US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records

Review	24-02154-154	August 7, 2025

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Executive Summary

VA can authorize veterans to receive care in the community in specific circumstances, such as when Veterans Health Administration (VHA) medical facilities do not provide the requested services, or a veteran must drive an average of at least 30 minutes for primary care or mental health care or 60 minutes for specialty care at a VHA facility.[1] In these instances, the veteran's VA healthcare provider submits a request for a consult, and responsible staff in a VHA facility's community care department help the veteran schedule medical appointments with providers in the community.[2] After the care occurs, the community provider must return associated medical records to VHA. Community care staff complete the consult once medical records are received by VHA.

Contractual language with third-party administrators—entities that provide and manage VHA's network of community care providers—requires community providers to return medical records to VA within 30 days of an appointment. If records are not received, VHA policy requires community care staff to administratively close consults and make three requests for the records within 90 days of the appointment.[3] Closing a record administratively not only allows facilities to show the veteran received care but also completes the consult without a medical record.

The VA Office of Inspector General (OIG) conducted this review to determine whether VHA staff took appropriate action to retrieve and document the medical records from community providers and import the records into the veterans' electronic health records (EHR).

What the Review Found

The OIG found that, as of December 16, 2024, VHA closed nearly 3 million community care consults for appointments scheduled to occur between October 1, 2023, and April 1, 2024.[4] Among these, over 2.4 million (82 percent) had the associated medical records attached, and

[1] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2025); 38 C.F.R. § 17.4040 (2025); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

[2] A consult is a request for clinical services created by a healthcare provider on behalf of a patient seeking an opinion, advice, or expertise regarding evaluation or management of a specific patient problem. VHA Directive 1232(5), *Consult Processes and Procedures*, December 5, 2022.

[3] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum to the Veterans Integrated Service Network directors, October 1, 2021.

[4] The review included 134 VHA facilities that used the legacy EHR. Five VHA facilities that used the modern EHR were excluded. This total excludes consults marked as low risk in the Consult Toolbox. See appendix A for a list of all 134 VHA facilities reviewed and for more information on the review's scope and methodology.

nearly 1 million were administratively closed (34 percent).[5] In addition, as of December 2024, VHA had 71,447 open consults linked to appointments occurring between October 1, 2023, and April 1, 2024.

Some facilities received nearly all community care medical records. Others struggled to retrieve records from community providers. Staff said competing priorities reduced the amount of time available to request and process incoming records. Once records were received, community care staff did not always use the Consult Toolbox to document the receipt, and the administrative closure policy was both unclear and inconsistently used. After the medical records arrive at a VHA medical center, policy suggests the community care office has two business days to review the records, and Health Information Management (HIM) or community care staff have three business days to import the records into the EHR.[6] VHA facilities varied in meeting these timeliness metrics because some facilities implemented tools to improve the timeliness of processing records and others faced technological barriers.

VHA Receipt of Community Care Medical Records

According to the OIG team's analysis, 62 facilities each imported 90 percent or more of their facility's records for completed community care consults into the veterans' EHR, including four of the facilities where the team conducted interviews: the Chillicothe VA Medical Center in Ohio; the Togus VA Medical Center in Augusta, Maine; the Aleda E. Lutz VA Medical Center in Saginaw, Michigan; and the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. Staff at these facilities said they had agreements to access some electronic medical records from community providers via secure internet portals or the Veterans Health Information Exchange to pull records themselves. Other facilities' staff said the return of records improved when VHA community care offices built strong relationships with community providers, such as by assigning a liaison to communicate with outside providers.

Some VHA facilities received records for 98 percent or more of consults. However, for closed community care consults with scheduled appointments between October 1, 2023, and April 1, 2024, staff at 11 facilities imported the records into the EHR for 60 percent or fewer of

[5] Closed consults with records received include both those that were closed when records were received and those that were closed administratively without records received, for which records may have been received later. VA facility community care staff are required to document when records from community care consults are received using the Consult Toolbox software. However, the team found community care staff did not always follow this requirement. This led to an undercounting of consults with records received. Due to this limitation, the team used the Text Integrated Utilities progress note from the EHR to determine which consults received the associated medical record.

[6] Practice Brief, "Community Care—VistA Imaging Capture Best Practice And Minimum Documentation Requirements," Health Information Management Office of Health Informatics, March 2021. The HIM department manages paper records, electronic health information, and health records at VA, including scanning documents and importing electronic records.

the consults.[7] Community care staff reported challenges with retrieving records because of competing priorities. In addition to requesting and processing medical records, community care staff gather documents for referrals, review eligibility determinations, contact veterans, schedule appointments, and complete authorizations. Staff explained they did not always have time to make the three required attempts for medical records or had backlogs of records they needed to process first.

The Consult Toolbox is software used for consult management that standardizes the documentation process and workflow for VHA staff. When updated correctly, the software identifies which steps are completed in the consult process. VHA staff did not mark records received in the Consult Toolbox for about 630,000 of the approximately 2.4 million consults (26 percent) with records imported into the EHR. Starting September 12, 2023, VHA's Office of Integrated Veteran Care (IVC) required the use of the Consult Toolbox by community care staff to document the return of medical records. However, the OIG team determined that IVC has not ensured medical facilities fill out required elements in the Consult Toolbox and that facility staff input information correctly. Correctly inputting information into the Consult Toolbox is critical to know which consults still require follow-up actions to retrieve the medical records and which have had records returned. The team found the Consult Toolbox did not have enough controls to ensure staff input information consistently and correctly. IVC's failure to implement controls led to incomplete data.

Unclear and Inconsistently Used Policy

A revised administrative closure memorandum was issued on October 1, 2021, to update the procedure for the administrative closure process. Additional guidance for administrative closure is in the IVC Field Guidebook. The administrative closure designation allows community care staff to complete consults without records when specific criteria are met.[8] The revised memorandum and guidebook clearly state that three attempts to request the record must occur within 90 days of the appointment. However, the policy was inconsistent for when to administratively close consults. The IVC Field Guidebook recommends that in 14 days, staff confirm the veteran attended the appointment, make a first request for records, and then administratively close the consult within 90 days of the appointment.[9] In contrast, the closure

[7] The 11 facilities included three of the eight facilities where the team interviewed staff: the Rocky Mountain Regional VA Medical Center in Aurora, Colorado; the Central Alabama Healthcare System in Montgomery, Alabama, and Tuskegee, Alabama; and the Joseph Maxwell Cleland Atlanta VA Medical Center in Decatur, Georgia.

[8] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum. According to this memorandum, community care staff shall administratively close a consult once the veteran is confirmed to have attended the appointment and one attempt to retrieve medical records is documented.

[9] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management," updated August 29, 2023.

memorandum did not clarify when attempts to acquire medical records should occur, nor did it advise a time frame for when administrative closure must occur. The OIG team determined that facilities' community care staff found the administrative closure requirements to be unclear between the IVC Field Guidebook and the VHA memorandum. Therefore, facilities interpreted the guidance in varying ways.

Some community care staff said they chose to keep consults open, rather than administratively close them, to ensure follow-up actions occurred. Of the 71,447 open consults, from October 1, 2023, to April 1, 2024, 71,429 (99.9 percent) were open more than 90 days from the scheduled appointment. The IVC Field Guidebook requires community care staff to administratively close consults within 90 days of the appointment, and the VHA administrative memorandum requires community care staff to review associated data reports monthly.

Importing Records

Staff did not always import records in a timely manner into the EHR after receipt. VHA policy requires that all internal and external documents be imported or scanned into the EHR within five business days of receipt.[10] VHA policy suggests community care staff have two business days to review medical records, and HIM or community care staff have three business days to import the records into the EHR.[11]

Barriers to importing records into the EHR in a timely manner included technology limitations. Each of the five facilities the team visited in person had delays in processing or importing records because of technological barriers. At the time of the review, the largest number of records came back via electronic fax, which is inefficient because of issues with fax systems not working for periods of time. During interviews with the team, staff at five facilities cited issues with electronic faxes in processing community care medical records. The VHA portal available for community providers to return records to VHA was generally not used because of the complexity for the individual providers. Facilities that used tools to improve processing shortened the time it took to import records into the EHR. VA has a national blanket purchase agreement, a type of contract, that is used when a backlog occurred.

Any medical records not imported into the EHR within five business days become part of the backlog of records. Backlogs increased the risk of duplicate requests because staff could not determine which records were in the backlog and would therefore request the same record multiple times. When community care records are not imported within five business days, it increases the risk that clinicians will not have records to review when needed or that VHA

[10] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021 (amended December 11, 2023).

[11] Practice Brief, "Community Care—VistA Imaging Capture Best Practice and Minimum Documentation Requirements."

clinicians will implement contingencies to request the record, which often add to clinical staff's workload.

What the OIG Recommended

The OIG made 10 recommendations to the under secretary for health to direct IVC to take corrective action.[12] The office should (1) evaluate which staff should have access to and should update the Consult Toolbox when records are requested or received and update the "Consult Business Rules and Uses of the Consult Package Standard Operating Procedure" to reflect necessary changes; (2) include additional controls within the Consult Toolbox; (3) determine whether metrics for the percentage of records received should be a requirement and update the consult closure policies and procedures to clarify requirements; and (4) determine whether the administrative closure report should still be used for reviewing administratively closed consults.

The OIG also recommended the IVC (5) evaluate the workload of community care staff to decide how best to structure and execute duties; (6) determine if there are mechanisms to identify standardization opportunities and increase efficiency for the return of records; (7) ensure community care staff follow procedures to reduce duplicate records received; (8) evaluate ways to increase use of provider electronic records portals; (9) consider implementing technologies to improve records processing; and (10) ensure records from the Joint Longitudinal Viewer are uploaded into the VHA EHR.

VA Management Comments and OIG Response

The acting under secretary for health concurred with recommendation 1 and recommendations 3 through 10, concurred in principle with recommendation 2, and provided an action plan detailing steps for implementation. The full text of the acting under secretary's comments appears in appendix B. The OIG found the action plan acceptable and will monitor progress and close each recommendation when adequate documentation demonstrates sufficient implementation steps have been taken.

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[12] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

Contents

Abbreviations

EHR	electronic health record
FY	fiscal year
HIM	Health Information Management
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

VA can authorize care in the community under specific circumstances, such as when Veterans Health Administration (VHA) medical facilities do not provide the requested services or when a veteran must drive an average of at least 30 minutes to receive primary care or mental health care or 60 minutes to receive specialty care at a VHA facility.[13] In these instances, the veteran's healthcare provider submits a request for a consult, and responsible staff in the VHA facility's community care department assist the veteran with scheduling medical appointments with community care providers.[14] Once the care is provided, the return of the medical records to VHA from the community provider signifies the completion of an episode of care. Figure 1 shows the consult cycle starting with an eligibility determination through when care is ultimately paid.[15]

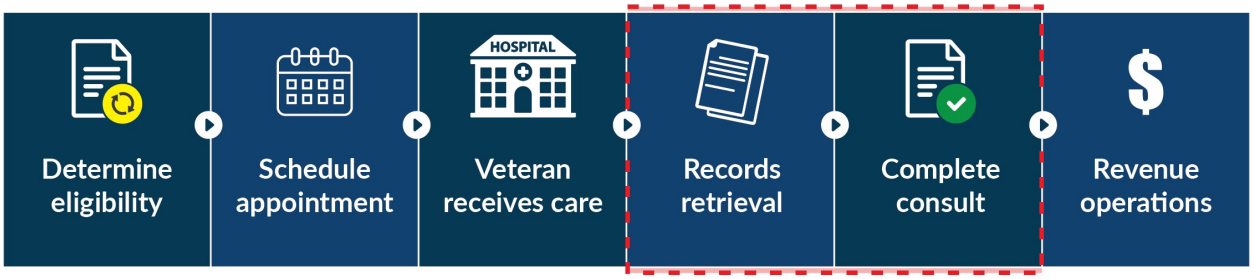

Figure 1. *VHA community care consult cycle.*
Source: VA Office of Inspector General (OIG) interpretation of consult process as outlined in VHA Community Care Operating Model Fact Sheet, February 2018.

VHA clinicians review the electronic health record (EHR) to obtain pertinent facts, findings, and observations resulting from veterans' appointments with community providers.[16] After community providers send medical records to VHA, they are imported into and become a part of a veteran's EHR. Federal law requires effective controls over the creation, maintenance, and use of records to conduct business, which according to policy requires VHA to maintain complete, accurate, timely, clinically pertinent, and readily accessible patient health records to serve as a basis to plan patient care, support diagnosis, and warrant treatment.[17] During interviews with the OIG team, VHA clinicians emphasized that prompt receipt of community care medical records is

[13] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2025); 38 C.F.R. § 17.4040 (2025); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

[14] A consult is a request for clinical services created by a healthcare provider on behalf of a patient seeking an opinion, advice, or expertise regarding evaluation or management of a specific patient problem. VHA Directive 1232(5), *Consult Processes and Procedures*, December 5, 2022.

[15] Figure 1 illustrates the intended process; however, the process does not always occur as depicted.

[16] This is an electronic record that contains veterans' health information, including medical records, and allows VA providers to share the information with healthcare professionals in the VHA system. VHA Health Information Management (HIM) Health Record Documentation Program Guide, ver. 1.2, September 29, 2023.

[17] 44 U.S.C. § 3102(1); VHA HIM Health Record Documentation Program Guide, ver. 1.2.

crucial for care coordination. However, VHA facilities face challenges both retrieving records from community care providers and managing them once they are received. Prior OIG reports indicated that a lack of access to medical records may jeopardize veterans' health outcomes and lead to duplicative or delayed care or missed appointments.[18]

The VA Office of Inspector General (OIG) conducted this review to determine whether VHA staff took appropriate action to retrieve and document the medical records from community providers and to import the records into the veterans' EHR.

Process for Closing Community Care Consults

According to the service contracts VHA maintains with its third-party administrators, as well as VHA's Office of Integrated Veteran Care (IVC) Field Guidebook, community providers are responsible for submitting medical records to VA following each episode of care.[19] Third-party administrators must inform providers of their responsibility to furnish medical records within 30 days of a veteran's appointment.

Community providers have many options for supplying records to VHA, including through electronic fax, email, online portals such as the HealthShare Referral Manager or Veterans Health Information Exchange, or by granting VHA staff direct access to the community provider's medical records system.[20] Community care staff generally follow the workflow outlined in figure 2 to request and process records. Steps include documenting confirmation of a veteran's appointment, documenting records received, scanning records, importing records, and closing consults.

[18] VA OIG, *Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims*, Report No. 21-03916-103, April 27, 2022; VA OIG, *Deficiencies in Select Community Care (Stat) Processes During the COVID-19 Pandemic*, Report No. 20-03437-26, November 10, 2021; VA OIG, *Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center*, Report No. 17-01757-50, January 28, 2019.

[19] Third-party administrators provide and manage a network of healthcare providers for VHA community care programs. IVC is the national program office that manages veterans' and beneficiaries' access to health care, including the administration of the Community Care Program and Community Care Networks. IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated August 29, 2023.

[20] The HealthShare Referral Manager is an electronic referral and authorization processing system used to accelerate access to community care. The Veterans Health Information Exchange allows providers and patients to access and share a patient's medical information. Providers can also send records by mail or traditional fax, even though these methods are used infrequently.

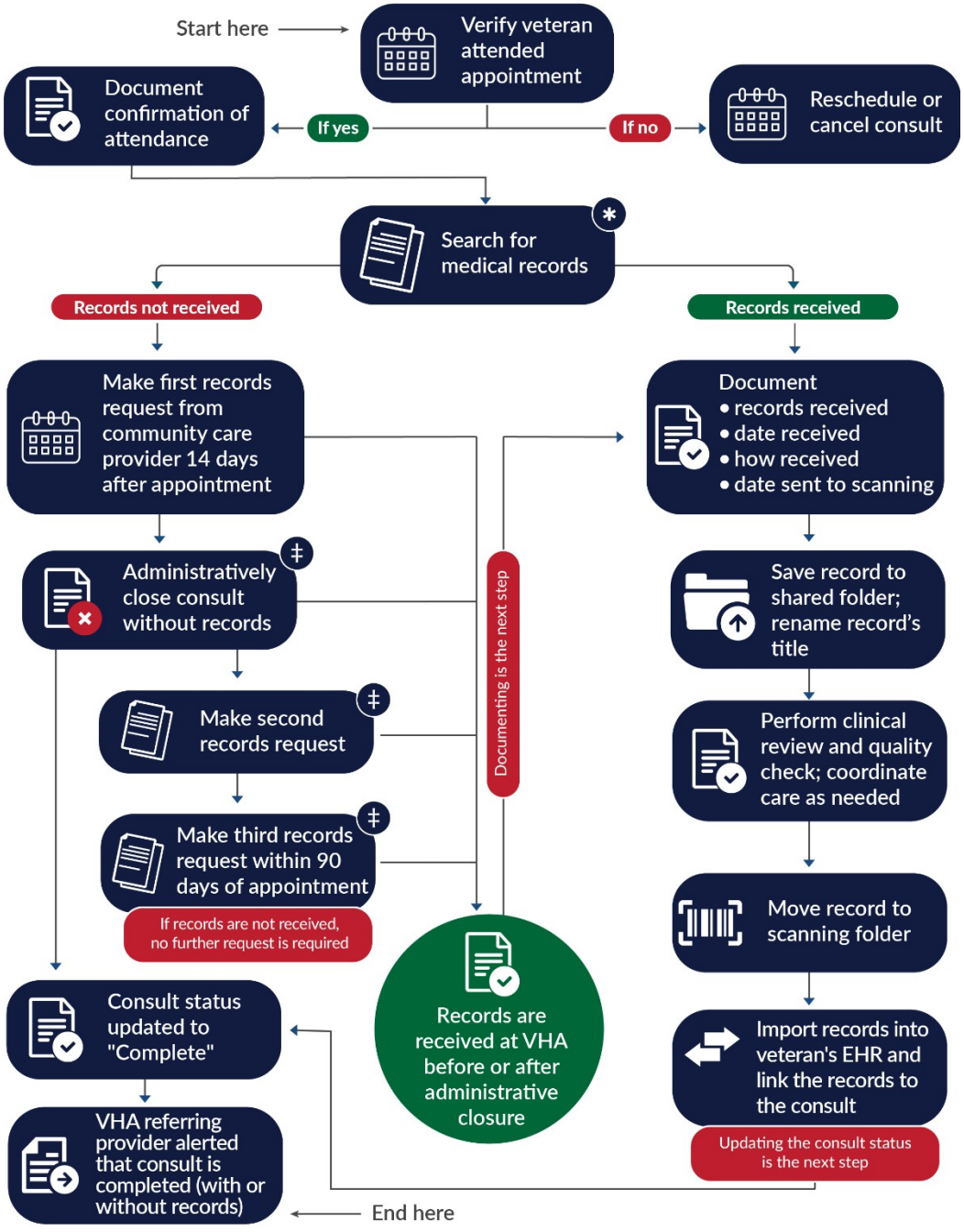

Figure 2. *Process for completing community care consults and retrieving records.*

Source: VA OIG interpretation of consult closure process in IVC Field Guidebook.

** Medical records may enter a facility in numerous ways including through electronic fax, email, and approved electronic portals. Community providers have 30 days from the appointment date to provide the records to VHA.*

‡ Once a consult is administratively closed, the consult is "completed," even if the records have not yet been received. After administrative closure, records may be received at any time; when records are not received, staff make a second or third request.

Administrative Closure Policy

IVC developed the Field Guidebook to outline "business and clinical processes for facility community care staff as they coordinate veteran care with community partners."[21] According to the IVC Field Guidebook, VHA staff must make every effort to obtain authenticated information from community providers and ensure it is imported into a veteran's health record.[22] However, when community providers do not return medical records, VHA staff shall administratively close consults. When staff take actions to mark consults as administratively closed, it means that the consult's status changes from "open" to "complete," indicating the appointment occurred and the consult is closed. Using administrative closure allows facilities to better distinguish veterans who have received care from those still needing it.[23]

VHA also issued a memorandum providing guidance on administrative closure policy, which it first published in 2018 and subsequently revised on October 1, 2021.[24] The OIG team was informed that the purpose of the administrative closure memorandum was to record open consults as complete if they had appointment dates that occurred in the past, even if records were not received. According to the memorandum, community care staff shall use the "administrative closure" designation without receiving the medical records when the following criteria are met:

- Staff confirm that the veteran attended the appointment, and
- One attempt to retrieve records is documented in the Consult Toolbox.[25]

To administratively close a consult, the IVC Field Guidebook suggests that staff can start with a follow-up action within two days of the scheduled appointment to confirm a veteran's attendance. This generally occurs by contacting the veteran or the community provider. If the veteran did not attend, a scheduler will attempt to reschedule the appointment. However, if the appointment occurred and the community care provider does not return the medical records within 14 days of the scheduled appointment date, staff can make a first attempt to request the records and then administratively close the consult. The consult remains designated as

[21] "Office of Integrated Veteran Care (IVC) Community Care Field Guidebook" (SharePoint site), IVC, accessed April 3, 2024. (This website is not publicly accessible.)

[22] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated August 29, 2023.

[23] Consults that are administratively closed are also in a completed status, but "administratively closed" indicates the consult was completed without a progress note and attached records.

[24] VHA memorandum, "Clarification of Administrative Closure of Community Care Consults," March 6, 2018; Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum to the Veterans Integrated Service Network directors, October 1, 2021.

[25] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum.

administratively closed, even if the medical records are received after the second or third outreach attempt.

IVC staff told the OIG team that the administrative closure of a consult does not release the facility from the obligation of gathering the medical records, consistent with IVC's Field Guidebook. In addition, the administrative closure memorandum directs community care staff to continue to make two more attempts to obtain the records after administrative closure for all non-low-risk consults.[26] Within 90 days of the appointment date, community care staff must document a second and third request for the records. Staff must administratively close the consult within 90 days of the scheduled appointment if the records have not yet been received.[27]

For consults that have been administratively closed, facilities are required to monitor at least monthly the number of attempts made to request medical records by using the "Admin Complete Report Consults Closed without Records Report."[28] The report is supposed to identify the administratively closed consults, including whether consults still have missing records and the number of documented follow-up requests for records.

Completing Consults When Records Are Received

VHA mandated the use of the Consult Toolbox by community care staff.[29] The toolbox standardizes the documentation process and workflow for VHA staff and aids in managing consults. For example, it allows VHA staff to determine whether a veteran is eligible for community care and for community care staff to determine where in the process a consult is. Community care staff are supposed to document actions completed on the consult in the toolbox to allow for the tracking and managing of consults. Whenever community care staff request or receive medical records, they must use the toolbox's consult completion workflow tab to record the action taken. Once medical records are received, the Consult Toolbox is updated to indicate how records were received, the date of receipt, and the date the records were sent to be uploaded to the EHR.[30]

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[26] Low-risk consults require only one request for medical records. VHA has defined 19 low-risk clinics nationally, including physical therapy, occupational therapy, kinesiotherapy, acupuncture, smoking, MOVE (weight management program), massage therapy, chiropractic care, and erectile dysfunction. VHA Directive 1232(5), *Consult Processes and Procedures*.

[27] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Consults," updated August 29, 2023.

[28] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum.

[29] Acting Assistant Under Secretary for Health for Integrated Veteran Care, "Mandatory Use of Consult Toolbox (CTB) For Consult Management," memorandum to Veterans Integrated Service Network directors, September 12, 2023.

[30] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Consults," updated January 7, 2025.

Importing Medical Documentation into a Veteran's EHR

When VHA receives a medical record from a community provider, community care staff at the facility conduct an initial records screening, appropriately title the file to prepare to import it, and send the file to a community care nurse to review. For records sent directly to another department rather than the Office of Community Care, each VHA facility determines how to transfer the records to community care staff for review. If the nurse in community care determines the records are sufficient, the files are imported into the veteran's EHR either by local Health Information Management (HIM) staff or by community care staff.[31]

The HIM department manages electronic and paper health information at VHA facilities, including document scanning and electronic record importing. Document scanning, also known as imaging, is a process in which a paper document is converted into an electronic file, while importing is the process of incorporating electronic files into the EHR. VHA policy requires staff to scan and import records into the EHR within five business days of receipt by a facility. [32] The HIM department does not perform clinical reviews for sufficiency or appropriateness.

[31] Practice Brief, "Community Care—VistA Imaging Capture Best Practice And Minimum Documentation Requirements," Health Information Management Office of Health Informatics, March 2021.

[32] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021 (amended December 11, 2023).

Results and Recommendations

Finding 1: Facilities Did Not Always Receive Records or Properly Document Retrieval Attempts or Actual Receipt of Records

As of December 16, 2024, VHA closed 2,953,865 community care consults for appointments that occurred between October 1, 2023, and April 1, 2024 (the review period).[33] Of the almost 3 million closed consults, associated medical records were imported into the EHR for 2,418,770 consults (82 percent).[34] For facilities that did not retrieve records from community providers, staff did not always take action because of competing priorities. Additionally, inconsistent and incorrect use of the Consult Toolbox resulted in incomplete data, limiting managers' ability to make informed decisions about community care consult closures.

Because the administrative closure policies and processes on closing consults were ambiguous as to which staff were responsible for oversight and which timelines were requirements, facilities did not use administrative closure in a uniform way. If the community care provider does not send records, the administrative closure memorandum and IVC Field Guidebook require VHA staff to make a first request to retrieve records, administratively close the consult, and then make two more requests within 90 days if no records are received.[35] However, only the Field Guidebook includes the requirement to follow up to confirm that the appointment occurred within 14 days and that consults must be administratively closed within 90 days, while the administrative closure memorandum did not.[36] In addition, neither document includes information related to oversight responsibilities for Veterans Integrated Service Networks (VISNs) or facilities to make sure the process is followed. During the review period, VHA staff reported that they found the policy for administrative closure and the Field Guidebook were not clear about when administrative closure should occur. Therefore, facilities used the policy inconsistently and relied on professional judgment to manage the closure of consults.

[33] The review included 134 VHA facilities that used the legacy EHR and excluded five facilities that used the modern EHR. The total consults for the 134 facilities exclude those marked as low risk in the Consult Toolbox.

[34] Closed consults with records received include both those that were closed when records were received and those that were closed administratively without records received, for which records may have been received later. VA facility community care staff are required to use the Consult Toolbox software to document when records from community care consults are received. However, the team found community care staff did not always follow this requirement. This led to an undercounting of consults with records received. Due to this limitation, the team used the Text Integrated Utilities progress note from the EHR to determine which consults received the associated medical record.

[35] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated August 29, 2023. This version of chapter 4 was in place at the time of the team's fieldwork. It was updated on January 7, 2025, after the scope of the team's review.

[36] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum.

In addition to the nearly 3 million closed consults, as of December 16, 2024, VHA had 71,447 open consults linked to an appointment that was scheduled between October 1, 2023, and April 1, 2024.[37] Of these, 71,429 were open more than 90 days from the scheduled appointment (99.9 percent). If records are not received, VHA policy requires community care consults to be administratively closed and three records requests documented within 90 days of the appointment.[38]

The finding is based on the following determinations:

- Some facilities received nearly all community care medical records, while others struggled.
- Competing priorities for community care staff reduced time spent ensuring records were returned.
- VHA staff did not always appropriately update the Consult Toolbox, as required.
- The administrative closure policy purpose was unclear and therefore inconsistently used.

What the OIG Did

To support the findings in this report, the OIG review team analyzed community care consult data, visited medical facilities, and interviewed VHA and facility officials. To look at completed and administratively closed consults by facility, the team reviewed consult data from the VHA Corporate Data Warehouse for all facilities that used the legacy electronic health record system (the VistA Computerized Patient Record System).

The team visited the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri (Columbia); the Central Alabama Health Care System in Montgomery, Alabama, and Tuskegee, Alabama (Central Alabama); and the Rocky Mountain Regional VA Medical Center in Aurora, Colorado (Denver) because these sites had at least 40,000 consults completed and either a high or low rate of administratively closing consults without records in fiscal year (FY) 2023. The team also visited the Joseph Maxwell Cleland Atlanta VA Medical Center in Decatur, Georgia (Atlanta) and the Togus VA Medical Center in Augusta, Maine (Togus) based on information collected during fieldwork. During site visits, the team interviewed the hospital executive suite and community care, HIM, and clinical staff.

[37] The open consults were in a scheduled status for an appointment in the past—meaning community care staff still needed to complete the consults either by retrieving the records, uploading or scanning them to the veterans' EHR, and linking them to the correct consults or by verifying each consult's appointment attendance, making and documenting one records request each, and then administratively closing them.

[38] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated August 29, 2023.

The team interviewed community care leaders at three additional VHA facilities because their data results implied a very high rate of medical records received: the three facilities were in Chillicothe, Ohio; Saginaw, Michigan; and Clarksburg, West Virginia. The team did not interview HIM, clinical, or executive-level staff at these facilities.

The team also followed up with community care leaders at the VA medical facilities in El Paso, Texas; Hudson Valley, New York; and Iowa City, Iowa, where data results implied a very low rate of medical records received. The team requested clarification on how the facilities used the Consult Toolbox and imported records into the EHR. Because of the limited nature of these conversations, these sites are not included in overall interview examples and results.

Additionally, the team interviewed national program office officials with IVC and HIM as well as VISN-level staff. The team requested information through email from third-party administrators of the Community Care Network contracts and interviewed staff from five community providers in the network for VHA facilities the team visited. Finally, the team reviewed VHA policies and the Community Care Network contracts.

Some Facilities Received Nearly All Community Care Medical Records, While Others Struggled

Facilities received medical records for 82 percent of the almost 3 million community care consults completed during the review period. The remaining 18 percent, representing 535,095 completed consults, did not have records uploaded into the EHR. VHA facilities across the country varied in how successful they were at retrieving medical records from community care providers. Some could obtain virtually all or most of the records, while others struggled to retrieve them.

According to results of the OIG's data analysis, 62 facilities each imported 90 percent or more of their facility's records for completed community care consults into the veterans' EHR. Of note, eight of these 62 facilities imported 98 percent or more of the records. Table 1 lists these eight facilities.

Table 1. Top Performing VHA Facilities Based on Rate of Records Imported into EHR

Healthcare system facility location	Percentage of closed consults with records imported into the EHR	Total number of closed consults with records imported into the EHR	Total number of closed consults
Chillicothe, Ohio	100%	19,849	19,891
Clarksburg, West Virginia	100%	11,661	11,703
Saginaw, Michigan	99%	30,650	30,911

Healthcare system facility location	Percentage of closed consults with records imported into the EHR	Total number of closed consults with records imported into the EHR	Total number of closed consults
Tomah, Wisconsin	98%	18,896	19,255
Altoona, Pennsylvania	98%	13,182	13,440
Black Hills, South Dakota	98%	15,965	16,318
Amarillo, Texas	98%	16,647	17,049
Bedford, Massachusetts	98%	2,304	2,360

Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database. See appendix A for a list of all 134 VHA facilities reviewed.

Note: These VHA facilities imported at least 98 percent of records from October 1, 2023, through April 1, 2024. The percentages are rounded to the nearest whole number.

For staff at four facilities where the review team conducted interviews (Chillicothe, Togus, Saginaw, and Clarksburg), records were returned and imported into the EHR for over 90 percent of consults. Staff at these facilities attributed the higher rates to having agreements to access some electronic medical records via community providers' secure internet portals or the Veterans Health Information Exchange, allowing staff to pull records themselves. The review team determined that using providers' internet portals enabled VHA staff to retrieve the records when ready without making any requests to the community provider to send the records, which reduced the number of electronic faxes sent and received and thus eliminated the inefficiency related to electronic faxes.

In addition, facility staff told the review team that building relationships with community providers made it easier to retrieve records. Staff at four facilities (Central Alabama, Columbia, Atlanta, and Saginaw) said having a staff member act as a liaison with outside providers improved the rate of returned records and allowed staff to mitigate problems and communication issues with outside providers. The community care chief at Saginaw said community care liaisons had great relationships with providers that proved successful for not only records retrieval but all processes. Although they did not have a liaison at Columbia, the chief of community care said they built successful relationships and action plans directly with the community providers' medical records departments.

Staff at four facilities (Central Alabama, Denver, Atlanta, and Clarksburg) said requesting records for one or a few clinical services allowed them to build relationships with providers. For example, one medical support assistant would be assigned to request cardiology records and another medical support assistant would request dermatology records. During interviews with the OIG team, community providers agreed with the importance of having an assigned VHA contact. An insurance administrator that sent medical records back to VHA for a dental community provider told the team it is helpful to have only one person with whom to discuss issues

regarding community care. Alternatively, some VHA facility staff said community providers could become frustrated with VHA when records requests were made by multiple people and medical records had already been sent.

Competing Priorities for Community Care Staff Reduced Time Spent Ensuring Records Were Returned

While some VHA facilities had a 98 percent or higher success rate at retrieving records, 11 facilities imported 60 percent or fewer records into the EHR for closed community care consults that had scheduled appointments between October 1, 2023, and April 1, 2024. Table 2 shows the lowest-performing VHA facilities for importing records into the EHR.

Table 2. Lowest-Performing VHA Facilities Based on Rate of Records Imported into the EHR

Healthcare system facility location	Percentage of closed consults with records imported into the EHR	Total number of closed consults with records imported into the EHR	Total number of closed consults
Puget Sound, Washington	60%	24,599	40,761
Milwaukee, Wisconsin	57%	14,083	24,595
Hampton, Virginia	57%	14,153	24,778
Denver, Colorado	56%	22,992	40,817
Coatesville, Pennsylvania	56%	1,821	3,267
Salt Lake City, Utah	54%	16,121	29,646
Dublin, Georgia	51%	9,126	17,788
Central Alabama	47%	20,528	43,179
Atlanta, Georgia	47%	16,028	34,048
Augusta, Georgia	46%	9,783	21,474
Hudson Valley, New York*	0.4%	11	2,783

Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workplace database. See appendix A for a list of all 134 VHA facilities reviewed.

Note: These VHA facilities imported fewer than 61 percent of records from October 1, 2023, through April 1, 2024. The percentages are rounded to the nearest whole number.

** The OIG team determined the Hudson Valley facility imported records into the EHR but was not attaching the records to the consults, as required; thus, only 11 consults with attached records were imported into the EHR.*

Facilities struggled to obtain records for various reasons. According to community care staff at Central Alabama, community providers did not answer phone calls from VHA staff because they were repeatedly contacted for records that had already been sent. Staff at Atlanta and Denver told the review team they did not regularly make at least three attempts to request records. These

three facilities received records back less than 60 percent of the time. Staff said they did not have time or enough staff to request records multiple times. Facilities had different workload challenges based on staffing levels. Staff also made the point that when they had backlogs of records waiting for processing, they did not use their limited resources to make additional requests for unreceived records. They instead reviewed the records already in the backlog to determine whether community providers sent the record back to VHA. When community care staff continued to make three requests with records backlogs, as was the case with Central Alabama, facilities risked duplicating requests and fracturing relationships with providers.

Community care staff must balance requesting and processing medical records with many other tasks such as gathering documents for referrals, determining eligibility, communicating with veterans, scheduling appointments, completing authorizations, and answering phone calls. The chief of community care at Columbia said records retrieval takes medical support assistants away from scheduling community care appointments, and a physician in Central Alabama said requesting records and obtaining medical documents pulls staff away from other duties.

The three facilities that received nearly all records employed strategies to decrease the number of tasks staff had to prioritize. An assistant nurse manager at Chillicothe said they have medical record technicians who receive incoming faxes, look up a patient's name, ensure document identifiers are correct, and name the faxes. They also sort the fax documents by categories of care. At Clarksburg, the Community Care Program manager said the office created a closing team whose only role was to request records. Saginaw also had a special team that only closed consults.

Across all five facilities where the team conducted in-person site visits, 15 VHA clinicians said not receiving medical records from community providers can lead to more work for clinical staff to obtain the records or possible delays in medical treatment. The chief of women's health at Atlanta explained a case where the associated medical records for a mammography screening were not received for two months after an appointment. This delayed the veteran's biopsy, which came back positive for cancer. Atlanta has since updated processes to ensure mammography records are received in a timely manner.

VHA Staff Did Not Always Appropriately Update the Consult Toolbox, as Required

When updated correctly, the Consult Toolbox allows staff to quickly identify which steps have been completed in the consult process without having to open and search a patient's EHR. Starting September 12, 2023, IVC required community care staff to use the Consult Toolbox to document medical records retrieval.[39] However, the OIG team determined IVC has not ensured

[39] Acting Assistant Under Secretary for Health for Integrated Veteran Care, "Mandatory Use of Consult Toolbox (CTB) For Consult Management," memorandum.

medical facilities fill out required elements in the Consult Toolbox or that facility staff input information correctly. Correctly inputting information into the Consult Toolbox is critical to distinguishing which consults still require follow-up actions to retrieve the medical records and which have records returned. Of the almost 3 million closed consults, only about 1.8 million (61 percent) had a corresponding notation in the Consult Toolbox that records were received. However, more than 2.4 million consults (82 percent) had records imported into the EHR. Therefore, for nearly 630,000 consults (26 percent) where records were imported into the EHR, the Consult Toolbox did not include a note indicating the records were received. The team found the inconsistent use of the Consult Toolbox could have contributed to VHA facility staff making duplicate requests for records.

The VHA standard operating procedure for consult management procedures and processes requires all users to update the Consult Toolbox for some mandatory fields, such as forwarding consults to community care and capturing community scheduling preferences.[40] The standard operating procedure requires community care staff to update the Consult Toolbox only for consult completion and records retrieval.[41] The review team determined this is problematic because records from community care providers may be requested by and received at multiple VHA facility departments, such as primary care, specialty care, HIM, or community care. Any staff outside community care, such as HIM staff importing records or clinical staff requesting a record, are not required to update the Consult Toolbox regarding records requests or records received. As a result, community care staff may be unaware that other facility staff have requested or received records already, creating duplication.

The team determined IVC does not monitor the receipt of records. IVC staff said monitoring occurs at the facility level. HIM staff said they did not use the Consult Toolbox and instead used their own monitoring tools. The team found the lack of controls and multiple errors for this tool led to inconsistent data for community care offices at VHA facilities. For example, community care staff typed unique entries to document how records were returned to the VHA facilities, resulting in over 250 different descriptions. This included the eight prepopulated options they could checkmark in the Consult Toolbox, making it hard to determine which methods were used most frequently to receive medical records. When the Consult Toolbox is not updated, the reports produced are inaccurate—misrepresenting the number of consults with records received. This diminishes facilities' ability to properly manage patient records and does not allow effective oversight of facility processes.

Table 3 lists the 12 lowest-performing VHA facilities (those with a documented records return rate of 15 percent or less according to the Consult Toolbox) and compares the number of

[40] VHA, "Consult Business Rules and Uses of the Consult Package Standard Operating Procedure," June 1, 2023.
[41] VHA, "Consult Business Rules and Uses of the Consult Package Standard Operating Procedure."

consults documented in the Consult Toolbox as having received the corresponding records versus the number of records actually received and imported into the EHR.

Table 3. Lowest-Performing VHA Facilities Based on Rate of Records Documented as Received in the Consult Toolbox

Facility location	Percentage of closed consults marked as records received in the Consult Toolbox	Percentage of closed consults with records imported into the EHR	Total number of closed consults
Dallas, Texas	15%	80%	45,346
Battle Creek, Michigan	14%	94%	24,914
Montana	14%	84%	48,323
Fargo, North Dakota	13%	97%	26,770
Martinsburg, West Virginia	10%	97%	12,148
Cincinnati, Ohio	8%	87%	8,790
Washington, DC	8%	67%	13,994
Iron Mountain, Michigan	7%	97%	24,766
Sioux Falls, South Dakota	6%	96%	21,233
New York Harbor	1%	94%	1,459
Clarksburg, West Virgina	0.27%	99.6%	11,703
Beckley, West Virginia	0.13%	80%	12,873

Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database; data from October 1, 2023, through April 1, 2024.

In addition to not marking the Consult Toolbox when records were received, staff incorrectly chose to administratively close consults using the designation that no further records requests would be made, as if the consult clinics were low risk when they were not. Low-risk consults require only one attempt to retrieve medical records instead of three. The Consult Toolbox allowed staff to administratively close any consult as low risk, even though VHA Directive 1232(5) includes a link to a list of 19 low-risk clinics.[42] If staff close out consults incorrectly as low risk, then VHA is at an increased risk of never receiving the record. The lack of controls in the Consult Toolbox and insufficient knowledge about which consults are

[42] Regarding consult processes, VHA defined low-risk clinics that do not require the same no-show rescheduling or medical records follow-up attempts as consults for clinics not included on the low-risk clinics list. Examples include physical therapy, occupational therapy, kinesiotherapy, acupuncture, and chiropractic care. For a complete list of clinics, see VHA, "Minimum Scheduling Effort For Outpatient Appointments Standard Operating Procedure," July 28, 2022.

considered low risk meant some staff administratively closed consults without records incorrectly, even though the policy clearly lays out which consults are considered low risk.[43]

The Administrative Closure Policy Purpose Was Unclear and Therefore Inconsistently Used

When community providers do not return medical records, the consult "administrative closure" designation allows community care staff to document that veterans received care while they continue efforts to retrieve records from the community provider. The OIG determined based on interviews with community care staff that the policy and procedures that were in effect during the review period for administratively closing consults were unclear regarding purpose and actionable time frames, which led to inconsistent implementation of the policy at VHA medical facilities.

The memorandum revising the administrative closure process for community care consults was issued to VISN directors.[44] An IVC official stated that the memorandum allowed community care departments to manage metrics related to measuring consult timeliness. Additionally, the IVC Field Guidebook provides step-by-step guidance to perform work in community care, including guidance to administratively close consults without medical records, but it also directs readers to the memorandum for further details.[45]

The policy and guidebook are clear that three attempts to request records should occur within 90 days of an appointment. However, as table 4 shows, the memorandum and guidebook included different language regarding when attempts to acquire medical records should occur as well as when administrative closure must occur.

Table 4. Comparison of Guidelines Between the IVC Field Guidebook and VHA Administrative Closure Memorandum

IVC Field Guidebook	Administrative Closure Memorandum
Community care staff "can" follow up for medical documentation at 14 days. Staff "shall" close the consult administratively after confirmation of attendance and one document request for records.	"Consult shall be administratively closed" when the following criteria are met: first attempt to request records and confirmation of attendance. ***Note: The memorandum does not include a timeline for pursuing medical records within 14 days.***

[43] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016 (amended December 5, 2022).

[44] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum.

[45] IVC Field Guidebook, chap. 1, "Introduction," updated July 11, 2024, and chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated April 7, 2023.

IVC Field Guidebook	Administrative Closure Memorandum
"Administrative closure MUST occur within 90 days of the initial scheduled appointment."	**No clear requirement to administratively close a consult within 90 days.**

Source: Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum to the Veterans Integrated Service Network directors, October 1, 2021; and IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated April 7, 2023, and August 29, 2023.

An IVC official told the review team that facility staff are allowed to make the first request for medical records 14 days after a consult's appointment date has passed. Another IVC official said although administrative closure of community care consults is recommended, it is not required. However, this response contradicts the language used in the memorandum, which says open community care consults shall be administratively closed.

The inconsistencies between the VHA memorandum and the IVC Field Guidebook led facilities to interpret how to properly handle administrative closures in varying ways. Although IVC updated the Field Guidebook in January 2025, it still included inconsistent language regarding when to administratively close a consult. In one location, it said staff must administratively close a consult after confirming the veteran attended the appointment and after documenting one attempt to obtain the records from the provider, while in a separate section it said staff should administratively close a consult once those conditions are met.[46] IVC has not updated the administrative closure memorandum that indicates administrative closure shall occur after confirming the veteran attended the appointment and after documenting a first request for records. IVC should clarify the policy's intent and determine whether facilities have discretion over when to close a consult within the 90 days or if staff must close the consult after the confirmation of an appointment and the first records request after 14 days. For example, at Chillicothe, the assistant nurse manager of community care will determine whether a consult should be administratively closed after staff have made three attempts to request a record. Chillicothe received over 99 percent of records. In contrast, the Atlanta acting chief of community care said community care administrative staff close consults after appointment confirmation and subsequently make first, second, and third requests at 30-day, 60-day, and 90-day intervals, respectively.

The OIG team's analysis of the Consult Toolbox data showed that for the first half of FY 2024, VHA facilities nationwide administratively closed 993,549 community care consults (34 percent) out of about 3 million closed overall. While these administratively closed consults originally did

[46] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated January 7, 2025.

not have records received when they were closed, eventually records were documented as received for 505,925 (51 percent) of the administratively closed consults.

Community care staff did not always follow requirements in the VHA memorandum to confirm a veteran attended their appointment and to make one records request before administratively closing a consult. The data showed 849,614 out of about 994,000 administratively closed consults (86 percent) had at least one of the required records requests made. For the administratively closed consults that did not have a records request, VHA facility community care staff told the review team they either did not always make the records requests or did not document requests in the Consult Toolbox. Also, community care staff did not always follow the administrative closure process to confirm a veteran attended their appointment and to document a records request, both of which were required for each administratively closed consult. The team found about 91,058 of the about 994,000 administratively closed consults (9 percent) were missing both a documented confirmation that the veteran attended the appointment and a documented first records request.

Of the 71,447 open consults from October 1, 2023, to April 1, 2024, 71,429 (99.9 percent) were open more than 90 days from the scheduled appointment. VHA policy requires community care staff to administratively close consults and review associated data reports monthly. Community care staff at four facilities said once a consult was administratively closed, they found it more difficult to ensure follow-up actions occurred to request records, and it increased the risk that facility staff would not follow up on the records. Therefore, they did not always administratively close consults after the first request for records and the confirmation of attendance, and at times they left the consult open until records were received.

For example, the community care chief at Columbia, which had a 95 percent rate of importing records into the EHR, said in his opinion the risk was too high to administratively close a consult, and they could lose sight of the consult after administrative closure. To avoid a negative effect on the ability to successfully retrieve records, they used administrative closure as a last resort when they could not get records from a community provider.

At facilities, community care staff told the review team they did not review the administrative closure report every month as required because they felt other reports provided them with better information to manage the consult closure and records-retrieval processes. Although the VHA memorandum required staff to review the report, it was not clear to the community care staff who should ensure the report was reviewed. Additionally, the level of oversight performed by facility leaders and corresponding VISN officials varied by location and was subject to each individual's interpretation of the memorandum requirements.

Finding 1 Conclusion

Once a veteran completes a community care appointment, the community provider is required by contract to send the medical records from the appointment to VA within 30 days. Although some

VHA facilities received nearly all medical records, others struggled and received fewer than half of these records. This occurred because of multiple reasons. Community care staff juggled duties related to scheduling appointments and managing consults. In addition, the OIG team determined based on interviews with facility staff that the administrative closure policies and processes were inconsistent with respect to staff responsibilities and timelines. The Consult Toolbox is mandated for consult management, yet IVC has not ensured medical facilities fill out its required elements or input the information correctly. Correct information in the toolbox allows community care staff to determine which consults still require follow-up to retrieve the medical records. VHA should evaluate whether all staff should update the Consult Toolbox for medical records retrieval efforts, rather than only community care staff. VHA should also add internal controls to the toolbox to prevent errors.

When community providers do not return medical records, staff can use the administrative closure designation to complete a consult without records. The OIG team determined that VHA staff found the policy and procedures were unclear regarding the purpose and time frame for administratively closing consults. As a result, some community care chiefs and facility leaders elected not to follow the administrative closure process. VHA should review the administrative closure policies to determine who maintains oversight responsibilities and what reports should be used for oversight.

Recommendations 1–4

The OIG recommended that the under secretary for health direct IVC to do the following:[47]

1. Evaluate which staff should have access to and should update the Consult Toolbox when records are requested or received and update the "Consult Business Rules and Uses of the Consult Package Standard Operating Procedure" to reflect necessary changes.
2. Include controls within the Consult Toolbox to prevent errors and improve data quality, including controls on administrative closure of low-risk consults and documenting the records-retrieval method.
3. Update consult closure policies and procedures to clarify requirements for administrative closure and determine whether metrics for the percentage of records received should be a requirement and included in policy.
4. Determine whether Veterans Health Administration facilities' community care offices should continue to be required to use the administrative closure report for oversight of administratively closed consults, and if not, determine what reports should be required.

[47] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

VA Management Comments

VHA's acting under secretary for health concurred with recommendations 1, 3, and 4; concurred in principle with recommendation 2; and provided an action plan for each recommendation. Appendix B includes the full text of the acting under secretary's comments, which are summarized below.

For recommendation 1, VHA will evaluate which staff should have access to and should update the Consult Toolbox when records are requested or received. VHA will also update the "Consult Business Rules and Uses of the Consult Package Standard Operating Procedure" as appropriate.

For recommendation 2, VHA is enhancing the Consult Toolbox to align with updated guidance and to make the process for requesting medical documentation consistent for all consults. The acting under secretary also noted that VHA will add controls to align with the updated process and ensure accuracy and improve data quality.

For recommendation 3, VHA will review existing consult closure policies and procedures to clarify requirements for administrative closure and will determine whether metrics for the percentage of records should be a requirement.

For recommendation 4, VHA will determine whether VHA facilities community care offices should continue to be required to use the administrative closure report for oversight of administratively closed consults or if other reports should be required.

OIG Response

The acting under secretary for health provided acceptable planned corrective actions for the four recommendations. The OIG will continue to evaluate VHA's actions and close recommendations when VHA provides complete documentation and sufficient evidence addressing the intent of the recommendations and issues identified.

Finding 2: VHA Did Not Always Import Records into the EHR in a Timely Manner

VHA facility staff faced technology barriers for the review and transfer of community care records into the EHR. In addition, some facilities had scanning backlogs of records that staff needed to process. Community care staff were unaware of which records were waiting for processing and which had never been received. This increased the likelihood staff would request a record again, exacerbating the backlog if a provider resent a record.

VHA community care staff process records and send them to be imported into the EHR within two business days; once in the scanning stage, VHA has three business days to import a record into the EHR.[48] For 52 of 134 facilities (39 percent), the average days between receipt and scanning was more than two days. Of the 134 facilities, 56 did not meet the three-day metric. At one facility, the records were not imported into the EHR for 49 days on average.[49]

The finding is based on the following determinations:

- Facilities varied in meeting timeliness metrics to import records into the EHR.
- Some facilities implemented tools and processes to improve the timeliness of importing records into the EHR.
- Technology issues created barriers to importing records into the EHR in a timely manner.
- Duplicate records and backlogs affected importing records into the EHR in a timely manner.

What the OIG Did

To determine whether VHA staff imported records into the EHR as required, the OIG team analyzed consult data, visited medical facilities, and interviewed VHA and facility officials. The team reviewed community care consult data from the VHA Corporate Data Warehouse for all facilities that used VHA's legacy EHR system (the VistA Computerized Patient Record System). Specifically, the team reviewed data related to timeliness metrics for importing records into the EHR. As noted in finding 1, staff did not always use the Consult Toolbox when records were received. Therefore, to determine whether facilities met required timeliness metrics, the team

[48] Practice Brief, "Community Care—VistA Imaging Capture Best Practice And Minimum Documentation Requirements."

[49] Due to data limitations, the OIG team could determine results based only on calendar days and not business days. The team could analyze metrics for consults only where staff documented in the Consult Toolbox when a record was received, when records were sent for scanning, or when records were imported into the EHR using a progress note. Some results produced negative or extremely high date ranges due to records possibly being received multiple times for ongoing care. Thus, the team's analysis removed any results with negative date range averages or any that were over an average of 365 days. Figures 3, 4, and 5 include a note to indicate how many consults were included for each analysis.

relied only on consults where staff entered a date in the Consult Toolbox, which created entries for the date records were received, the date records were sent for scanning, or the entry date for the consult's result note that would have been attached to a scanned document for viewing.[50] Appendix A provides more information on how the team selected parameters for the data.

Facilities Varied in Meeting Timeliness Metrics to Import Records into the EHR

VHA facilities had varied success with reviewing and adding medical records to the EHR in a timely manner. VHA policy and third-party administrator contracts require community providers to send medical records to VA within 30 days of an appointment occurring.[51] The team found that the average number of days between the appointment date and the date a facility marked the records as received varied, as shown in figure 3.

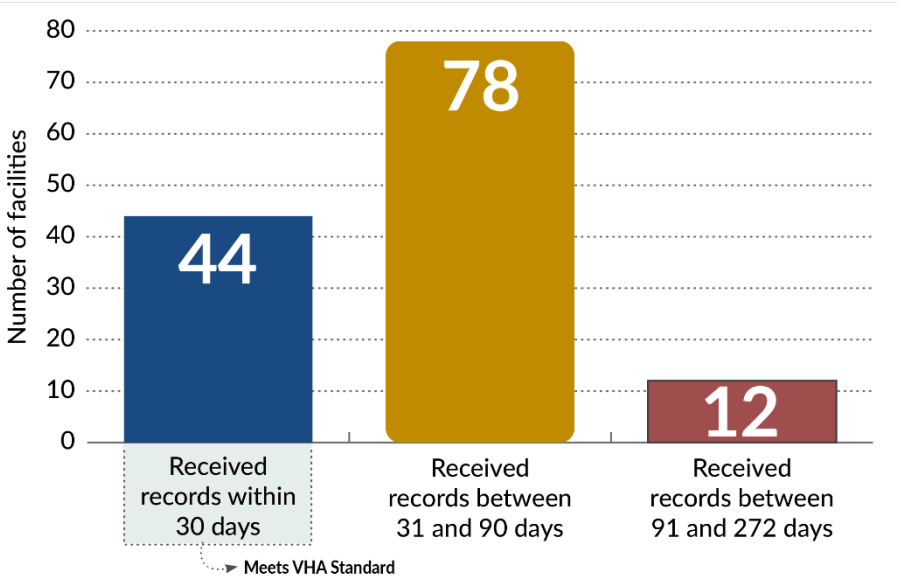

Figure 3. *VHA facilities' average days from consult appointment to records received.*

Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: This analysis reviewed 1,802,385 completed community care consults that had a documented date of when records were received for 134 VHA facilities. Of these, the OIG team removed 42,345 consults (2 percent) where the result was negative or over 365 days.

[50] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated January 7, 2025. This version of the guidebook instructs staff to create a community care consult result note with the associated imported document/medical record and attach the note to the consult. An alert then goes to the appropriate VA provider.

[51] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated April 7, 2023.

Once records are received at a facility, the HIM records policy requires all internal and external documents to be imported or scanned into the EHR within five business days.[52] Guidance states that staff have two business days for community care to review medical records and three business days for HIM or community care staff to import the records into the EHR.[53] The guidance also stated that this timeline ensures the appropriate consult is identified and allows both clinical and administrative staff to view the image without delays to ensure continuity of care. Any records that are not in the EHR within five business days become part of a backlog.

Community care offices varied on meeting the goal of reviewing records and sending them for importing into the EHR (HIM or community care) within two days, as shown in figure 4.

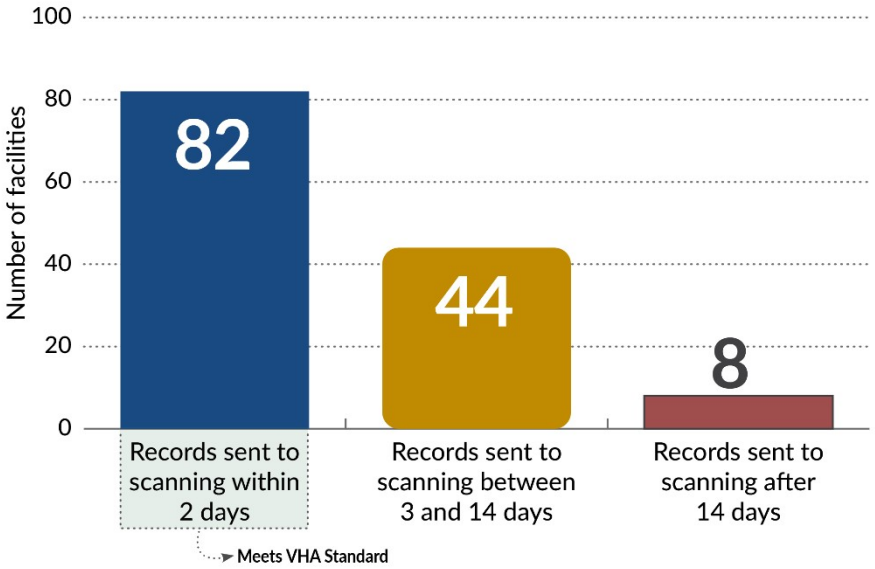

Figure 4. *VHA facilities' average days from records received to records sent for scanning.*
Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.
Note: This analysis reviewed 1,800,389 completed community care consults that had a documented date of when records were received and when records were sent to scanning for 134 VHA facilities. Of these, the OIG team removed 9,707 consults (0.5 percent) where the result was negative or over 365 days.

After community care office staff process the record and perform the required review, staff in either HIM or community care have three days to add the record into the EHR and attach the record to the consult. Facilities varied in the average days this step took, as presented in figure 5 on the next page.

[52] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*. OIG data analysis does not account for business days and is based on calendar days due to data limitations when incorporating the days over a large scope of time.

[53] Practice Brief, "Community Care—VistA Imaging Capture Best Practice And Minimum Documentation Requirements."

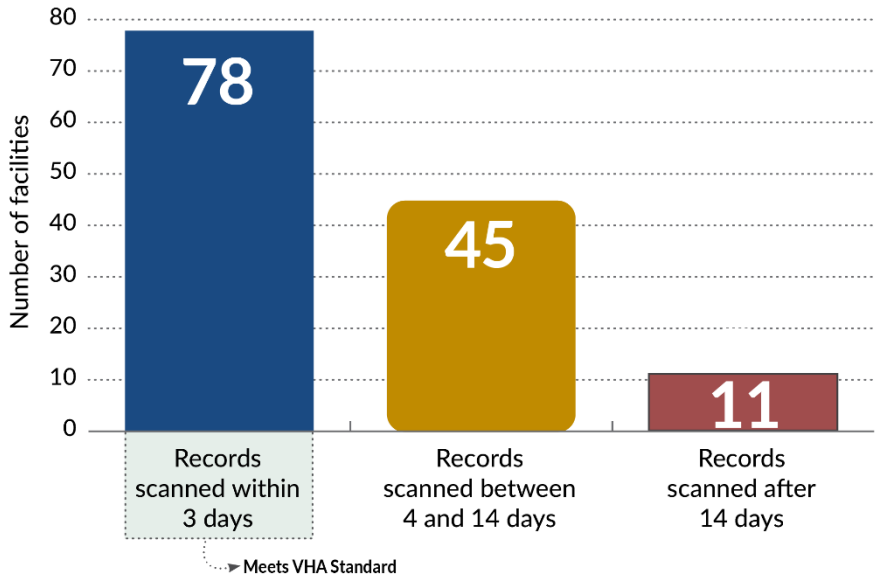

Figure 5. *VHA facilities' average days from records sent to scanning to records scanned into the EHR.*

Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: This analysis reviewed 1,726,554 completed community care consults that had a documented date of when records were sent to scanning and had a progress note with scanned records attached to the consult in the EHR for 134 VHA facilities. Of these, the OIG team removed 85,658 consults (5 percent) where the result was negative or over 365 days.

Some Facilities Implemented Tools and Processes to Improve the Timeliness of Importing Records into the EHR

Staff interviewed by the OIG team relayed that certain tools improved the timeliness of importing returned records into the EHR. One option facilities now have is the Enterprise Precision Scanning and Indexing program.[54] Staff use this program at Togus, and Central Alabama and Atlanta were launching it. Atlanta staff said although there has been a learning curve, the scanning and indexing program has improved their ability to import medical records to the EHR. While a VA HIM specialist told the team that not all facilities have rolled out the program, there is some indication that use of this program will continue to increase. For example, in response to an OIG finding in a prior report, the continued use and rollout of the system was cited by VISN 9 leaders as a way to significantly speed up the scanning process and allow records to be indexed in a timely manner.[55] IVC said it is working with HIM and the Digital

[54] The Enterprise Precision Scanning and Indexing program is a collection of processes and automation tools used for indexing and storing documents received from community care providers.

[55] VA OIG, *Care in the Community Inspection of VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers*, Report No. 23-01737-205, August 15, 2024.

Health Office to understand how IVC can further deploy the Enterprise Precision Scanning and Indexing program.

The review team found that the community care office at Clarksburg assigned staff exclusively to retrieving records and had about 100 percent of closed consults with records imported to the EHR. These staff were responsible for monitoring incoming records from community providers and taking the necessary steps to ensure records were uploaded into the EHR. This practice allowed other staff, who were not exclusively retrieving records, to provide greater attention to competing priority tasks, such as scheduling appointments and processing authorizations.

At the time of this review, VA had a national blanket purchase agreement, a type of contract, that VHA facilities can use to procure assistance in scanning documents. The director of the national HIM program office said VHA facilities can submit a local task order to use the vendor for scanning support. The HIM chief at Columbia said when their department gets close to having a backlog of records needing to be scanned, they send records to the contractor.

Technology Issues Created Barriers to Importing Records into the EHR in a Timely Manner

VHA facilities reported varying access to technology to help them efficiently process and import records into the EHR. Staff from each of the five facilities the team visited reported delays in processing or importing records because of technological barriers.

VHA community care staff generally send authorization information to community providers through electronic fax or the HealthShare Referral Manager.[56] Community providers have many options for how to send records back to VA, including by electronic fax or email, electronic portals such as the HealthShare Referral Manager or Veterans Health Information Exchange, or direct access to community providers' medical records systems. Although community care providers can use the HealthShare Referral Manager as a portal to send back records, three staff said this system was not used by most providers because of the user requirements. In particular, the HealthShare Referral Manager requires individual logins for each user, and therefore VHA staff said community providers choose not to use it. The five community providers interviewed had either not heard about the HealthShare Referral Manager or said gaining access to the system had too many requirements to make it feasible.

At El Paso, community care staff accessed community provider records directly out of the Joint Longitudinal Viewer but did not import the records into veterans' EHR using VistA Imaging. A medical support assistant at Denver also said they identified 400 records from a community

[56] The HealthShare Referral Manager is an electronic referral and authorization processing system used to accelerate access to community care. The Veterans Health Information Exchange allows providers and patients to access and share a patient's medical information. Providers can also send records by mail or traditional fax, even though these methods are used infrequently.

provider where the records were in the Joint Longitudinal Viewer but were not sent to HIM to import into the EHR. While this practice saved the facility time, national HIM staff confirmed the practice was incorrect because the records were not added into the EHR. El Paso's administrative manager for community care services provided the OIG team with an action plan from April 2024 to import records from the Joint Longitudinal Viewer into the EHR.

At the time of the OIG's review, the largest number of records came back via electronic fax, which is inefficient. Staff at five facilities cited issues with electronic fax in processing community care medical records. Atlanta community care staff said the electronic fax system would be down for periods of time either on the community provider side or the VHA facility side. Community care staff said they sometimes requested records that had already been sent because of the inefficiencies with electronic fax. Additional requests can lead to duplicate records and add to processing time.

Duplicate Records and Backlogs Affected Importing Records into the EHR in a Timely Manner

When staff do not process community care records in a timely manner, it causes a backlog of records that need to be imported into the EHR and increases the risk of duplicate records. In quarter two of FY 2024, four sites where the team conducted interviews had a backlog of records to process (Atlanta, Central Alabama, Togus, and Denver), meaning the records were waiting to be imported into the EHR for more than five days. Table 5 highlights the facilities with backlogs.

Table 5. Medical Record Scanning Backlogs for VHA Facilities with Staff Interviewed by the OIG Team

Facility	Total backlog (second quarter, FY 2024)
Central Alabama	99,891
Atlanta	39,843
Denver	39,181
Togus	119

Source: VHA National Scanning Monitor Dashboard.

Note: Columbia, Chillicothe, Clarksburg, and Saginaw did not have a backlog during the second quarter of FY 2024.

Backlogs increase the likelihood of duplicate requests. When a medical record is received via electronic fax, it is assigned a random text string as a file name with no patient identifying information, which requires staff to manually open each file and rename it. This resulted in staff's inability to easily determine which records were already in the fax queue, and thus staff made duplicate records requests. Also, records may have been available in other locations; however, staff did not always check all available locations before making duplicate requests.

The IVC Field Guidebook explains community care staff should perform a quality check of records received, including identifying duplicate records.[57] The quality check should be done before records are sent for importing into the EHR. Community care medical support assistants also need to check to ensure records were not sent to VHA before making a request to the provider. The Central Alabama HIM chief stated that community care staff sometimes did not check for records, causing VHA to request records that were already received and increasing the backlog. The chief had seen instances where three requests were made, and a record was sent three separate times.

During interviews with the OIG team, staff at four facilities said duplicate requests for the same records affected the workload, led to inefficiency in processing medical records, and contributed to the backlog because the multiple requests resulted in receiving multiple copies of records. In one month, three scanning clerks at Central Alabama found 5,864 duplicate community care medical records had been sent for scanning. Duplicate records waste time because each record requires a review before being deleted and takes away from importing the nonduplicate records for other consults. Both community care and HIM staff said the volume of community care records to process overwhelms staff and continues to grow. Staff at two facilities noted it was challenging to process the large numbers of consults received.

Without adequate staff to process the community care medical records, combined with an increase in community care usage, backlogs of records needing to be imported into veterans' EHRs continued to grow. A total of 23 staff from six facilities mentioned inadequate staffing as a barrier to processing and importing records into the EHR. For example, the acting community care chief at Atlanta said the community care demand for services has outgrown staff's ability to keep up with the volume of consults.

When community care records are not processed in a timely manner, it increases the risk that clinicians will not have the consult results to review when needed or that VHA clinicians will implement workarounds to retrieve a record. VHA doctors at all five facilities the review team visited in person reported assigning VHA clinic staff to retrieve records in addition to their regular clinical duties when community care staff were not successful at obtaining the records. A staff physician at Central Alabama said most doctors come up with contingency plans, such as calling the community provider directly for records. Two VHA doctors interviewed said they could access community provider portals to retrieve records. Separately, two other doctors said they ask veterans to bring their medical records back to VHA for their next appointment. VHA facility staff told the OIG team that when VHA clinicians retrieve records on their own, it takes valuable time away from clinical activities to accomplish administrative tasks that should have been completed by community care staff.

[57] IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated April 7, 2023.

Finding 2 Conclusion

VHA varied in its success with reviewing medical records and adding them to the EHR in a timely manner. Staff at VHA facilities stated they used different strategies to improve the timeliness of importing records, such as using software tools like the Enterprise Precision Scanning and Indexing program or creating teams that exclusively focused on consult closeout. Facility staff reported that technological barriers delayed processing and importing records into the EHR. VHA should evaluate ways to increase the use of vendor portals to reduce reliance on electronic fax and implement other automated methods.

A backlog of records waiting to be processed caused a delay for staff to import records into the EHR. Additionally, requests for records already received caused duplicates and created more work. Without adequate staff and efficient processes for reviewing incoming medical records, backlogs of records needing to be imported into veterans' EHRs continued to grow. VHA should evaluate the workload of community care staff and identify strategies to maximize efficiency.

Recommendations 5–10

The OIG recommended that the under secretary for health direct the IVC to do the following:[58]

5. Evaluate the workload of community care staff to determine the most efficient way to structure and execute their duties.
6. Determine if there are mechanisms to identify standardization opportunities and increase efficiency for improving records return processes.
7. Ensure community care staff follow procedures to reduce duplicate records received.
8. Evaluate ways to increase use of provider electronic records portals to reduce reliance on electronic fax when retrieving medical records.
9. Consider increased implementation of technologies to improve records processing once received to reduce the manual renaming of electronic files and uploading of records into the electronic health record.
10. Ensure records from the Joint Longitudinal Viewer are uploaded into the electronic health record.

[58] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

VA Management Comments

VHA's acting under secretary for health concurred with recommendations 5 through 10 and provided an action plan for each recommendation. Appendix B includes the full text of the acting under secretary's comments, which are summarized below.

For recommendation 5, IVC is working to expand a new volume-based staffing tool to include incorporating predefined operating variances, expanding the input data to include information from six advisory committee sites, and thoroughly testing the tool's outputs.

For recommendation 6, IVC (in partnership with the Digital Health Office) has developed a medical documentation framework to streamline and standardize processes and ensure comprehensive medical records are accurately, efficiently, and securely retrieved and recorded.

For recommendation 7, IVC will collaborate with Revenue Operations Consolidated Patient Accounts Centers, HIM, and community care staff to implement a standardized and continuous process across different service lines to reduce duplicate records requests from community care providers.

For recommendation 8, IVC and the Digital Health Office are assessing strategies to increase the use of providers' electronic record portals and leverage advanced technology.

For recommendation 9, IVC and the Digital Health Office developed a medical documentation framework that includes a workstream to assess current manual processes and develop requirements and technological solutions to enhance or replace them to streamline and enhance the efficiency of records processing.

For recommendation 10, VHA will review and strengthen requirements for closing consults when community care records are viewed through the Joint Longitudinal Viewer and will work with the VISNs on monitoring and compliance. Additionally, IVC, the Digital Health Office, and HIM will reinforce existing requirements and create and disseminate training to all relevant staff on the requirements for uploading records obtained from the Joint Longitudinal Viewer.

OIG Response

The acting under secretary for health provided acceptable planned corrective actions for the six recommendations. The OIG will continue to evaluate VHA's actions and close recommendations when VHA provides complete documentation and sufficient evidence addressing the intent of the recommendations and issues identified.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) review team conducted its work from April 2024, through May 2025. The team conducted this review to determine whether the Veterans Health Administration (VHA) has taken appropriate action to retrieve and document records from community providers in veterans' electronic health records (EHR) during fiscal year 2024. The team also examined challenges to accomplish document retrieval and related impacts.

Methodology

The team identified and reviewed relevant VHA and local facility documents, including training materials; applicable laws and regulations; and VA policies, procedures, and guidebooks related to community care consult closure. The team obtained and analyzed community care consult closure data from the Integrated Care Workspace Palantir consult data dashboard and VHA's Corporate Data Warehouse to determine the nature and extent of community care consult closure within VHA.

The team selected sites based on the number of community care consults closed (at least 40,000 consults completed), the administrative closure rate of those consults, and the location of the facility. Initially, the team selected three facilities to visit: the Harry Truman Memorial Veterans' Hospital in Columbia, Missouri; the Central Alabama Health Care System in Montgomery, Alabama, and Tuskegee, Alabama; and the Rocky Mountain Regional VA Medical Center in Aurora, Colorado. The team chose to visit another site after it became aware of an OIG hotline complaint about delays with community care medical records at the Joseph Maxwell Cleland Atlanta VA in Decatur, Georgia, which also had a high number of community care consults closed and high administrative closure rates. The final site for an official site visit was the Togus VA Medical Center in Augusta, Maine, which was selected because it received nearly all medical records after a community care appointment occurred. The OIG team conducted official site visits at these five locations, which enabled the team to observe how community care staff administratively closed consults and processed medical records, as well as to speak with hospital staff. Official site visits included entrance and exit conferences along with interviews of staff from multiple VHA departments.

The team also spoke with community care staff at six other VHA locations. Three of these facilities were the Chillicothe VA Medical Center in Chillicothe, Ohio; the Aleda E. Lutz VA Medical Center in Saginaw, Michigan; and the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. The team interviewed community care staff at these facilities because their data results implied a very high rate of medical records received. The team also interviewed community care staff at the El Paso VA Clinic in Texas, the VA Hudson Valley Healthcare

System in New York, and the Iowa City VA Medical Center in Iowa to request clarification on how the facilities used the Consult Toolbox and imported records into the EHR. Because of the limited nature of these conversations, these sites are not included in overall interview examples and results.

In total, the team interviewed medical center executive leaders and staff in the community care departments from 11 facilities. Also, the team interviewed employees from Veterans Integrated Service Network (VISN) 7, VISN 19, VISN 15, and Integrated Veteran Care (IVC) with knowledge of community care consult closure processes. The site visits and other interviews provided the team with an understanding of the processes, challenges, and general governance structure used to determine the consult closure process.

Internal Controls

The team assessed the internal controls significant to the review objective and (based on its fieldwork) assessed the five internal control components of control environment, risk assessment, control activities, information and communication, and monitoring.[59] In addition, the team reviewed the principles of internal controls associated with the objective. The team identified three components and three principles as significant to the objective. The team identified internal control weaknesses during this review and proposed recommendations to address the following control deficiencies:

- Component 3—Control Activities
  - Principle 11: Design Activities for the Information System
- Component 4—Information and Communication
  - Principle 13: Use Quality Information
- Component 5—Monitoring Activities
  - Principle 16: Perform Monitoring Activities

Data Reliability

The team relied on computer-processed data to support the findings, conclusions, and recommendations of this review. Electronic data retrieved from VA's Integrated Care Workspace data dashboard and VHA's Corporate Data Warehouse were used to determine whether medical records resulting from community care consult appointments were received by VHA medical facilities and VHA staff's efforts to document and import those records into veterans' EHR. The review team checked for the completeness and accuracy of the data from both electronic data

[59] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

systems by checking for missing or duplicate entries, text and number format accuracy, and testing of consult records' data entries against source consult documentation in Veterans Health Information System Technology Architecture electronic medical records. The review team's assessment determined the electronic data the team relied on were complete, accurate, and relevant for supporting the review objective and results. The team did not conduct statistical sampling reviews and projections of results, as it reviewed the entire population of community care consults that occurred during the first half of fiscal year 2024 and originating from all reporting VHA hospital facilities that stored medical records electronically in Veterans Health Information System Technology Architecture. The results represent the actual results of all the data available for analysis as of December 16, 2024.

To identify consults that had records returned, the team used consult factors, which are codes used to identify actions taken in the Consult Toolbox. In addition, because schedulers did not always update the toolbox when records were received, the team also used data reflecting the result note attached to consults, which generally included a scanned document and indicated an electronic record had been received and attached to the EHR. Although community care staff did not always use the title "community care consult result" in the note definition when medical records were returned as instructed in the IVC Field Guidebook, most documents received were medical records.[60] The team came to this determination after having discussions with IVC data staff and cross-referencing consults documented as records received in the Consult Toolbox.

As of December 16, 2024, VHA closed 2,953,865 community care consults that had scheduled appointments between October 1, 2023, and April 1, 2024. See table A.1 for results from all VHA hospital facilities or healthcare systems the OIG team reviewed.

Table A.1. Total Closed Consults and Documented Results in the Consult Toolbox

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
VISN 1	**97,146**	**71,487**	**74%**	**84,501**	**87%**
Togus, ME	30,795	24,160	78%	28,412	92%
Manchester, NH	17,751	14,074	79%	15,190	86%
Central Western Massachusetts*	15,476	11,199	72%	13,479	87%

[60] The IVC Field Guidebook, chap. 4, "Consult Completion and Medical Records Management How to Close Community Care Consults," updated January 7, 2025.

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
White River Junction, VT	13,772	8,170	59%	10,950	80%
Connecticut*	9,285	6,585	71%	6,953	75%
Providence, RI	4,614	3,604	78%	4,260	92%
Boston, MA	3,093	1,465	47%	2,953	95%
Bedford, MA	2,360	2,230	94%	2,304	98%
VISN 2	**54,474**	**32,243**	**59%**	**45,575**	**84%**
Syracuse, NY	12,559	5,699	45%	11,431	91%
Finger Lakes, NY	10,416	9,456	91%	10,099	97%
Albany, NY	9,146	6,342	69%	8,544	93%
New Jersey*	8,842	4,772	54%	5,619	64%
Northport, NY	5,073	1,682	33%	4,598	91%
Western New York*	3,384	2,655	78%	3,128	92%
Hudson Valley, NY	2,783	998	36%	11	0%
New York Harbor*	1,459	11	1%	1,371	94%
Bronx, NY	812	628	77%	774	95%
VISN 4	**95,703**	**69,022**	**72%**	**89,298**	**93%**
Wilkes-Barre, PA	14,683	11,569	79%	14,227	97%
Lebanon, PA	14,335	12,701	89%	13,969	97%
Altoona, PA	13,440	11,141	83%	13,182	98%
Erie, PA	12,685	2,293	18%	11,926	94%
Wilmington, DE	11,655	9,067	78%	10,693	92%
Pittsburgh, PA	8,755	7,956	91%	8,287	95%
Philadelphia, PA	8,744	6,246	71%	7,356	84%
Butler, PA	8,139	6,440	79%	7,837	96%
Coatesville, PA	3,267	1,609	49%	1,821	56%
VISN 5	**90,252**	**20,077**	**22%**	**78,567**	**87%**

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
Huntington, WV	21,381	7,021	33%	20,055	94%
Baltimore, MD	18,153	10,665	59%	15,346	85%
Washington, DC	13,994	1,130	8%	9,425	67%
Beckley, WV	12,873	17	0%	10,316	80%
Martinsburg, WV	12,148	1,212	10%	11,764	97%
Clarksburg, WV	11,703	32	0%	11,661	100%
VISN 6	**202,204**	**133,838**	**66%**	**161,498**	**80%**
Fayetteville, NC	51,811	39,782	77%	45,128	87%
Salisbury, NC	40,768	31,920	78%	34,649	85%
Hampton, VA	24,778	9,769	39%	14,153	57%
Richmond, VA	24,055	14,792	61%	17,007	71%
Durham, NC	22,805	13,814	61%	14,563	64%
Asheville, NC	21,249	19,313	91%	19,907	94%
Salem, VA	16,738	4,448	27%	16,091	96%
VISN 7	**223,260**	**107,616**	**48%**	**137,763**	**62%**
Central Alabama*	43,179	17,206	40%	20,528	48%
Columbia, SC	34,314	25,799	75%	26,402	77%
Atlanta, GA	34,048	15,069	44%	16,028	47%
Birmingham, AL	30,867	19,194	62%	19,521	63%
Charleston, SC	30,599	8,393	27%	26,010	85%
Augusta, GA	21,474	9,830	46%	9,783	46%
Dublin, GA	17,788	3,356	19%	9,126	51%
Tuscaloosa, AL	10,991	8,769	80%	10,365	94%
VISN 8	**197,528**	**140,239**	**71%**	**159,484**	**81%**
Gainesville, FL	54,682	46,805	86%	39,413	72%
Bay Pines, FL	41,168	31,294	76%	35,855	87%
Orlando, FL	36,949	34,199	93%	34,712	94%
Tampa, FL	28,051	14,129	50%	21,159	75%
West Palm Beach, FL	18,044	3,289	18%	11,776	65%

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
San Juan, PR	15,418	8,215	53%	14,039	91%
Miami, FL	3,216	2,308	72%	2,530	79%
VISN 9	**137,337**	**86,142**	**63%**	**111,145**	**81%**
Middle Tennessee*	50,294	37,110	74%	41,028	82%
Mountain Home, TN	34,884	24,618	71%	30,469	87%
Memphis, TN	22,211	6,398	29%	14,494	65%
Louisville, KY	17,538	14,231	81%	16,130	92%
Lexington, KY	12,410	3,785	30%	9,024	73%
VISN 10	**185,414**	**87,110**	**47%**	**176,318**	**95%**
Saginaw, MI	30,911	6,041	20%	30,650	99%
Northern Indiana*	29,407	18,185	62%	26,436	90%
Battle Creek, MI	24,914	3,420	14%	23,445	94%
Chillicothe, OH	19,891	17,938	90%	19,849	100%
Cleveland, OH	19,687	3,503	18%	19,169	97%
Dayton, OH	18,808	17,219	92%	17,872	95%
Indianapolis, IN	16,067	5,790	36%	15,202	95%
Cincinnati, OH	8,790	732	8%	7,609	87%
Ann Arbor, MI	8,550	7,158	84%	8,178	96%
Detroit, MI	8,389	7,124	85%	7,908	94%
VISN 12	**121,146**	**61,959**	**51%**	**101,872**	**84%**
Iron Mountain, MI	24,766	1,672	7%	24,028	97%
Milwaukee, WI	24,595	10,158	41%	14,083	57%
Danville, IL	22,889	18,537	81%	20,185	88%
Tomah, WI	19,255	16,612	86%	18,896	98%
Madison, WI	9,868	4,362	44%	7,965	81%
Chicago, IL	7,761	2,281	29%	6,885	89%
Hines, IL	7,132	5,142	72%	5,154	72%

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
North Chicago, IL[61]	4,880	3,195	65%	4,676	96%
VISN 15	**146,284**	**100,287**	**69%**	**129,225**	**88%**
Marion, IL	32,489	25,708	79%	30,231	93%
Columbia, MO	25,577	18,951	74%	24,363	95%
Poplar Bluff, MO	25,260	17,718	70%	22,687	90%
Eastern Kansas*	21,441	10,971	51%	14,012	65%
Wichita, KS	18,302	16,195	88%	17,312	95%
Kansas City, MO	12,767	3,300	26%	11,221	88%
St. Louis, MO	10,448	7,444	71%	9,399	90%
VISN 16	**255,668**	**198,917**	**78%**	**222,521**	**87%**
Gulf Coast, MS	52,011	38,854	75%	45,784	88%
Houston, TX	43,858	31,787	72%	34,302	78%
Fayetteville, AR	37,676	31,668	84%	33,675	89%
Jackson, MS	26,688	20,724	78%	22,781	85%
Alexandria, LA	26,348	19,586	74%	22,479	85%
New Orleans, LA	25,860	21,287	82%	24,013	93%
Shreveport, LA	23,157	18,791	81%	21,741	94%
Little Rock, AR	20,070	16,220	81%	17,746	88%
VISN 17	**260,018**	**137,652**	**53%**	**200,765**	**77%**
Texas Valley Coastal Bend*	53,856	30,894	57%	42,002	78%
El Paso, TX	47,707	16,540	35%	34,958	73%
Dallas, TX	45,346	6,616	15%	36,270	80%
San Antonio, TX	40,269	26,871	67%	29,211	73%
Temple, TX	32,303	25,001	77%	20,005	62%
Big Spring, TX	23,488	20,833	89%	21,672	92%
Amarillo, TX	17,049	10,897	64%	16,647	98%

[61] According to the VHA VISN 12 quality management officer, the North Chicago, Illinois, facility transitioned to the modern EHR in March 2024.

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
VISN 19	**200,903**	**92,977**	**46%**	**152,664**	**76%**
Montana*	48,323	6,543	14%	40,631	84%
Aurora, CO	40,817	24,300	60%	22,992	56%
Salt Lake City, UT	29,646	6,641	22%	16,121	54%
Oklahoma City, OK	25,786	15,638	61%	20,860	81%
Muskogee, OK	20,237	17,604	87%	17,708	88%
Sheridan, WY	13,403	4,576	34%	12,754	95%
Grand Junction, CO	13,046	9,347	72%	12,476	96%
Cheyenne, WY	9,645	8,328	86%	9,122	95%
VISN 20	**137,771**	**74,238**	**54%**	**102,571**	**74%**
Portland, OR	41,848	22,492	54%	28,262	68%
Puget Sound, WA	40,761	24,568	60%	24,599	60%
Anchorage, AK	40,076	22,796	57%	36,726	92%
Boise, ID	15,086	4,382	29%	12,984	86%
VISN 21	**160,341**	**120,187**	**75%**	**136,553**	**85%**
Honolulu, HI	49,705	35,351	71%	42,968	86%
Las Vegas, NV	35,483	29,119	82%	29,957	84%
Northern California*	30,732	18,340	60%	23,451	76%
Fresno, CA	15,536	12,746	82%	14,707	95%
San Francisco, CA	10,949	9,474	87%	10,261	94%
Reno, NV	9,742	8,944	92%	8,933	92%
Palo Alto, CA	8,194	6,213	76%	6,276	77%
VISN 22	**213,295**	**154,973**	**73%**	**177,411**	**83%**
Northen Arizona*	36,907	31,385	85%	34,733	94%
Phoenix, AZ	36,351	30,577	84%	32,491	89%

VISN and VHA healthcare system facility	Total number of closed consults	Number of closed consults with documented records received in the Consult Toolbox	Percentage of closed consults with documented records received in the Consult Toolbox	Number of closed consults with records imported into the EHR	Percentage of closed consults with records imported into the EHR
New Mexico*	31,633	16,908	53%	24,268	77%
Greater Los Angeles, CA	31,079	21,866	70%	22,910	74%
Southern Arizona*	30,057	26,242	87%	27,456	91%
Loma Linda, CA	23,418	14,397	61%	16,887	72%
San Diego, CA	16,387	9,461	58%	12,285	75%
Long Beach, CA	7,463	4,137	55%	6,381	86%
VISN 23	**175,121**	**99,998**	**57%**	**151,039**	**86%**
Minneapolis, MN	39,199	32,644	83%	32,066	82%
Fargo, ND	26,770	3,348	13%	25,847	97%
Sioux Falls, SD	21,233	1,207	6%	20,424	96%
Nebraska–Western Iowa*	20,713	15,447	75%	13,908	67%
St. Cloud, MN	20,663	17,166	83%	19,925	96%
Iowa City, IA	18,113	12,380	68%	11,471	63%
Black Hills, SD	16,318	8,345	51%	15,965	98%
Central Iowa*	12,112	9,461	78%	11,433	94%
Total	**2,953,865**	**1,788,962**	**61%**	**2,418,770**	**82%**

Source: VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

** Denotes a healthcare system without a city and state–based name.*

Government Standards

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

Appendix B: VA Management Comments, Acting Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: June 25, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records.

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's draft report on Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records. The Veterans Health Administration (VHA) concurs with recommendations 1 and 3-10 and concurs in principle with recommendation 2 made to the Under Secretary for Health and provides an action plan in the attachment.

2. VHA is committed to continually improving our processes and tools to support the optimal performance of community care staff, ensuring that we provide the best possible care to Veterans. Thank you for highlighting this important area of focus.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven Lieberman, MD, MBA, FACHE

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION

Action Plan

Office of Inspector General Draft Report–Facilities Faced Challenges Retrieving Medical Records From Community Providers and Importing Them Into Veterans' Electronic Health Records

(OIG Project Number 2024-02154-AE-0082)

Recommendation 1: Evaluate which staff should have access to and should update the Consult Toolbox when records are requested or received and update the Consult Business Rules and Uses of the Consult Package Standard Operating Procedure to reflect necessary changes.

VHA Comments: Concur. Veterans' Health Administration (VHA) will evaluate which staff should have access to and should update the Consult Toolbox when records are requested or received and will update the Consult Business Rules and Uses of the Consult Package Standard Operating Procedure to reflect necessary changes identified by the evaluation.

Target Completion Date: December 2025

Recommendation 2: Include controls within the Consult Toolbox to prevent errors and improve data quality, including controls on administrative closure of low-risk consults and documenting the records-retrieval method.

VHA Comments: Concur in Principle. VHA is enhancing the Consult Toolbox to align with updated guidance. This updated guidance will be disseminated through the Integrated Veteran Care (IVC) Field Guidebook and a national memorandum. The goal is to make the process for requesting medical documentation the same for all consults, thus removing the differences between low-risk and non-low-risk consults. Additional controls will be added to ensure accuracy and improve data quality by aligning with the updated process.

Target Completion Date: December 2025

Recommendation 3: Update consult closure policies and procedures to clarify requirements for administrative closure and determine whether metrics for the percentage of records received should be a requirement and included in policy.

VHA Comments: Concur. VHA will review existing consult closure policies, procedures, guidance to the field, and other relevant documents to clarify requirements for administrative closure. VHA will further review and determine whether metrics for the percentage of records received should be a requirement and included in the relevant documentation (such as policy, standard operating procedures, and guidance).

Target Completion Date: December 2025

Recommendation 4: Determine whether VHA facilities' community care offices should continue to be required to use the administrative closure report for oversight of administratively closed consults, and if not, determine what reports should be required.

VHA Comments: Concur. VHA will determine whether VHA facilities' community care offices should continue to be required to use the administrative closure report for oversight of administratively closed consults, and if not, determine what reports should be required.

Target Completion Date: December 2025

Recommendation 5: Evaluate workload of community care staff to determine the most efficient way to structure and execute their duties.

VHA Comments: Concur. IVC is working to expand a new volume-based staffing tool that was successfully piloted at the Washington DC VA Medical Center. The primary objectives of this effort include refining the pilot tool's algorithm to incorporate pre-defined operating variances, expanding the input data to include information from six Advisory Committee sites, and thoroughly testing and reviewing the outputs to identify any further improvements needed before scaling up to all VA medical centers. While the tool offers valuable insights, it is essential that each facility's management team tailors and adapts the recommendations to fit each facility's unique operational context. The algorithm within the updated tool is versatile enough to accommodate approximately 70% of Community Care operations. Workload variation due to site variation requires local facility leadership to be responsible for structuring and executing staff duties. By enhancing this staffing tool, IVC aims to optimize personnel allocation.

Target Completion Date: May 2026

Recommendation 6: Determine if there are mechanisms to identify standardization opportunities and increase efficiency for improving records return processes.

VHA Comments: Concur. IVC, in partnership with Digital Health Office (DHO), has developed a Medical Documentation Framework that organizes an Integrated Project Team into four multi-service line workstreams. This framework aligns policy, legislation, governing body recommendations, technology, contractual agreements, and oversight or compliance to reorganize medical documentation efforts across the enterprise.

The objective is to streamline and standardize processes by incorporating innovative technology solutions to ensure comprehensive medical records are accurately, efficiently, and securely retrieved and indexed. This approach will enhance overall operational efficiency, improve patient care, ensure compliance with regulatory requirements, and enable better coordination and continuity of care across various health care providers and services between VA and Community Care staff.

Target Completion Date: May 2026

Recommendation 7: Ensure community care staff follow procedures to reduce duplicate records received.

VHA Comments: Concur. IVC will implement a standardized and continuous process that involves collaboration among Revenue Operations Consolidated Patient Accounts Centers, Health Information Management (HIM), and Community Care staff. IVC aims to enhance communication across different service lines, enable efficient utilization of resources, reduce redundant requests to community care providers, establish clear roles and responsibilities, improve transparency, and ensure the secure handling of medical records. Standardizing communication and clear roles will streamline processes and reduce outreach efforts that lead to duplicate records from community care providers. Enhanced interdepartmental coordination will ensure efficient management of medical record returns and prevent overlap.

Target Completion Date: December 2025

Recommendation 8: Evaluate ways to increase use of provider electronic records portals to reduce reliance on electronic fax when retrieving medical records.

VHA Comments: Concur. IVC and DHO are conducting an environmental assessment to identify potential strategies to increase the use of electronic record portals and leverage advanced technology. This assessment aims to improve efficiencies in the retrieval of community care medical records and reduce the reliance on electronic fax.

Target Completion Date: May 2026

Recommendation 9: Consider increased implementation of technologies to improve records processing once received to reduce the manual renaming of electronic files and uploading of records into the electronic health record.

VHA Comments: Concur. IVC, in partnership with DHO has created a Medical Documentation Framework that is structured into four multi-service line workstreams. Workstream Two is dedicated to assessing current processes related to the manual renaming of electronic files, developing business requirements and technological solutions to enhance or replace these manual processes, and improving the uploading of records into the Electronic Health Record (EHR). This structured approach aims to address the recommendation through collaboration and focused efforts, thus leveraging advanced technologies to streamline and enhance the efficiency of records processing.

Target Completion Date: May 2026

Recommendation 10: Ensure records from Joint Longitudinal Viewer are uploaded into the electronic health record.

VHA Comments: Concur. VHA does not have a mechanism to monitor whether community care documents from the Joint Longitudinal Viewer (JLV) have been uploaded into the EHR. To address this, VHA will review and strengthen the requirements for closing consults when community care records are viewed through JLV. To support compliance, IVC, DHO, and HIM will reinforce existing requirements to upload records obtained from the JLV into the EHR in accordance with applicable VHA policies and guidance. This process will involve creating and disseminating training materials and promoting best practices with the goal of ensuring all relevant staff fully understand these requirements. Furthermore, VHA will explore internal reporting capabilities and work with the Veterans Integrated Service Network to support monitoring and compliance.

Target Completion Date: May 2026

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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