends but does not require contacts based on assigned levels of care, the OIG made no recommendation.

Documentation of Care Coordination Activities

The OIG found that Marion community care staff did not consistently create the Community Care–Care Coordination Plan note in the electronic health record to document care coordination for consults with an assigned level of care other than basic, as required.[60] Additionally, the OIG found that when Battle Creek, Indianapolis, and Marion community care staff created the note,

[58] Deputy Under Secretary for Health for Operations and Management (10N), "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum to Veterans Integrated Service Network Directors (10N1-23), September 16, 2019; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[59] Statistical analysis for facility noncompliance appears in appendix C.

[60] Deputy Under Secretary for Health for Operations and Management (10N), "National Deployment of the Community Care Coordination Model (VIEWS #01360306)," memorandum; VHA IVC, chap. 3 in *Community Care Field Guidebook*.

they did not consistently use it. Specifically, the OIG estimated that for patients referred to community care by VHA providers,

- Battle Creek community care staff consistently created the note but did not use it 96 percent (95% CI: 89 to 100) of the time;
- Indianapolis community care staff consistently created the note but did not use it 98 percent (95% CI: 93 to 100) of the time; and
- Marion community care staff did not create the note 55 percent (95% CI: 41 to 69) of the time and did not use the note 86 percent (95% CI: 70 to 100) of the time.[61]

When staff fail to create and use the note as required, patients' medical information may be more difficult to locate, and they may experience delays in care. Indianapolis and Marion community care leaders reported reasons for noncompliance, including staff being unaware of the requirement and nursing shortages. The OIG made one recommendation.

Recommendation 13

13. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create and use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care coordination other than basic.

The VISN Director concurred and provided an action plan with a completion date of February 2026.

Confirmation Patients Attended Community Care Appointments

The OIG found that facility community care staff at Battle Creek and Marion did not consistently confirm patients attended their scheduled community care appointments, as required. Before searching for medical documents from the visit, facility community care staff contact the patient, and if unable to reach them, contact the community provider to determine whether the patient kept the appointment.[62] The OIG estimated that Battle Creek and Marion facility community care staff did not confirm appointment attendance for 39 percent (95% CI: 19 to 59) and 30 percent (95% CI: 17 to 43) of patients, respectively.[63]

Battle Creek community care leaders explained that during internal audits of community care consults, they identified one employee who consistently failed to verify appointment attendance. Community care leaders from Marion acknowledged staff had not completed the appointment

[61] Statistical analysis for facility noncompliance appears in appendix C.

[62] VHA IVC, chap. 4 in *Community Care Field Guidebook*.

[63] Statistical analysis for facility noncompliance appears in appendix C.

verification process consistently, adding that they now discuss it in weekly huddles with staff. The OIG made one recommendation.

Recommendation 14

14. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended their scheduled community care appointments and received care.

The VISN Director concurred and provided an action plan with a completion date of February 2026.

Community Urgent Care Coordination and Management

Urgent care services include the treatment of injuries and illnesses that need immediate attention but are not life threatening, such as skin infections, minor burns, and influenza.[64] VHA staff must "ensure continuity of care" for patients who receive community urgent care services.[65]

The urgent care benefit in community care became available in 2019.[66] The primary purpose was for eligible veterans to access services from urgent care providers in VA's network without prior VA approval or a community care consult.[67] Within VISN 10 alone, over 23,000 patients received community urgent care services at a cost of $4.4 million during fiscal year 2024.[68]

VHA requires community urgent care providers to submit medical documents to VHA facilities within 30 calendar days of the patient's urgent care visit; this allows facility staff to arrange needed follow-up care.[69] VHA also requires facility community care staff to

- create the Community Care–Urgent Care Record note in the electronic health record and attach the medical documents;
- identify the patient's signer for the documentation (a provider responsible for receiving an alert and reviewing documents, usually the patient's primary care provider); and

[64] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[65] MISSION Act.

[66] The OIG selected a new domain, Community Urgent Care Coordination and Management, for Chillicothe, Dayton, and Saginaw because the OIG team that developed the new domain reviewed those facilities.

[67] VHA IVC, chap. 8 in *Community Care Field Guidebook*, August 2024.

[68] The facilities reviewed in this domain spent over $990,000 for over 5,400 patients to be treated at community urgent care clinics in fiscal year 2024. VHA Urgent Care Dashboard report, Totals by VISNs & Facilities.

[69] VHA IVC, chap. 3 in *Community Care Field Guidebook*.

- have the Chief of Staff designate a provider to be the signer if the patient does not have an assigned primary care provider.[70]

Notification of Patients Receiving Community Urgent Care Services

The OIG found that VHA lacks a process to notify facility community care staff when patients receive urgent care services in the community. VHA provided feedback in response to the OIG report, *Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers*, and stated veterans and community urgent care centers are not required to notify the local VHA facility of community urgent care visits.[71] If community care staff are not aware of community urgent care visits, they may not have a reason to expect or seek documentation from urgent care providers. As a result, the lack of follow-up care may lead to poorer clinical outcomes. The OIG is concerned that although VHA requires urgent care providers to submit medical documents to VHA facilities, it does not have a process to notify facility staff of the visits. The OIG made one recommendation.

Recommendation 15

15. Veterans Health Administration creates a process for facility staff notification of patients' urgent care visits in the community.

The Under Secretary for Health concurred in principle and provided an action plan with a completion date of September 2025. The OIG had concerns with the action plan submitted and detailed those concerns in appendix F, page 49.

Documentation of Patients Receiving Community Urgent Care Services

The OIG determined that Chillicothe, Dayton, and Saginaw community care staff did not create the Community Care–Urgent Care Record note in the electronic health record for any patients who received community urgent care.[72] Community care leaders from the three facilities reported several reasons for noncompliance, including not being aware of the requirement to use the Community Care–Urgent Care Record note. They added that the standardized note title had not been loaded into their electronic health record system and staff did not always know when

[70] Department of Veterans Affairs, Veterans Health Administration, Office of Community Care Delivery Operation, *Community Care–Urgent Care Record Note Setup Guide*, February 1, 2018.VHA IVC, chap. 3 in *Community Care Field Guidebook*.

[71] VA OIG, *Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers*, Report No. 24-00823-68, March 20, 2025.

[72] Statistical analysis for facility noncompliance appears in appendix C.

patients went to community urgent care providers. Failure to create the community urgent care note in patients' electronic health records may result in their primary care providers or designated signers being unaware of a patient's treatment or need for follow-up. The OIG made one recommendation.

Recommendation 16

16. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create the Community Care–Urgent Care Record note in electronic health records when they receive urgent care documents.

The VISN Director concurred and provided an action plan with a completion date of April 2025.[73]

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at selected facilities within VISN 10, the OIG conducted a detailed inspection from June 24 through July 5, 2024. Addressing five clinical or administrative aspects of community care domains across eight VISN facilities with community care programs, the inspection resulted in 16 recommendations on systemic issues that may adversely affect patient outcomes. The number of recommendations does not necessarily reflect the overall quality of all services delivered by facility community care staff within this VISN. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

[73] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

Appendix A. Summary of Recommendations

Domain	Recommendation
Leadership and Administration of Community Care	1. Community care oversight councils function according to their charters and meet the required number of times per fiscal year. 2. Facility directors confirm community care clinical staffing needs and take action as necessary. 3. Facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system. 4. Patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings. 5. VHA staff import all community care documents into patients' electronic health records within five business days of receipt.
Administratively Closed Community Care Consults	6. Facility community care staff confirm patients attended their appointments and attempt to obtain community providers' medical documents prior to administratively closing consults. 7. Facility community care staff make two additional attempts to obtain community providers' medical documents within 90 days of the appointment following administrative closure of non-low-risk consults.
Community Care Provider Requests for Additional Services	8. Facility community care staff process community providers' requests for additional services within three business days of receipt. 9. Facility community care staff incorporate supporting medical documents with requests for additional services forms into patients' electronic health records. 10. Facility community care staff confirm community providers signed the requests for additional services forms. 11. Facility community care staff send approval letters to community providers for requests for additional services. 12. Facility community care staff send approval letters to patients for requests for additional services.
Care Coordination Activities for Patients Referred for Community Care	13. Facility community care staff create and use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care coordination other than basic. 14. Facility community care staff confirm patients attended their scheduled community care appointments and received care.
Community Urgent Care Coordination and Management	15. Veterans Health Administration creates a process for facility staff notification of patients' urgent care visits in the community. 16. Facility community care staff create the Community Care–Urgent Care Record note in electronic health records when they receive urgent care documents.

Appendix B: Methodology

The OIG reviewed community care processes at eight VISN 10 medical facilities with a community care program from June 24 through July 5, 2024. The facilities were the Battle Creek VA Medical Center (Battle Creek), Chillicothe VA Medical Center (Chillicothe), Cincinnati VA Medical Center (Cincinnati), Dayton VA Medical Center (Dayton), John D. Dingell VA Medical Center (Detroit), Richard L. Roudebush VA Medical Center (Indianapolis), Marion VA Medical Center (Marion), and Aleda E. Lutz VA Medical Center (Saginaw).

The OIG reviewed electronic health records and results from an OIG survey distributed to VHA facility primary care providers.[1] The OIG also examined the Community Care Oversight Council charters and meeting minutes for fiscal year 2023 to determine whether facilities had a council and if it met the minimum number of times per year, as required by the charter. The OIG interviewed leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance.

The OIG electronically distributed the survey to primary care providers on June 20, 2024, and ended it on July 3, 2024. The OIG emailed 413 surveys to VISN 10 primary care providers and received 120 replies, a 29 percent response rate.[2] The OIG's analysis relied on inspectors identifying information from surveys, interviews, documents, and observational data based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*[3]

The inspection team examined operations and electronic health records from October 1, 2022, through September 30, 2023. The OIG reviewed each selected facility for performance in the Leadership and Administration of Community Care domain. After reviewing facility performance data relevant to each respective domain, the OIG selected two additional domains for each facility for a total of three per facility, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Community Urgent Care Coordination and Management. OIG Care in the Community program leaders approved all domain selections based on content and professional judgment. The domains selected for each VISN 10 facility are shown in figure 6.

[1] Liaisons at each medical facility identified primary care providers. The OIG contacted them using their VA email addresses, and staff from the OIG Office of Data Analytics analyzed the responses. Participation in the survey was voluntary.

[2] VA OIG Survey of VISN 10 Primary Care Providers' Experience with Community Care. Survey responses may not be representative of all primary care providers in VISN 10 due to the low response rate.

[3] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

	Battle Creek MI	Chillicothe OH	Cincinnati OH	Dayton OH	Detroit MI	Indianapolis IN	Marion IN	Saginaw MI
Leadership and Administration	✓	✓	✓	✓	✓	✓	✓	✓
Administratively Closed Consults	✓		✓		✓	✓	✓	
Requests for Service		✓	✓	✓	✓			✓
Care Coordination	✓					✓	✓	
Urgent Care		✓		✓				✓

Figure 6. *Domain selections for VISN 10 facilities.*

Source: OIG analysis of VHA data.

For the Leadership and Administration of Community Care domain, the OIG interviewed VISN and facility executive and community care leaders, identified participants according to their roles or titles, and used standardized interview questions to maintain consistency.

For each VISN 10 facility reviewed, the OIG used the following criteria to select electronic health records during the review period for each domain:

- Administratively Closed Community Care Consults: community care consults administratively closed without medical documentation, excluding referrals for low risk, dental, and geriatrics and extended care services.
- Community Care Provider Requests for Additional Services: patients with requests for additional services submitted by community providers, excluding requests for dental or geriatrics and extended care services. If a patient had more than one request, the OIG evaluated the earliest request during the study period.
- Care Coordination Activities for Patients Referred for Community Care: community care consults for which VHA community care staff scheduled the community care appointment for the patient and did not complete the consult within 90 calendar days, excluding referrals for low risk, basic or moderate level of care, optometry, audiology, dental, future care, imaging or radiology, emergency or urgent care, and geriatrics and extended care services.
- Community Urgent Care Coordination and Management: paid invoices for community urgent care visits of patients with cardiac, respiratory, pain, and mental health needs, excluding patients referred for emergency care the same day as the urgent care visit.

For all the above domains, the OIG randomly selected 50 electronic health records that met the criteria for the review period. During the review process, the OIG may have excluded some records, which resulted in the analysis of less than 50. In addition, for some facilities, fewer than

50 records met the criteria listed above during the review period, so the OIG examined all records, which is called a census review. The OIG statistically analyzed all randomly selected samples and reported the results in appendix C.

The OIG reported a confidence interval for the statistical analysis for all random samples. A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. A 95 percent confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence interval 95 percent of the time. The OIG did not include confidence intervals for census reviews. The OIG also did not calculate a confidence interval if the noncompliance percent was equal to 100 or 0. The OIG made a recommendation when the noncompliance percentage was statistically significantly above the 10 percent deficiency benchmark, and the lower bound of the 95 percent confidence interval was above 10 percent.

This report is a review of VISN 10 facilities' use of and adherence to VHA community care policies. The OIG included attribution, where appropriate, because information shared during surveys or interviews was not verified for accuracy or completeness. Findings cannot be generalized across VHA.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability. The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[4] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix C: Statistical Analysis

Please refer to appendix B for a detailed description of the OIG's methods for selecting and statistically analyzing data and determining findings based on the results.

The OIG estimated that community care staff at Marion did not consistently confirm appointment attendance and attempt to obtain community providers' documents prior to administratively closing consults, as shown in Table C.1.

Table C.1. Confirming Appointment Attendance and Attempting to Obtain the Community Provider's Documents Prior to Administratively Closing Consults

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Battle Creek	48	15	6 to 25
Cincinnati	47	19	9 to 31
Detroit	49	0	n/a*
Indianapolis	49	2	0 to 6
Marion	43	37	23 to 52

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

The OIG found that Battle Creek, Cincinnati, Detroit, Indianapolis, and Marion community care staff did not consistently make two additional attempts within 90 days to obtain medical documents after the consult's administrative closure, as shown in Table C.2.

Table C.2. Additional Attempts to Obtain Medical Documents After Administrative Closure

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Battle Creek	30	100	n/a*
Cincinnati	33	100	n/a*
Detroit	16	94	80 to 100
Indianapolis	33	100	n/a*
Marion	33	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

The OIG found that only community care staff at Cincinnati consistently processed requests for additional services within three business days of receipt, as shown in Table C.3.

Table C.3. Requests for Additional Services Processed Within Three Business Days of Receipt

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	47	26	14 to 38
Cincinnati	45	20	9 to 32
Dayton	46	33	20 to 47
Detroit	23	35	n/a*
Saginaw	47	30	17 to 43

Source: OIG analysis of VHA data.

**A confidence interval is not included for a census review because the data represents every patient in the study population.*

The OIG estimated that Saginaw community care staff did not consistently incorporate requests for additional services forms into the electronic health records, as shown in Table C.4.

Table C.4. Incorporating Community Providers' Requests for Additional Services into Patients' Electronic Health Records

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	50	0	n/a*
Cincinnati	46	2	0 to 7
Dayton	49	16	6 to 27
Detroit	31	3	n/a‡
Saginaw	47	28	15 to 41

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

‡A confidence interval is not included for a census review because the data represents every patient in the study population.

The OIG estimated that Cincinnati community care staff did not consistently incorporate supporting medical documents with requests for additional services into patients' electronic health records, as shown in Table C.5.

Table C.5. Incorporating Supporting Medical Documents with Requests for Additional Services into Patients' Electronic Health Records

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	50	8	2 to 16
Cincinnati	46	48	33 to 62
Dayton	49	2	0 to 6
Detroit	31	10	n/a*
Saginaw	47	2	0 to 7

Source: OIG analysis of VHA data.

**A confidence interval is not included for a census review because the data represents every patient in the study population.*

The OIG found that Detroit community care staff did not consistently ensure requests for additional services forms include the community provider's signature, as shown in Table C.6.

Table C.6. Ensuring Requests for Additional Services Forms Include the Community Provider's Signature

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	50	18	8 to 30
Cincinnati	45	11	2 to 21
Dayton	41	7	0 to 16
Detroit	30	27	n/a*
Saginaw	34	12	3 to 24

Source: OIG analysis of VHA data.

**A confidence interval is not included for a census review because the data represents every patient in the study population.*

The OIG found that community care staff at Chillicothe, Cincinnati, Dayton, Detroit, and Saginaw did not consistently send community providers approval letters for requests for additional services, as shown in Table C.7.

Table C.7. Approval Letters Sent to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	42	67	52 to 81
Cincinnati	39	100	n/a*
Dayton	37	100	n/a*
Detroit	13	100	n/a*
Saginaw	44	98	93 to 100

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

The OIG found that Chillicothe, Cincinnati, Dayton, Detroit, and Saginaw community care staff did not consistently send approval letters to patients for requests for additional services, as shown in Table C.8.

Table C.8. Approval Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	42	100	n/a*
Cincinnati	39	74	60 to 87
Dayton	37	100	n/a*
Detroit	13	100	n/a*
Saginaw	44	93	85 to 100

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

The OIG estimated that Battle Creek, Indianapolis, and Marion community care staff did not consistently contact patients according to the recommended frequency for consults with complex/chronic levels of care coordination, as shown in Table C.9.

Table C.9. Patient Contacts According to the Recommended Frequency

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Battle Creek	49	98	94 to 100
Indianapolis	47	77	64 to 88
Marion	49	96	90 to 100

Source: OIG analysis of VHA data.

The OIG estimated that Marion community care staff did not consistently create the Community Care–Care Coordination Plan note to document care coordination for consults with an assigned level of care coordination other than basic, as shown in Table C.10.

Table C.10. Community Care–Care Coordination Plan Note Created to Document Care Coordination for Patients with an Assigned Level of Care Coordination Other than Basic

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Battle Creek	49	4	0 to 10
Indianapolis	47	2	0 to 7
Marion	49	55	41 to 69

Source: OIG analysis of VHA data.

The OIG estimated that Battle Creek, Indianapolis, and Marion community care staff did not consistently use the Community Care–Care Coordination Plan note when they created it to document care coordination for consults with an assigned level of care coordination other than basic, as shown in Table C.11.

Table C.11. Community Care–Care Coordination Plan Note Used to Document Care Coordination for Patients with an Assigned Level of Care Coordination Other than Basic

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Battle Creek	47	96	89 to 100
Indianapolis	46	98	93 to 100
Marion	22	86	70 to 100

Source: OIG analysis of VHA data.

The OIG estimated that Battle Creek and Marion community care staff did not consistently confirm patients attended their community care appointments, as shown in Table C.12.

Table C.12. Appointment Attendance Confirmed

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Battle Creek	23	39	19 to 59
Indianapolis	0	n/a	n/a*
Marion	47	30	17 to 43

Source: OIG analysis of VHA data.

**Estimates cannot be provided when the number of patients in the sample is 0.*

The OIG found that Chillicothe, Dayton, and Saginaw community care staff did not create the Community Care–Urgent Care Record note in the electronic health record for patients who received community urgent care, as shown in Table C.13.

Table C.13. Community Care–Urgent Care Record Note Created for Patients Who Received Community Urgent Care

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Chillicothe	17	100	n/a*
Dayton	20	100	n/a*
Saginaw	42	100	n/a*

Source: OIG analysis of VHA data.

**A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

Appendix D: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 16, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG draft report, Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan.
2. The Veterans Health Administration (VHA) concurs in principle with recommendation 15 made to the Under Secretary for Health and provides an action plan in the attachment. The Veterans Integrated Service Network 10 concurs with recommendations 1-14 and 16 and provides an action plan.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(*Original signed by:*)

Steven L. Lieberman, M.D., MBA, FACHE

Appendix E: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 15, 2025

From: Acting Network Director, VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

Subj: Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan

To: Director, Office of Healthcare Inspections (54CC02)

Executive Director, Office of Integrity and Compliance (10OIC)

1. Thank you for the opportunity to review and comment on the OIG Draft Report, Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan.
2. I concur with the report findings and recommendations and appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans.
3. Should you need further information, contact the VISN 10 Deputy Quality Management Officer.

(*Original signed by:*)

Beth Lumia, MSW

Appendix F: Action Plans

Recommendation 1

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures community care oversight councils function according to their charters and meet the required number of times per fiscal year.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

The Veterans Integrated Services Network (VISN) 10 Business Implementation Manager (BIM) and VISN 10 Community Care Health Systems Specialist (HSS) implemented a process in September 2024 to monitor facility Community Care Oversight Council meeting minutes to verify that meetings are occurring at the frequency required by facility Community Care Oversight Council charters. The VISN 10 BIM will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee with a target of 90% compliance with meeting frequency.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 2

The Veterans Integrated Service Network Director, in conjunction with facility directors, confirms community care clinical staffing needs and takes action as necessary.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: March 2025

VHA Comments

The Office of Integrated Veterans Care (IVC) has required quarterly completion of the Community Care Operating Model Staffing Tool Reassessment since 2022. The VISN 10 BIM and VISN 10 Community Care HSS have and will continue to ensure facility staff complete this reassessment every 90 days and use the tool's outputs, as well as other data sources, to determine staffing needs. Identified staffing needs and recommendations were acted upon by each facility based on their individual priority analysis. VISN 10 requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff enter community care patient safety events into the Joint Patient Safety Reporting system.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: January 2026

VHA Comments

The IVC Community Care Quality and Patient Safety team released version 6.2 of the IVC Community Care Patient Safety Guidebook on November 18, 2024. The updates clarified roles, responsibilities, and business processes related to reporting events that may impact the safety or quality of Veteran care in the community. The IVC Community Care Quality and Patient Safety team hosted office hours for VISN 10 Patient Safety Managers and VISN 10 Community Care Managers on January 23, 2025, and February 3, 2025, to summarize and answer questions about the guidebook updates. The VISN 10 BIM and VISN 10 Community Care RN Manager will implement a tracking mechanism to ensure that Joint Patient Safety Reports (JPSRs) are entered for applicable Potential Quality Issues (PQIs) in alignment with the IVC Community Care Patient Safety Guidebook and report compliance quarterly to the Soonest and Best Care Committee. Compliance will be monitored for a minimum of six months with a target of 90% and action taken as warranted.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 4

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures patient safety managers or designees brief community care patient safety event trends, lessons learned, and corrective actions at community care oversight council meetings.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: January 2026

VHA Comments

The VISN 10 Patient Safety Officer (PSO) has and will continue to provide quarterly reports on community care patient safety event trends at the VISN 10 Patient Safety and Community Care Collaboration, VISN 10 Quality and Patient Safety Committee, and the VISN 10 Soonest and Best Care Committee. These reports are also shared by the VISN 10 PSO quarterly at the VISN 10 Community Care Facility Chiefs/Managers meeting.

The VISN 10 PSO reinforced the requirement for reporting community care patient safety event trends, lessons learned, and corrective actions quarterly at facility Community Care Oversight Council Meetings with facility Patient Safety Managers at the July 2024 Patient Safety Subcommittee meeting. The VISN 10 BIM and VISN 10 Community Care RN Manager will monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 5

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures staff import all community care documents into patients' electronic health records within five business days of receipt.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: March 2025

VHA Comments

The VISN 10 BIM, through the Health Information Management Service (HIMS) Program Office, monitors the 5 business days scanning standard. To support oversight of this standard, VISN 10 implemented a weekly process to monitor the HIMS/Community Care Scanning backlog and require action plans from facilities with a backlog of greater than 5 business days. Additionally, the VISN 10 BIM conducts a bi-weekly action plan call with sites reporting a backlog of over 400 documents for more than 2 consecutive weeks. Compliance is reported monthly to the VISN 10 HIMS Community of Practice, the VISN 10 Business Resource Management Committee, and the National HIMS Program Office call. According to the National Scanning Monitor Dashboard, VISN 10 has demonstrated a consistent reduction in the Community Care scanning backlog for four consecutive quarters, from 11,095 in fiscal year (FY) 2024, quarter (Q) 2 to 249 in FY 2025 Q 2. VISN 10 requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 6

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended their appointments and attempt to obtain community providers' medical documents prior to administratively closing consults.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

During the July 2024 VISN 10 Community Care Manager Huddle, the VISN 10 BIM reinforced with facility community care managers the requirement for facility community care staff to confirm that Veterans attended their appointments and attempt to obtain medical documentation before administratively closing consults. VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM and VISN 10 Community Care Registered Nurse (RN) Manager will monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 7

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff make two attempts to obtain community providers' medical documents within 90 days of the appointment following administrative closure of non-low-risk consults.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

The VISN 10 BIM and VISN 10 Community Care Program and Management Analyst reviewed and confirmed that facilities have processes in place for community care staff to obtain community providers' medical documents that is aligned with current guidance in the IVC Community Care Field Guidebook. The VISN 10 Community Care Program and Management Analyst will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 8

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff process community providers' requests for additional services within three business days of receipt.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

The VISN 10 BIM reviewed existing processes and identified ongoing challenges with the current tracking mechanisms for Request for Service (RFS) documents and statuses. Accurate tracking of RFS documents and statuses is dependent upon individual users' utilization of the Consult Toolbox (CTB). Clinical review of RFS documents may require additional time, for example, due to lack of medical record justification from Community Care Network providers, or RFS clinical review through Referral Coordination Team pathways.

VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 9

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff incorporate supporting medical documents with requests for additional services forms into patients' electronic health records.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

During the July and August 2024 VISN 10 Community Care Manager Huddles, the VISN 10 BIM reinforced with facility community care managers the requirement for RFS processes to include incorporation of supporting medical documentation for RFS requests into patients' electronic health records in alignment with current IVC Community Care guidance. VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 10

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm community providers signed the requests for additional services forms.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

During the July and August 2024 VISN 10 Community Care Manager Huddles, the VISN 10 BIM reinforced with facility community care managers the requirement for RFS processes to include confirmation of community provider signature on the RFS form in alignment with current IVC Community Care guidance. VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 11

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval letters to community providers for requests for additional services.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

During the July and August 2024 VISN 10 Community Care Manager Huddles, the VISN 10 BIM reinforced with facility Community Care Managers the requirement for facility RFS processes to include confirmation that approval/denial letters are sent to community providers in alignment with current IVC Community Care guidance. VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 12

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff send approval letters to patients for requests for additional services.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: September 2025

VHA Comments

During the July and August 2024 VISN 10 Community Care Manager Huddles, the VISN 10 BIM reinforced with facility community care managers the requirement for facility RFS processes to include confirmation that approval/denial letters are sent to Veterans in alignment with current IVC Community Care guidance. VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM will continue to monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 13

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create and use the Community Care–Care Coordination Plan note to document all care coordination activities for consults with an assigned level of care coordination other than basic.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: February 2026

VHA Comments

The VISN 10 BIM and VISN 10 Community Care RN Manager will ensure that facilities have a process in place for community care staff to initiate the Community Care-Care Coordination Plan (CC-CCP) note for Veterans with a Level of Care Coordination (LOCC) designated as moderate or complex. The existing monthly audit/internal control structure that has been in place since September 2024 will be utilized to track compliance with this action. Additionally, VISN 10 will create a monthly audit to review the use of the CC-CCP note for care coordination activities related to the episode of care. The VISN 10 BIM and VISN 10 Community Care RN Manager will monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 14

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff confirm patients attended their scheduled community care appointments and received care.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: February 2026

VHA Comments

During the July 2024 VISN 10 Community Care Manager Huddle, the VISN 10 BIM reinforced with facility community care managers the requirement for facility community care staff to confirm that Veterans attended their appointments and attempt to obtain medical documentation before administratively closing consults. VISN 10 will continue to utilize the existing monthly audit/internal control structure that has been in place since September 2024 to track compliance with this action. The VISN 10 BIM will monitor and report compliance quarterly to the Soonest and Best Care Committee for a minimum of two consecutive quarters with an established target compliance rate of 90%.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 15

Veterans Health Administration creates a process for facility staff notification of patients' urgent care visits in the community.

____Concur

__X__Concur in Principle

____Nonconcur

Target date for completion: September 2025

VHA Comments

The current contract does not require the contractor or its providers to notify VHA of urgent care services. Changing these processes would require contract modifications.

VHA is committed to ensuring that Veterans receive the highest quality of care, whether within our facilities or in the community. We recognize the importance of timely and coordinated care and are dedicated to exploring all feasible options to enhance communication and care coordination for our Veterans.

If notification of an urgent care visit is made, the information is entered into the electronic medical record. Urgent care is considered an open access benefit and allows Veterans to access urgent care within VA's network and receive timely care without prior authorization from VA and without delay. As such, VHA concurs in principle with the recommendation as written. VHA will communicate with each facility to ensure that they are aware of the requirement to use the templated Community Care-Urgent Care Record note when the facility staff become aware of an urgent care visit. Additionally, VHA will verify that Community Care-Urgent Care note

template has been uploaded and is functioning in the VHA Electronic Health Record. VHA will also conduct refresher training through established field facing calls to ensure staff are aware of these requirements and guidance for documentation of urgent care visits in the community.

OIG Comments

VHA's action plan does not address the findings prompting this recommendation and therefore will remain open. Without a modification to the current contract, or a requirement in the future community care contract, the OIG is concerned that veterans face significant risk when seeking urgent care in the community. Effective care coordination requires all providers participating in the management of a patient to be informed of all diagnostic and therapeutic interventions that are performed or recommended. This information sharing is even more critical when results and required follow-up care are time sensitive. Failure to ensure this coordination subjects veterans enrolled in VHA to two separate standards of care.

Recommendation 16

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care staff create the Community Care–Urgent Care Record note in electronic health records when they receive urgent care documents.

__X__ Concur

____ Concur in Principle

____ Nonconcur

Target date for completion: April 2025

VHA Comments

The VISN 10 BIM confirmed that 100% of VISN 10 facilities have created the Community Care-Urgent Care Record note in CPRS for their station. Use of the note was reinforced with all facility Community Care Managers at the August 2024 VISN 10 Community Care Manager huddle. VISN 10 requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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