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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of Medical Facilities in VISN 4: VA Healthcare

Care in the Community Inspection	24-00825-176	July 30, 2025

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Executive Summary

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

Inspection Summary

The OIG reviewed community care processes at eight medical facilities in VISN 4: VA Healthcare with a community care program from August 26 through September 6, 2024. The OIG evaluated each facility's processes for community care referral and coordination in the following domains: Leadership and Administration of Community Care, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Community Urgent Care Coordination and Management. The OIG issued 13 recommendations across these five domains. The intent is for leaders to use the recommendations as a road map to improve processes that support efficient delivery and coordination of community care going forward. The elements evaluated and OIG findings are summarized below.

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

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

Community Care Provider Requests for Additional Services 	To assess how facility staff coordinated the processing and notifications when community providers requested additional services not covered by the initial referral, the OIG determined whether they • processed requests for additional services within three business days and • notified community providers and patients of approval or denial, as required. The OIG issued **three recommendations:** facility community care staff process community providers' requests for additional services within three business days of receipt (recommendation 8) and send approval or denial letters to community providers and patients for requests for additional services (recommendations 9 and 10).
Care Coordination Activities for Patients Referred for Community Care 	To evaluate how effectively facility community care staff coordinated care for patients, the OIG determined whether they • contacted patients based on VHA's recommended frequencies, • documented care coordination using the required note, and • confirmed patients attended their appointments. The OIG issued **two recommendations:** facility community care staff create and use the Community Care–Care Coordination Plan note in the electronic health record to document all care coordination activities for consults with an assigned level of care coordination other than basic (recommendation 11), and confirm patients attended their scheduled community care appointments and received care (recommendation 12).
Community Urgent Care Coordination and Management 	To determine how VHA facility providers and community care staff coordinated and managed care for patients who received community urgent care services, the OIG evaluated whether community care staff were notified of patients who received urgent care in the community and created the Community Care–Urgent Care Record note in the patient's electronic health record and attached the medical documents. The OIG issued **one recommendation:** facility community care staff create the Community Care–Urgent Care Record note in the electronic health record when they receive urgent care documents (recommendation 13).

VA Comments and OIG Response

The Veterans Integrated Service Network Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes D and E for the full text of the Director's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Abbreviations

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

Introduction

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

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

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

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

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

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

VISN 4: VA Healthcare

VISN 4: VA Healthcare includes nine medical facilities and covers areas in Pennsylvania and Delaware, and parts of Ohio, West Virginia, New York, and New Jersey.[5]

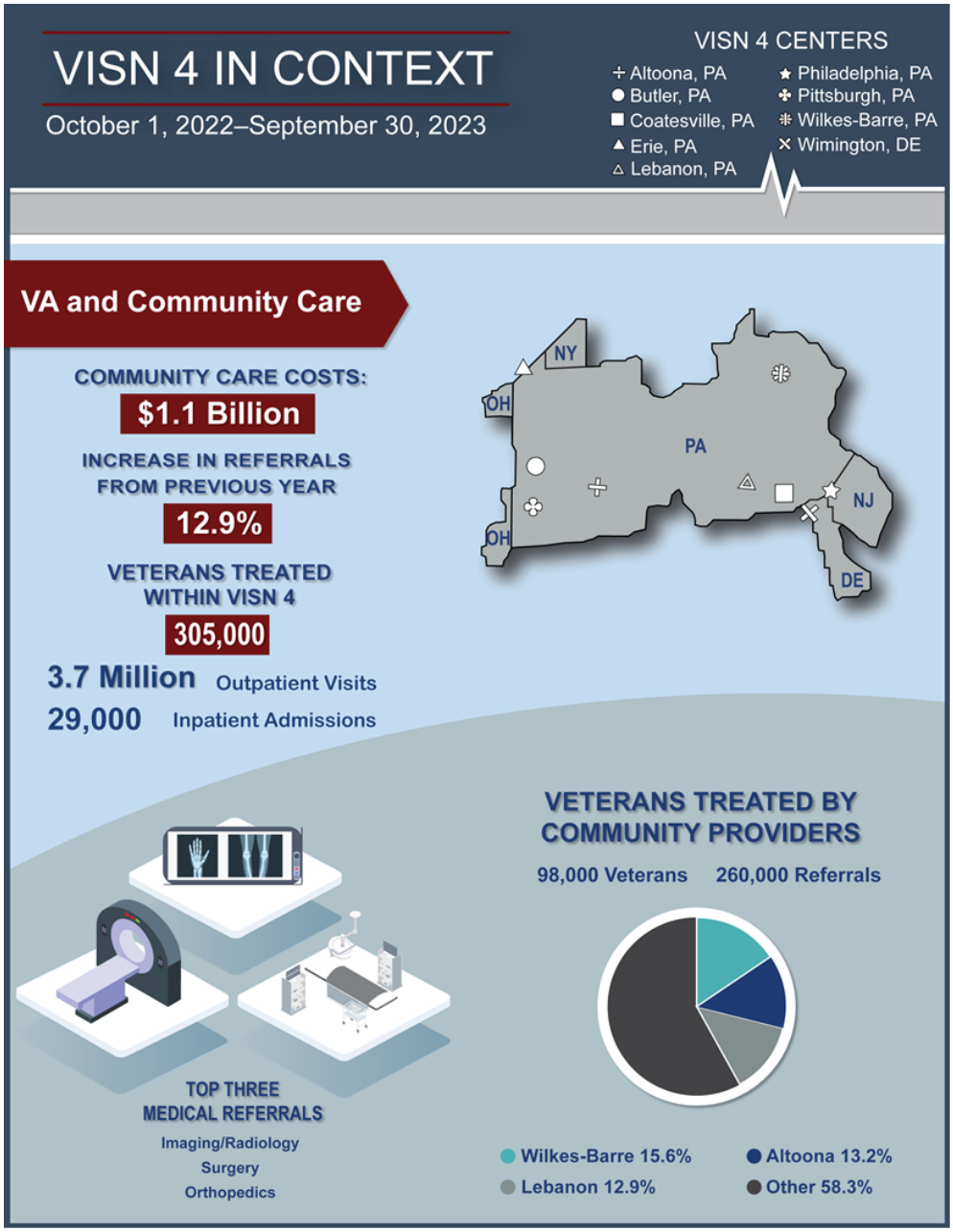

Figure 1. *Community care referral data for VISN 4.*
Source: VHA data. The OIG did not verify the data's accuracy.

[5] "Veterans Health Administration VISN 4," Department of Veterans Affairs, accessed April 16, 2025, https://department.va.gov/integrated-service-networks/visn-04/.

Community Care Consult Management

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

Inspection Elements

The OIG evaluated eight of the nine VISN 4 facilities' processes for community care referral and coordination in the following domains: Leadership and Administration of Community Care, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Care Coordination Activities for Patients Referred for Community Care, and Community Urgent Care Coordination and Management.[6] The inspection results describe the OIG's findings related to care coordination activities for patients referred for community care. This report highlights opportunities and challenges for VISN and facility staff as they navigate current community care referral processes (see appendix A for a list of all report recommendations).

[6] Due to staffing limitations, the OIG did not to review the Pittsburgh, Pennsylvania, medical facility because it was the VISN 4 facility with the fewest patients referred to community care.

Inspection Results

Leadership and Administration of Community Care

Effective leaders make decisions that directly or indirectly have an impact on every aspect of operations.[7] In health care, leaders create "policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services."[8] Leaders should ensure patients receive the same level of care whether it is delivered through the medical facility or care in the community.[9]

To determine how VISN 4 and its facility leaders supported community care services, the OIG evaluated requirements established by VHA in the field guidebook. The OIG team discussed required program elements with facility community care and executive leaders, as well as VISN leaders, and elicited reasons when the OIG found noncompliance with requirements. The team also sought input from the leaders and primary care providers about the effectiveness of the community care program based on their experiences.

Community Care Oversight Councils

VHA requires VISN directors to ensure all medical facilities with community care programs within their network establish a local community care oversight council. These councils consist of clinical and nonclinical staff working together to equitably allocate resources, so all patients receive quality care in the community.[10] The OIG examined the fiscal year 2023 council charters and meeting minutes for the eight VISN 4 facilities inspected and determined they all had councils that reviewed relevant issues, such as community care utilization.[11] However, the OIG determined the council in Erie only met 8 of the 12 times required by its charter for the fiscal year. Facilities without a consistently functioning oversight council may be unable to ensure patients receive quality care. The OIG made one recommendation.

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

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

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

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

[11] The Philadelphia council did not have a charter at the time of this inspection, but it provided meeting minutes.

Recommendation 1

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

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

Resource Utilization

When analyzing ongoing community care decisions, "VA Medical Center leadership must consider the ability to provide higher quality care, community capabilities, projected demand, current in-house and community access, costs, space constraints, impact on VA's education and research mission, sustainability, and the Veteran experience."[12]

Altoona, Butler, Erie, Lebanon, and Wilkes-Barre facility leaders expressed concerns with escalating community care spending. For example, a leader at Lebanon highlighted increased costs associated with community urgent and emergency care. Erie and Lebanon leaders also mentioned the challenges of meeting the needs of veterans while trying to manage expenditures.

Leaders at all eight facilities inspected said they evaluated whether to continue to purchase specific care in the community or to provide it internally. Additionally, leaders at five of the eight facilities met to evaluate whether they could deliver services more efficiently at their respective medical facilities or refer veterans to other VHA facilities within the VISN as an alternative to community care.

Leaders at Altoona said they reviewed their ability to offer veterans specialty services.[13] They explained the facility was an outpatient surgery center, and staff did not perform complex surgical or orthopedic procedures; therefore, they referred veterans who needed major procedures to other facilities in VISN 4 or to the community.

According to leaders at Butler, they expanded podiatry and physical therapy services by offering them in community-based outpatient clinics. Philadelphia leaders said they also hired additional physical therapists at the facility. In another example, VISN leaders said they purchased magnetic resonance imaging machines for Butler and Erie, and a computed tomography scanner

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

[13] Orthopedics is a branch of medicine that treats conditions associated with bones and soft tissues. *Merriam-Webster,* "Orthopedics," accessed February 4, 2025, https://www.merriam-webster.com/orthopedics.

for Butler.[14] They said these purchases would reduce the number of veterans referred to the community for radiology services. However, leaders at Butler added that they need new construction to accommodate these machines and expand magnetic resonance imaging services.

Staffing and Operations

The OIG found that leaders at all facilities, except those at Coatesville and Wilkes-Barre, reassessed staffing at the required intervals.[15] VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[16] The model includes a staffing tool designed to provide leaders a method to quantify the numbers of administrative and clinical personnel necessary to successfully operate their community care programs.[17] VHA requires facility leaders to conduct an initial assessment using the tool, then reassess staffing every 90 days.[18] When facility leaders do not reassess staffing at the required intervals, they may fail to meet workload demands, which could negatively affect community care program operations and patient care.

Community care program leaders said the staffing tool generally did not accurately assess staffing needs. For example, Butler, Coatesville, and Lebanon leaders explained the staffing tool did not adequately account for the additional time staff needed to schedule patients' appointments and review medical documents.

Community Care leaders said they made staffing decisions based on their own data, in addition to the staffing tool. For example, leaders at Butler also evaluated workload data every six months to see if it had increased. Leaders at Erie, Lebanon, Philadelphia, and Wilmington said they based staffing requests on internal reports and metrics.

[14] Magnetic resonance imaging is a diagnostic technique that produces detailed images of internal organs within the body. *Merriam-Webster,* "Magnetic Resonance Imaging," accessed January 8, 2025, https://www.merriam-webster.com/MagneticResonanceImaging. Computed tomography is a diagnostic technique that creates a three-dimensional image of body structures. *Merriam-Webster,* "Computed Tomography," accessed January 8, 2025, https://www.merriam-webster.com/ComputedTomography.

[15] The Coatesville facility only provided the OIG with staffing reassessments for three of four quarters for fiscal year 2023.

[16] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum; VA Community Care, "VA Community Care Operating Model" (fact sheet), May 12, 2017.

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

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

The OIG is concerned the staffing tool may not correctly reflect community care staffing needs, yet VHA requires facility leaders to use it. Community care departments may not be able to provide necessary services to patients if they are unable to accurately assess community care staffing. The OIG made one recommendation.

Recommendation 2

2. The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care leaders complete the staffing tool reassessment every 90 days.

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

Third-Party Administrator Interactions

VHA established contracts with third-party administrators to create regional networks of community providers able to provide care to veterans. Third-party administrators are responsible for ensuring safe medical care by network providers and for investigating potential quality issues that may affect patient safety to ensure, if needed, appropriate follow-up actions are taken.[19] All VISN 4 facilities had contracts with the same third-party administrator.[20]

Facility patient safety managers and VISN patient safety officers may request updates for potential quality issues from third-party administrators. Patient safety managers and officers may then update their facility community care program team.

During interviews, facility community care leaders shared concerns about the third-party administrator. Community care leaders at Lebanon and Wilmington said they received slow responses to safety issues submitted to the third-party administrator, and Altoona leaders added that it could take up to six months for the administrator to respond to concerns. Erie leaders explained the administrator did not provide them with any details about the issues. VISN leaders said VHA community care leaders implemented a dashboard in July 2024 that allowed staff to check the status of reported issues, but the administrator still did not describe how they addressed the issue.

Some facility leaders discussed difficulties caused by community providers failing to provide medical documents to VHA providers in a timely manner, adding that this affects quality of care.

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

[20] Optum is the third-party administrator for all VISN 4 facilities.

Facility leaders at Coatesville emphasized the third-party administrator contract allowed community providers to be paid before sending medical documents to the VHA provider.

The OIG is concerned the limited information the third-party administrator provides to facility leaders regarding potential quality issues, as well as the administrator failing to resolve delays with community providers sending medical documents to the facilities, negatively affects VHA's oversight efforts to ensure patients receive quality care. The OIG made no recommendation but suggests VHA leaders discuss these concerns with the third-party administrator.

Patient Safety Event Reporting

Facility community care staff provided the OIG with a list of potential patient safety issues submitted to the third-party administrator in fiscal year 2023. The OIG compared the lists with events entered into VHA's Joint Patient Safety Reporting system and found staff at Lebanon, Philadelphia, Wilkes-Barre, and Wilmington did not enter all of them into the system.[21] VHA requires staff to enter these events into its Joint Patient Safety Reporting system, and facility patient safety managers to review the events to determine the need for immediate actions.[22] If staff do not enter the events, patient safety managers may miss opportunities to address patient safety risks.

Additionally, the OIG found that Lebanon, Philadelphia, and Wilkes-Barre patient safety managers did not brief patient safety event trends, lessons learned, and corrective actions to their community care oversight councils. Wilkes-Barre council meeting minutes showed they discussed patient safety events, but not lessons learned, trends, or corrective actions. VHA requires facility patient safety managers or designees to brief the oversight council on these items.[23] Failure to brief patient safety events could jeopardize safe, high quality care. The OIG made two recommendations.

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

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

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

Recommendation 3

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

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

Recommendation 4

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

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

Medical Documentation Importing Performance

Although all facility community care leaders said their staff track medical documents to identify backlogs in importing them into the patient's electronic health record, only Wilmington leaders reported a backlog, which they said staff decreased over the past eight months by working overtime. VHA requires staff to import all community care documents into the patient's electronic health record within five business days of receipt.[24]

Failing to promptly import medical documents from community providers could negatively affect care coordination and quality of care. The OIG made one recommendation.

Recommendation 5

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

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

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

Community Care Concerns Expressed by Facility and VISN Leaders

During interviews, the OIG asked VISN and facility leaders to share top concerns for their community care programs. In response, the leaders stated their top concerns were quality of care, increased costs of community care, and continued expansion of community care. VISN and facility leaders' concerns provide insight into potential community care vulnerabilities, challenges, and areas for improvement that IVC leaders could consider for program changes at these facilities.

Primary Care Provider Survey Responses

VHA primary care providers address patients' healthcare needs by diagnosing and managing conditions and coordinating their overall care and may initiate referrals to community providers.[25] The OIG surveyed VISN 4 primary care providers anonymously for feedback about issues they encountered with the community care program, including questions about community care referrals (see appendix B for detailed survey information). The feedback could improve processes at both the local and national levels.[26] Table 1 lists selected survey results.

Table 1. Survey Respondents' Reported Issues

Reported Issues	Percent*
Delays receiving community provider medical documents	80
Appointment scheduling delays	70
Document receipt delays negatively affecting patient outcomes	54
Quality of care concerns when referring patients to community care	35
Appointment delays negatively affecting patient outcomes	50

Source: VA OIG survey of VISN 4 primary care providers' experience with community care.

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

VHA primary care providers generally reported concerns similar to those of VISN and facility leaders. The OIG identified the following recurring themes:

- Insufficient communication between community and VHA primary care providers
- Perceptions that community care is of lower quality than VHA care, and community providers order unnecessary tests

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

[26] Survey responses may not be representative of all primary care providers in VISN 4 due to the low response rate.

- Delays with community care staff scheduling appointments in the community

In addition, VHA primary care providers noted the lack of community providers' medical documents or images as an issue.

Administratively Closed Community Care Consults

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

The OIG reviewed three facilities to determine whether community care staff followed VHA processes for non-low-risk administratively closed community care consults.[27] VHA established a process for staff to administratively close consults if they do not get the medical documents following their first attempt. After the date of the community care appointment, facility community care staff

- contact the patient to confirm appointment attendance,
- attempt to obtain the community provider's documents and record the effort in the electronic health record if they have not received them within 14 days of the scheduled appointment, and
- close the consult administratively and make two additional attempts to obtain the documents within 90 days of the appointment.[28]

Confirmation of Appointment Attendance and Attempts to Obtain Medical Documents

The OIG was unable to determine Altoona's compliance with the requirement to attempt to obtain community providers' medical documents before administratively closing non-low-risk consults.[29] Instead of administratively closing the consult if the community provider did not send

[27] The OIG assessed performance in three domains for each facility and selected the two poorest performing domains to review. Based on those criteria, the OIG reviewed Altoona, Coatesville, and Philadelphia for this domain.

[28] VHA IVC, chap. 4 in *Community Care Field Guidebook*; Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consults Process (VIEWS #06042227)," memorandum to Veterans Integrated Service Network Directors (VISN 1-23), October 1, 2021.

[29] Because Altoona failed to follow the correct process for closing consults, the OIG excluded 37 of 50 records that were randomly selected for the analysis. Therefore, there were too few remaining records for the OIG to perform statistical analysis and determine compliance rates. Statistical analysis appears in appendix C.

the documents, staff waited to close the consult until after they received them. When questioned, Altoona community care leaders explained their staff encountered computer system problems and could not close consults unless they selected administrative closure in the system. Therefore, they closed all consults using the administrative closure function, even when records had been received. This work-around removed consults from the open consults list but incorrectly showed staff still needed to get the associated medical documents.

Additionally, the OIG estimated that Coatesville community care staff did not confirm patients attended appointments and attempt to obtain community providers' medical documents prior to administratively closing 30 percent (95% CI: 16 to 45) of non-low-risk consults.[30] Coatesville community care staff said they confirmed patients' appointments and requested the documents, but the OIG found no evidence of these actions. Failure by community care staff to complete or document required tasks prior to administratively closing the consults could delay patients' follow-up care. The OIG made one recommendation.

Recommendation 6

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

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

Additional Attempts to Obtain Medical Documents After Administrative Closure

As described above, Altoona community care staff did not follow the correct process for closing consults, so the OIG was also unable to determine staff's compliance with making two additional attempts to obtain community providers' medical documents after administratively closing non-low-risk consults.[31] With respect to Coatesville and Philadelphia, the OIG estimated that, following administrative closure, community care staff did not make two additional attempts to obtain the documents within 90 days of the appointment for any of the non-low-risk consults reviewed.

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

[31] Statistical estimates for facility noncompliance are reported in appendix C.

A community care leader at Coatesville explained that it was difficult for staff to keep track of administratively closed consults because it required them to generate a separate report. Therefore, they preferred to keep the consults open to track them more easily until they either made three attempts or received the documents. The leaders said they trained staff on the correct procedure for administratively closing consults several times, but they still kept consults open. Philadelphia community care leaders attributed the deficiency to new staff who had not received training on the consult closure process.

If staff do not administratively close the consult, it remains in an open status and staff cannot track it using VHA's administrative closure report, as required.[32] The OIG made one recommendation.

Recommendation 7

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

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

Community Care Provider Requests for Additional Services

Community providers may submit requests for additional services in circumstances when they determine the need for continued care under an expiring VHA authorization, a new specialty referral, or a procedure that was not previously authorized by VHA. VHA staff review and make timely decisions on the requests.[33]

The OIG reviewed seven facilities to determine whether community care staff followed VHA procedures for requests for additional services.[34] The OIG found that community care staff did not consistently process community providers' requests for additional services in a timely

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

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

[34] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG reviewed Altoona, Butler, Coatesville, Lebanon, Philadelphia, Wilkes-Barre, and Wilmington for this domain.

manner or send approval and denial letters to community providers and patients, as detailed below.

VHA has established a process for community providers' requests for additional services not already approved under the VHA referral.[35] The process requires community providers to submit the request and supporting medical documents on a VHA-provided form. Then, facility community care staff must

- review the request for the provider's signature and supporting documents,
- approve or deny the request within three business days of receipt,
- incorporate the request and supporting medical documents into the patient's electronic health record, and
- send a letter to the community provider and patient to inform them of the decision and explain the reasons for a denied request.[36]

Timely Processing of Requests for Additional Services

The OIG estimated that community care staff at Altoona, Coatesville, Philadelphia, Wilkes-Barre, and Wilmington did not consistently process requests for additional services within three business days of receipt.[37]

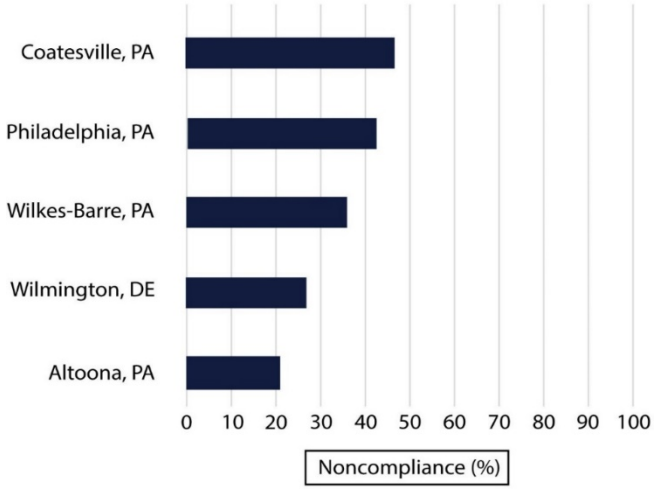

Figure 2. *Requests for additional services processed within three business days of receipt.*

Source: OIG analysis of VHA data.

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

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

[37] Statistical estimates for facility noncompliance appears in appendix C.

When staff do not process requests for additional services within three business days, it may delay care and negatively affect patient outcomes. The facilities' community care leaders shared reasons staff did not process the requests within three business days, including

- staff misunderstood the process, or new staff had not been trained;
- staff received large volumes of requests for additional services; and
- VHA providers designated to review the requests had competing priorities, which delayed decisions.

The OIG made one recommendation.

Recommendation 8

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

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

Community Provider Notification of Requests for Additional Services Decisions

The OIG found some facilities' community care staff failed to consistently send decision letters to community providers for requests for additional services, as required.[38] Specifically, the OIG estimated that community care staff at Coatesville, Philadelphia, and Wilmington did not send any approval letters to community providers; and Altoona and Wilkes-Barre community care staff did not consistently send the letters.[39] Failure to send approval letters may delay patient care because community providers could be unaware staff approved the requests. Community care leaders at Coatesville, Philadelphia, Wilmington, and Wilkes-Barre said staff sent community providers a new authorization when they approved requests instead of a letter.

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

[39] Statistical estimates for facility noncompliance are reported in appendix C.

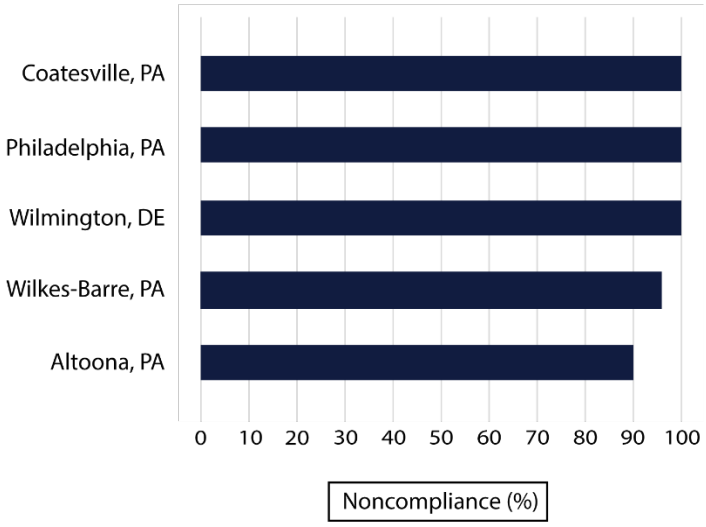

Figure 3. *Community provider notification of requests for additional services approvals.*

Source: OIG analysis of VHA data.

The OIG also estimated that facility community care staff at Philadelphia and Wilmington did not send denial letters to 87 percent (95% CI: 67 to 100) and 92 percent (95% CI: 75 to 100) of community providers, respectively, when they denied their requests for additional services. When staff do not send denial letters, it may prevent community providers from coordinating alternative treatment options or addressing deficiencies with the initial request. Additionally, staff may miss opportunities to educate community providers on the requests for additional services process.

Community care leaders at Philadelphia said they struggle to send denial letters due to decreased staffing, while leaders at Wilmington reported they were not aware of the requirements to send letters. The OIG made one recommendation.

Recommendation 9

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

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

Patient Notification of Requests for Additional Services Decisions

The OIG found some facilities' community care staff failed to consistently send letters to patients when they approved or denied requests for additional services, as required.[40] Specifically, the OIG estimated that community care staff at Coatesville failed to consistently send patients letters when they approved the requests, and staff at Altoona, Lebanon, Philadelphia, Wilkes-Barre, and Wilmington failed to send any letters.[41] If community care staff do not send approval letters, patients may be unaware VHA has authorized ongoing care, which may result in delayed care or no care at all. Altoona, Coatesville, Philadelphia, Wilkes-Barre, and Wilmington community care leaders said staff did not know it was required, or they sent patients a copy of the authorization or an appointment letter in place of an approval letter.

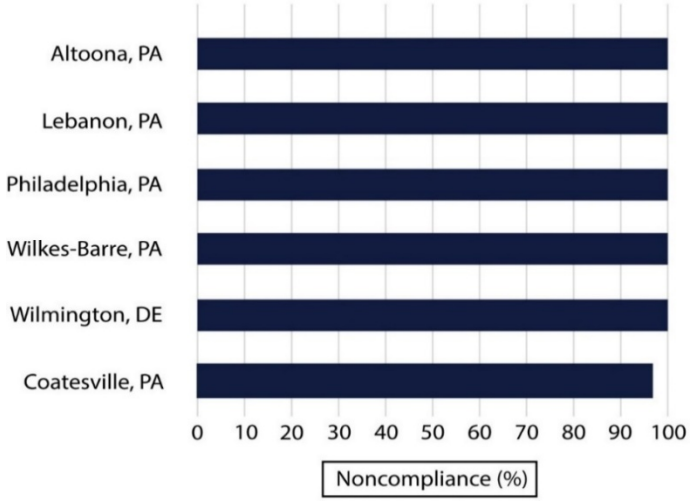

Figure 4. *Patient notification for requests for additional services approvals.*

Source: OIG analysis of VHA data.

The OIG also determined community care staff at Philadelphia and Wilmington failed to send letters to patients when they denied requests for additional services.[42] Failure to send denial letters to patients may prevent them from potentially resolving the reasons for denial or delay working with the VHA provider to find care alternatives. One Philadelphia community care leader said the requirement to send denial letters was new, but they were developing a process to

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

[41] Statistical estimates for facility noncompliance are reported in appendix C.

[42] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Statistical estimates for facility noncompliance are reported in appendix C.

use them.[43] Wilmington community care leaders said they were unaware of the requirement. The OIG made one recommendation.

Recommendation 10

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

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

Care Coordination Activities for Patients Referred for Community Care

Facility community care staff use care coordination to organize services and resources with patients and community providers based on an individual patient's needs. A VHA care coordination plan addresses activities, such as appointment scheduling, follow-up, communication with the patient and community providers, and transition back to VHA medical care.[44]

The OIG reviewed three facilities to evaluate care coordination activities for patients referred to community care.[45] The OIG found that community care staff did not consistently contact patients according to VHA's recommended frequency; use the Community Care–Care Coordination Plan note to document coordination activities; or confirm patients attended their appointments, as detailed below.

VHA has established a care coordination model as a framework for overseeing care and aligning resources based on the individual patient's needs. The model details the principles of care coordination, defines staff roles and responsibilities, and describes specific ways to accomplish goals, such as improved care transitions between VHA and community providers.[46]

[43] The OIG's review of requests for additional services examined electronic health records from October 1, 2022, through September 30, 2023. The requirement for sending decision letters to patients was included in VHA's September 2023 community care staff training. Tamika Taylor, VHA IVC, "Request for Services (RFS) Form 10-10172 Training."

[44] VHA IVC, "Community Care–Care Coordination Plan (CC-CCP) Note Standard Operating Procedure," June 2022.

[45] The OIG assessed performance in three domains for each facility and selected the two poorest performing areas to review. Based on those criteria, the OIG selected Erie, Lebanon, and Wilmington for this domain.

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

Facility community care staff use an automated algorithm called the Screening Triage Tool to determine the appropriate level of care coordination for each consult.[47] Levels are based on the intensity, frequency, duration, and type of care coordination each patient needs. As care complexity increases, so does the type and frequency of care coordination services, including contact with the patient.[48] Table 2 lists the levels of care coordination and corresponding recommended frequency of patient contact.[49]

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

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

Source: VHA, Screening Triage Tool Standard Operating Procedure.

VHA also developed a standardized progress note in the electronic health record called the Community Care–Care Coordination Plan that facility community care staff use to document aspects of care coordination, such as clinically indicated services and patients' psychosocial needs, preferences, and goals. VHA requires staff to document all care coordination activities in the note, except for consults with a basic level.[50]

Patient Contacts According to Recommended Frequencies

The OIG found that Erie, Lebanon, and Wilmington community care staff did not consistently contact patients requiring complex/chronic levels of care coordination according to the recommended frequency. Specifically, the OIG estimated that Erie community care staff did not consistently contact 68 percent (95% CI: 55 to 81) of patients, and Lebanon and Wilmington community care staff did not contact any patients at the recommended frequency.

Erie, Lebanon, and Wilmington community care leaders attributed these failures to the high volume of community care consults, insufficient staffing, and need to educate staff about the

[47] The Screening Triage Tool is a tool in the electronic health record that community care staff use to assess a patient's care coordination needs. VHA Office of Community Care, "Screening Triage Tool Standard Operating Procedure," July 2, 2019.

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

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

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

recommended contact frequencies. The OIG made no recommendation but is concerned that VHA requires staff to assign a level of care but only recommends frequencies of associated follow-up, which may compromise patient safety.[51]

Documentation of Care Coordination Activities

The OIG found that community care staff at Erie and Wilmington did not consistently create the Community Care–Care Coordination Plan note in the electronic health record to document care coordination activities for consults with an assigned level of care coordination other than basic, as required. Additionally, the OIG found that when staff at Erie, Wilmington, and Lebanon created the note for these consults, they did not consistently use it to document activities. Specifically, the OIG estimated that for patients referred to community care by VHA providers, community care staff at

- Erie did not create the note 31 percent (95% CI: 18 to 44) of the time, and did not use it to document care coordination activities in any of the records reviewed;
- Wilmington did not create the note 63 percent (95% CI: 50 to 77) of the time, and did not use it to document care coordination activities 89 percent (95% CI: 73 to 100) of the time, and
- Lebanon did not use the note to document care coordination activities 98 percent (95% CI 93 to 100) of the time.[52]

When staff fail to create and use the Community Care–Care Coordination Plan note, patients' medical information may be more difficult to locate, and they may experience delays in care. Erie community care leaders said the Community Care–Care Coordination Plan note requirement was new, and they had been using the Consult Review Note to document care coordination activities at the time of the OIG review. Leaders at Lebanon reported facility providers instructed staff to document on the facility provider's initial request for care, so the entire episode of care could be viewed in one document. The OIG made one recommendation.

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

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

Recommendation 11

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

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

Confirmation Patients Attended Community Care Appointments

The OIG found that Erie community care staff did not consistently confirm patients attended their scheduled community care appointments, as required.[53] If facility community care staff schedule the appointment, they are responsible for contacting the patient to determine if they kept it before searching for medical documents from the visit. If the patient cannot be reached, staff must contact the community provider to verify the patient's attendance.

Specifically, the OIG estimated that when Erie community care staff scheduled patients' appointments, they did not confirm they attended 53 percent (95% CI: 37 to 68) of the time. When staff fail to confirm if a patient kept the appointment, they cannot determine whether to request medical documents, reschedule the appointment, or if the patient no longer needs to be seen by the provider. Erie community care leaders said staffing shortages contributed to the lack of appointment verifications. The OIG made one recommendation.

Recommendation 12

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

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

[53] Statistical estimates for facility noncompliance are reported in appendix C.

Community Urgent Care Coordination and Management

Urgent care services include the treatment of injuries and illnesses that need immediate attention but are not life threatening, such as skin infections, minor burns, and influenza.[54] VHA staff must "ensure continuity of care" for patients who receive community urgent care services.[55]

The OIG reviewed three facilities to evaluate urgent care coordination and management.[56] The urgent care benefit in community care became available in 2019. The primary purpose was for eligible veterans to access services from urgent care providers in VA's community care network without prior VA approval or a community care consult.[57] Within VISN 4 alone, over 14,000 patients received community urgent care services at a cost of $2.7 million during fiscal year 2024.[58]

VHA requires community urgent care providers to submit medical documents to VHA facilities within 30 calendar days of the patient's urgent care visit; this allows facility staff to arrange needed follow-up care.[59] VHA also requires facility community care staff to

- create the Community Care–Urgent Care Record note in the electronic health record and attach the medical documents;
- identify the patient's signer for the documents (a provider responsible for receiving an alert and reviewing documents, usually the patient's primary care provider); and
- have the Chief of Staff designate a provider to be the signer if the patient does not have an assigned primary care provider.[60]

Notification of Patients Receiving Community Urgent Care Services

The OIG found that VHA lacks a process to notify facility community care staff when patients receive urgent care services in the community. VHA provided feedback in response to the OIG report, *Care in the Community Inspection of South Central VA Health Care Network (VISN 16)*

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

[55] MISSION Act.

[56] The OIG selected the two worst performing domains to review for each facility. Butler, Erie, and Wilkes-Barre each had only one poorly performing domain, so the OIG selected the Community Urgent Care Coordination and Management review for these facilities. Statistical analysis for facility noncompliance appears in appendix C.

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

[58] The facilities reviewed in this domain spent over $542,000 for 3,030 patients to be treated at community urgent care clinics in fiscal year 2024. VHA Urgent Care Dashboard report, Totals by VISNs & Facilities.

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

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

and Selected VA Medical Centers, and said patients and community urgent care centers are not required to notify the local VHA facility of community urgent care visits.[61]

Community care leaders at Butler and Wilkes-Barre told the OIG they did not receive notification of visits from either patients or urgent care centers and did not receive associated medical documents. If community care staff are unaware of the visits, they do not have a reason to request the medical documents and arrange follow-up care, which may lead to poorer clinical outcomes.

The OIG is concerned that although VHA requires urgent care providers to submit medical documents to VHA facilities, it does not have a process to notify community care staff of the visits. The OIG made a recommendation for VHA to create a process to notify facility community care staff of patients' community urgent care visits in a prior OIG report. The OIG did not repeat the recommendation in this report.

Documentation of Patients Receiving Community Urgent Care Services

The OIG determined that Wilkes-Barre community care staff did not create the Community Care–Urgent Care Record note in the electronic health record for any patients when community urgent care providers sent medical documents indicating they received community urgent care.[62] Failure to create the note may result in patients' primary care providers being unaware of the need to follow up. The OIG made one recommendation.

Recommendation 13

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

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

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

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

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at selected facilities within VISN 4, the OIG conducted this inspection from August 26 through September 6, 2024. Addressing five clinical or administrative aspects of community care domains across eight VISN facilities with community care programs, the inspection resulted in 13 recommendations on systemic issues that may adversely affect patient outcomes. The total number of recommendations does not necessarily reflect the overall quality of all services delivered by facility community care staff within this VISN. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A. Summary of Recommendations

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

Appendix B: Methodology

The OIG reviewed community care processes at eight VISN 4 medical facilities with a community care program from August 26 through September 6, 2024. The eight facilities were the James E. Van Zandt VA Medical Center (Altoona), Butler VA Medical Center (Butler), Coatesville VA Medical Center (Coatesville), Erie VA Medical Center (Erie), Lebanon VA Medical Center (Lebanon), Corporal Michael J. Crescenz VA Medical Center (Philadelphia), Wilkes-Barre VA Medical Center (Wilkes-Barre), and Wilmington VA Medical Center (Wilmington).

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

The OIG electronically distributed the survey to primary care providers from August 21 through September 4, 2024. The OIG emailed 350 surveys to VISN 4 primary care providers and received 106 responses, a 30 percent response rate.[2] The OIG's analysis relied on inspectors identifying information from surveys, interviews, documents, and observational data based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*[3]

The inspection team examined operations and electronic health records from October 1, 2022, through September 30, 2023. The OIG reviewed each selected facility for performance in the Leadership and Administration of Community Care domain. After reviewing facility performance data relevant to each respective domain, the OIG selected two additional domains for each facility, for a total of three per facility. OIG leaders approved all domain selections based on content and professional judgment. The domains selected for each VISN 4 facility are shown in figure 5.

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

[2] VA OIG Survey of VISN 4 Primary Care Providers' Experience with Community Care. Survey responses may not be representative of all primary care providers in VISN 4 due to the low response rate.

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

	Altoona PA	Butler PA	Coatesville PA	Erie PA	Lebanon PA	Philadelphia PA	Wilkes-Barre PA	Wilmington DE
Leadership and Administration	✓	✓	✓	✓	✓	✓	✓	✓
Administratively Closed Consults	✓		✓			✓		
Requests for Service	✓	✓	✓		✓	✓	✓	✓
Care Coordination				✓	✓			✓
Urgent Care		✓		✓			✓	

Figure 5. *Domain selections for VISN 4 facilities.*

Source: OIG analysis of VHA data.

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

For each VISN 4 facility reviewed, the OIG used the following criteria to select electronic health records during the review period for each domain:

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

For all the above domains except Community Urgent Care Coordination and Management, the OIG randomly selected 50 electronic health records that met the criteria for the review period. During the review process, the OIG may have excluded some records, which resulted in the

analysis of less than 50 records. In addition, for some facilities, fewer than 50 records met the criteria listed above during the review period, so the OIG examined all records that met the criteria, which is called a census review. The OIG statistically analyzed all randomly selected samples and reported the results in appendix C.

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

This report is a review of VISN 4 and selected facilities' use of and adherence to VHA community care policies. The OIG included attribution, where appropriate, because information shared during surveys or interviews was not verified for accuracy or completeness. Findings cannot be generalized across VHA.

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

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

Appendix C: Statistical Analysis

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

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

Table C.1. Confirmed Appointment Attendance and Attempt to Obtain the Community Providers' Documents Prior to Administratively Closing Consults

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona*	13	n/a	n/a
Coatesville	40	30	16 to 45
Philadelphia	49	2	0 to 6

Source: OIG analysis of VHA data.

**Estimates are omitted for Altoona because the facility did not follow the correct procedures for closing consults, resulting in 37 of 50 records being excluded from statistical analysis. Therefore, there were too few remaining records for the OIG to perform statistical analysis and determine compliance rates.*

The OIG found that Coatesville and Philadelphia community care staff did not consistently make two additional attempts within 90 days to obtain medical documents after they administratively closed consults, as shown in Table C.2.

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

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona*	13	n/a	n/a
Coatesville	16	100	n/a‡
Philadelphia	20	100	n/a‡

Source: OIG analysis of VHA data.

**Estimates are omitted for Altoona because the facility did not follow the correct procedures for closing consults, resulting in 37 of 50 records being excluded from statistical analysis. Therefore, there were too few remaining records for the OIG to perform statistical analysis and determine compliance rates.*
‡*A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

The OIG estimated that community care staff at Altoona, Coatesville, Philadelphia, Wilkes-Barre, and Wilmington did not consistently process requests for additional services within three business days of receipt, as shown in Table C.3.

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

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona	48	21	10 to 33*
Butler	12	0	n/a‡
Coatesville	45	47	33 to 61
Lebanon	49	10	2 to 19
Philadelphia	38	42	26 to 58
Wilkes-Barre	50	36	24 to 50
Wilmington	48	27	15 to 40

Source: OIG analysis of VHA data.

**The estimate of the CI is (10.2 to 33.33), the report shows the rounded figures (10 to 33).*

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

The OIG estimated that community care staff at Altoona, Coatesville, Philadelphia, Wilkes-Barre, and Wilmington did not consistently send community providers approval letters for requests for additional services, as shown in Table C.4.

Table C.4. Approval Letters Sent to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona	39	90	79 to 98
Butler	8	n/a*	n/a
Coatesville	37	100	n/a‡
Lebanon	42	17	7 to 29
Philadelphia	23	100	n/a‡
Wilkes-Barre	48	96	90 to 100
Wilmington	35	100	n/a‡

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients is less than 11.*

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

The OIG estimated that Philadelphia and Wilmington community care staff did not consistently send denial letters for requests for additional services to community providers, as shown in Table C.5.

Table C.5. Denial Letters Sent to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona	9	n/a*	n/a
Butler	4	n/a*	n/a
Coatesville	8	n/a*	n/a
Lebanon	7	n/a*	n/a
Philadelphia	15	87	67 to 100
Wilkes-Barre	2	n/a*	n/a
Wilmington	13	92	75 to 100

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients is less than 11.*

The OIG estimated that community care staff at Altoona, Coatesville, Lebanon, Philadelphia, Wilkes-Barre, and Wilmington failed to consistently send patients approval letters for requests for additional services, as shown in Table C.6.

Table C.6. Approval Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona	39	100	n/a*
Butler	8	n/a‡	n/a
Coatesville	37	97	91 to 100
Lebanon	42	100	n/a*
Philadelphia	23	100	n/a*
Wilkes-Barre	48	100	n/a*
Wilmington	35	100	n/a*

Source: OIG analysis of VHA data.

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

‡*Estimates are omitted when the number of patients is less than 11.*

The OIG estimated that community care staff at Philadelphia and Wilmington failed to send denial letters to patients, as shown in Table C.7.

Table C.7. Denial Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Altoona	9	n/a*	n/a
Butler	4	n/a*	n/a
Coatesville	8	n/a*	n/a
Lebanon	7	n/a*	n/a
Philadelphia	15	100	n/a‡
Wilkes-Barre	2	n/a*	n/a
Wilmington	13	100	n/a‡

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients is less than 11.*
‡*A confidence interval cannot be calculated when the noncompliance percentage was equal to 100 or 0 since there was no variation in compliance.*

The OIG estimated that Erie community care staff did not consistently confirm patients attended VA-scheduled community care appointments, as shown in Table C.8.

Table C.8. Appointment Attendance Confirmed

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Erie	38	53	37 to 68
Lebanon	50	0	n/a*
Wilmington	48	4	0 to 11

Source: OIG analysis of VHA data.

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

The OIG estimated that community care staff at Erie and Wilmington did not consistently create the Community Care–Care Coordination Plan note in the electronic health record to document care coordination for consults with an assigned level of care coordination other than basic, as shown in Table C.9.

Table C.9. Community Care–Care Coordination Plan Note Created to Document Care Coordination for Consults with an Assigned Level of Care Coordination Other than Basic

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Erie	49	31	18 to 44
Lebanon	50	12	4 to 22
Wilmington	49	63	50 to 77

Source: OIG analysis of VHA data.

The OIG estimated that Erie, Lebanon, and Wilmington community care staff did not consistently use the Community Care–Care Coordination Plan note in the electronic health record to document care coordination for consults with an assigned level of care coordination other than basic, as shown in Table C.10.

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

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Erie	34	100	n/a*
Lebanon	44	98	93 to 100
Wilmington	18	89	73 to 100

Source: OIG analysis of VHA data.

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

The OIG estimated that Erie, Lebanon, and Wilmington community care staff did not consistently contact patients according to the recommended frequency for consults requiring complex/chronic levels of care coordination, as shown in Table C.11.

Table C.11. Patient Contacts According to the Recommended Frequency for Consults with Complex/Chronic Level of Care Coordination

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Erie	47	68	55 to 81
Lebanon	50	100	n/a*
Wilmington	49	100	n/a*

Source: OIG analysis of VHA data.

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

The OIG estimated that Wilkes-Barre community care staff did not create the Community Care–Urgent Care Record note in the electronic health record for patients who received community urgent care, as shown in Table C.12.

Table C.12. Community Care–Urgent Care Record Note Created for Patients Who Received Community Urgent Care

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Butler	8	n/a*	n/a
Erie	7	n/a*	n/a
Wilkes-Barre	28	100	n/a‡

Source: OIG analysis of VHA data.

**Estimates are omitted when the number of patients is less than 11.*

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

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 11, 2025

From: Acting Director, Veterans Integrated Service Network (VISN) 4: VA Healthcare (10N4)

Subj: Care in the Community Inspection of Medical Facilities in VISN 4: VA Healthcare

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

Director, GAO/OIG Accountability Liaison (10OIC)

1. I have reviewed the responses provided by the VISN 4, Pittsburgh, PA and I am submitting to your office as requested. I concur with their responses.
2. Should you need further information, please contact the VISN 4 Quality Management Officer.

(*Original signed by:*)

Denise Boehm
Acting Network Director, VISN 4

Appendix E: Action Plans

Recommendation 1

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

__X__ Concur

____ Nonconcur

Target date for completion: May 2026

VHA Comments

Veterans Integrated Services Network (VISN) 4 conducted a review of all facility community care council charters. All sites are functioning according to their charters and meet the required number of times as outlined by each charter. VISN 4 will continue to monitor facility community care council meetings and request signed minutes after each meeting for continued review and tracking. Compliance will be monitored using facility Community Care Oversight Council meeting minutes and reported at the VISN 4 Community Care Oversight Committee.

OIG Comments

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

Recommendation 2

The Veterans Integrated Service Network Director, in conjunction with facility directors, ensures facility community care leaders complete the staffing tool reassessment every 90 days.

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

VHA Comments

VISN 4 Community Care Leadership initiates a quarterly suspense to coincide with the Integrated Veteran Care (IVC) request for stations to complete the staffing tool reassessment. These quarterly suspense items will now require a copy of the completed reassessment. Compliance will be monitored for six months by reviewing the facility Community Care

Oversight Council meeting minutes and reporting at the quarterly VISN 4 Community Care Oversight Committee.

OIG Comments

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

Recommendation 3

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

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

VHA Comments

In collaboration with Integrated Veteran Care (IVC), National Center for Patient Safety (NCPS), and the National Quality Patient Safety Program Office, VISN 4 will continue to educate facility community care staff on the requirement to report all community care-related patient safety events by submitting a Joint Patient Safety and Reporting (JPSR) (VA side), and, when applicable, a Patient Quality Issue form will be submitted to Optum for Community Care Network (CCN) Providers. The VISN 4 Community Care Manager will include a standing JPSR Entry reminder on every bi-weekly Community Care Manager Forum. Performance of JPSR entry will be monitored by the VISN 4 Patient Safety Officer, with a quarterly review of JPSRs entered by all VISN 4 Community Care programs, with results reported to the VISN 4 Community Care Oversight Committee. Areas to be reported include volume of JPSRs by station, sub-type of JPSR categories, and the rolling 12-month breakdown by JPSR event category by station.

OIG Comments

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

Recommendation 4

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

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

VHA Comments

The VISN 4 Patient Safety Officer will continue to report on a quarterly basis community care patient safety event trends, lessons learned, and corrective actions to the VISN Community Care Oversight Committee. VISN 4 facility Patient Safety Managers or designees will brief community care patient safety event trends, lessons learned, and corrective actions quarterly at the facility Community Care Oversight Council Meetings. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 4 Community Care Oversight Committee through the VISN Governance structure.

OIG Comments

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

Recommendation 5

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

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

VHA Comments

As of Fiscal Year 2025, Quarter 2, only one VISN 4 station has a backlog in scanning community care documents. This backlog is being tracked within Healthcare Information Management (HIM) and through a VISN-level weekly suspense. This station is currently implementing the Enterprise Precision Scanning and Indexing (EPSI) solution as part of its action plan. EPSI is a collection of processes and automation tools used for indexing and storing documents received from community care providers. It allows VA staff to receive community

care documentation via electronic fax, copy them into EPSI, and transition the documentation into the VA electronic health record (EHR) with just a few clicks. This streamlines the process/steps of moving paper records from one area to another for incorporation into the EHR. VISN 4 reports Community Care backlogs (>5 days) to the National HIM Program Office through a quarterly monitor of facility scanning backlogs. Action plans are provided, as required, through the national process. Compliance will be monitored by reviewing the facility Community Care Oversight Council meeting minutes that capture the facility performance of meeting/not meeting the community care scanning metric and reporting results at the quarterly VISN 4 Community Care Oversight Committee.

OIG Comments

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

Recommendation 6

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

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

VHA Comments

VISN 4 will ensure facility community care staff confirm patients attended their appointments and attempted to obtain medical documentation before administratively closing consults. VISN 4 facilities will conduct reviews of consults closed administratively, without medical records to determine if attempts were made to obtain medical documents from the community provider. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 4 Community Care Oversight Committee until 90 percent compliance is sustained.

OIG Comments

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

Recommendation 7

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

__X__Concur

____Nonconcur

Target date for completion: December 2025

VHA Comments

VISN 4 will continue to engage with the IVC national office to ensure community care staff make the appropriate number of attempts as specified by national guidance for appointments following administrative closure of non-low-risk consults. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 4 Community Care Oversight Committee until 90 percent compliance is sustained.

OIG Comments

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

Recommendation 8

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

__X__Concur

____Nonconcur

Target date for completion: September 2025

VHA Comments

Daily, VISN 4 facilities will review Request for Service (RFS) documents, utilization of the Consult Toolbox, and escalate delays to facility leadership. Individual facility RFS tracking compliance will be captured and reported at the facility Community Care Oversight Council meetings. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 4 Community Care Oversight Committee until 90 percent compliance is sustained.

OIG Comments

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

Recommendation 9

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

__X__ Concur

____ Nonconcur

Target date for completion: September 2025

VHA Comments

All VISN 4 facility Community Care teams are currently sending Community Care related Request for Additional Services (RFS) approval/denial letters to community providers in response to RFS documents received. VISN 4 Community Care leadership will require facility attestations ensuring that facilities have implemented RFS letters to community providers. Monitoring will be met through facility attestation. Compliance will be reported at the VISN 4 Community Care Oversight Committee through the Governance structure.

OIG Comments

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

Recommendation 10

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

__X__ Concur

____ Nonconcur

Target date for completion: September 2025

VHA Comments

A review of all VISN 4 facilities determined that six VISN 4 facility Community Care teams are sending RFS approval/denial letters to patients in response to RFS documents. Two VISN 4 facility Community Care teams are working through staff education and monitoring to achieve

compliance. The VISN 4 Community Care leadership will require facility attestations ensuring that facilities have implemented RFS letters to veterans. Monitoring will be met through facility attestation and reviewing the Integrated Veterans Care (IVC) RFS – Request for Services Notification Details Report Compliance will be reported at the VISN 4 Community Care Oversight Committee until 90 percent compliance is sustained.

OIG Comments

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

Recommendation 11

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

__X__ Concur

____ Nonconcur

Target date for completion: September 2025

VHA Comments

Seven VISN 4 facility Community Care teams reviewed are currently using the Community Care-Care Coordination Plan Note as prescribed. One VISN 4 facility Community Care team reviewed is implementing the Community Care-Care Coordination Plan Note throughout the team and will be in sustainment by the target completion date. VISN 4 Community Care Leadership will review the station's progress via bi-weekly check-ins. VISN 4 Community Care Leadership will include this recommendation in future site visit reviews to ensure continued compliance.

OIG Comments

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

Recommendation 12

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

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

VHA Comments

The Field Guidebook (FGB) Chapter 4 states community care staff will verify the Veteran attended the appointment by calling the Community Provider, calling the Veteran or using other tasks including the Health Share Referral Manager Task List (including obtaining Medical Records).

The VISN 4 Community Care Leadership confirmed that VISN 4 facilities currently comply with outlined FGB methods of verifying patient care was received. Subsequent consult actions, follow all outlined IVC FGB guidance, and VISN 4 currently tracks all 'scheduled linked to past appointment' Community Care metrics. Compliance will be monitored by review of the facility Community Care Oversight Council meeting minutes and reported at the VISN 4 Community Care Oversight Committee through the VISN Governance structure.

OIG Comments

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

Recommendation 13

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

__X__ Concur

____ Nonconcur

Target date for completion: September 2025

VHA Comments

Seven VISN 4 facility Community Care teams reviewed are currently using the Community Care – Urgent Care Record Note when they receive urgent care documents. One VISN 4 facility Community Care team reviewed is working through staff education and monitoring to achieve

compliance with the use of the Urgent Care Record Note. VISN 4 Community Care Leadership will review the station's progress via bi-weekly check-ins. VISN 4 Community Care Leadership will include this recommendation in future site visit reviews to ensure continued compliance.

OIG Comments

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

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