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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

VISN 12 Needs to Improve How It Administers the Veterans Community Care Program

Review | **24-01757-146** | **August 27, 2025**

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Executive Summary

The Veterans Health Administration (VHA) provides care to veterans through more than 150 VA medical facilities divided among 18 regional Veterans Integrated Service Networks (VISNs).[1] VA can also authorize veterans to receive care in the community if certain criteria are met, as described more fully below. This review focused on VISN 12, also known as the VA Great Lakes Health Care System. It covers northeastern Illinois including Chicago, northwestern Indiana, Michigan's Upper Peninsula, and eastern Wisconsin. VISN 12 served about one million veterans in fiscal year (FY) 2024, with an operating budget of about $6.3 billion. Approximately $1.3 billion of that operating budget was for community care.[2]

The VA Office of Inspector General (OIG) initiated this review in May 2024 to determine whether medical facilities in VISN 12 were appropriately identifying veterans eligible for community care, informing eligible veterans of their care options, and delivering such care in a timely manner.[3]

This work is particularly important given the continual increases in the cost and use of community care. The team focused on VISN 12 because in September 2023—before this review was initiated—the VISN had mandated use of the Consult Toolbox (a web application) that assists with documenting community care eligibility determinations, a veteran's decision on where to receive care, and the consult scheduling process.[4] VISN 12 was one of the first four VISNs to complete the rollout of the toolbox in that same month.[5]

For a veteran to receive care, a VHA provider must make a request on the veteran's behalf by submitting a referral, which VHA calls a consult.[6] Once a request for healthcare services is made, VA staff use eligibility criteria from the VA MISSION Act of 2018 to determine whether

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[1] The VISNs manage day-to-day functions of medical centers and provide administrative and clinical oversight. VHA, "Veterans Integrated Services Networks (VISNs)," https://www.va.gov/HEALTH/visns.asp.

[2] VA OIG Financial Analysis Tool, FY 2024 data.

[3] The Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No. 118-210, § 110, 138 Stat. 2706 (2025), requires the OIG to assess VA's performance in appropriately identifying veterans eligible for care and services under the VA MISSION Act, informing veterans of their eligibility for such care and services, and delivering the care and services in a timely manner. The OIG is conducting two national audits subsequent to this review to fulfill this requirement, using the VISN 12 approach as a model. To assess whether VA was "appropriately identifying veterans for [community] care" in VISN 12, the review team tested the accuracy and consistency of VA's determinations of veterans' eligibility for care in the community.

[4] VA, *Consult Toolbox (CTB) User Guide*, September 2023. As of December 2023, use of the toolbox was required for all facilities across every VISN. Acting assistant under secretary for health for integrated veteran care, "Mandatory Use of Consult Toolbox (CTB) For Consult Management (10796909)," memorandum to VISN directors, September 12, 2023.

[5] VISN 12 was selected also because it was the only one of the four networks that did not have related OIG oversight work being conducted, or recently completed, at that time.

[6] VHA Directive 1232(5), *Consult Processes and Procedures,* December 5, 2022.

the veteran is eligible for community care.[7] Under the VA MISSION Act and related regulations, veterans are eligible to receive community care when

- a veteran needs a service unavailable at a VA medical facility;
- a veteran lives in a US state or territory that does not have a full-service VA medical facility;
- the service at the VA medical facility does not meet specific quality standards;[8]
- a veteran's provider, with agreement from the veteran, determines community care is in the veteran's "best medical interest";
- a veteran must drive an average of at least 30 minutes for primary care, mental health care, or noninstitutional services at a VA medical facility or must drive an average of at least 60 minutes for specialty care at a VA medical facility; or
- a veteran's wait time for an appointment at a VA medical facility is more than 20 days for primary care, mental health care, or noninstitutional services or more than 28 days for specialty care.[9]

When a veteran is eligible for community care, they must be informed of their care options—including information on available care within VA and in the community, wait times, and drive times—to help the veteran decide which option to pursue. If an eligible veteran opts out of community care, that decision must be documented in VHA's Consult Toolbox using a designated code to make sure veterans are informed of their care options and are deciding to stay within VA even when eligible for community care.[10]

VHA's timeliness expectations for community care and VHA consults are classified in three categories:[11]

- **Pending**: The consult has been sent but not yet acted on by the receiving service (that is, where the care is requested).

[7] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

[8] VHA policy requires VA medical facilities to maintain healthcare accreditation for ongoing compliance with regulatory standards and processes consistent with industry standards and community healthcare delivery. VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs,* July 19, 2022.

[9] VA MISSION Act; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

[10] According to the VA MISSION Act, "The Secretary shall ensure that the access standards provide covered veterans … with relevant comparative information that is clear, useful, and timely, so that covered veterans can make informed decisions regarding their health care"; VA, *Consult Toolbox (CTB) User Guide*, p. 30.

[11] Patient Eligibility and Scheduling Reference Sheet, February 15, 2022; VHA Directive 1232(5).

- **Active**: Within two business days, the receiving service is working to fulfill the consult.
- **Scheduled**: The appointment has been made—either within seven business days for community care or within three days for direct care within VA.

What the Review Found

VHA staff within VISN 12 did not always ensure eligible veterans were appropriately identified and offered all their care options within and outside VA. The review team analyzed VA and community care consults and VA appointments that were requested or occurred in the first quarter of FY 2024 and met judgmental selection criteria (such as not being administrative in nature, walk-in services, or services commonly provided only by VA or only in the community). This included 30,300 community care consults for mental health or specialty care and 178,900 VA appointments to determine the accuracy of community care eligibility determinations for wait times and drive times. The team also looked at 77,600 VA appointments for whether they had evidence of informing the veteran of community care eligibility. Finally, the team considered 35,000 community care consults and 84,000 VA consults in examining timeliness of care.

The analysis included replicating wait-time and drive-time eligibility decision-making processes to test the accuracy of staff determinations. In addition, while VISN 12 had no states without full-service VA medical facilities, the team still tested this eligibility criteria to see if it had been used inappropriately. The team did not need to test the other community care eligibility criteria because

- services that could be offered only at VA or in the community were excluded from the review population,
- VA has not implemented the criteria related to quality standards, and
- determinations of "best medical interest" are based on clinical decisions between providers and veterans.[12]

The team then examined documentation to verify that veterans who received care within VA (when eligible for community care) had the required evidence in their medical records of being

[12] The review team implemented several testing criteria to make sure the analysis represented a fair comparison of care that could be provided by VA and community care services. The review team tested only wait-time and drive-time eligibility determinations because they could be replicated and assessed for accuracy. In contrast, the team did not assess the accuracy of "best medical interest" determinations because those are clinical in nature. Other criteria—such as service not offered by VA—did not need to be tested because the team reviewed only services that *could* be offered by VA or in the community. Others—such as service does not meet quality criteria—were not being used by VA at the time of this review. See appendix A for further detail on the scope and methodology and appendix B for additional exclusion criteria.

informed and opting out of community care.[13] The team also calculated consult timeliness through each stage—from pending to active status, then to scheduled, and finally to completion of the appointment.

The review team determined that VISN 12 schedulers did not always accurately identify veterans eligible for community care or inform them of both in-house and community care options. Specifically, based on OIG testing, medical facility staff

- sent to community care about 23 percent of the 30,300 consults related to mental health or specialty care although the veteran did not meet the wait-time or drive-time standards, partly due to scheduling system limitations;
- sent to VA about 37 percent of the 178,900 appointments that were eligible for community care based on wait-time or drive-time standards with no indications staff checked these veterans' eligibility; and
- scheduled within VA about 85 percent of the 77,600 appointments eligible for community care based on wait-time or drive-time standards without evidence in the Consult Toolbox or appointment notes that schedulers informed veterans of their community care options.[14]

This occurred because VISN 12 lacked an effective process to identify available appointments at other VA medical facilities, either inside or outside VISN 12, when services could not be provided in a timely manner or were not available at veterans' regular facilities. Additionally, while guidance from VHA's Office of Integrated Veteran Care required schedulers to check all eligibility criteria for new patients, established patients needed to be assessed only for excessive wait times. Although this has been a common practice across VHA since the MISSION Act was implemented, the OIG determined this practice is not consistent with the act—and it hindered veterans' awareness of all care options.

Finally, veterans in VISN 12 waited an average of about 44 days to receive community care and waited an average of 35 days to receive care within VA; this is based on the time between the file entry date of the consult and the appointment date.[15] Longer wait times continue to be directly attributed to scheduling and capacity challenges, including ineffective processes to

[13] VA Office of Integrated Veteran Care, *National Standardized Scheduling Audit Guidebook*, August 2023; VA, *Consult Toolbox (CTB) User Guide*.

[14] Documentation is required and, as a result, is the best indicator to assess whether all care options were provided to veterans. The OIG acknowledges that options could have been provided without documentation.

[15] The file entry date reflects when a veteran or care provider initiates an appointment request or a consult request to help determine community care eligibility. It documents the day a VHA provider requests a consult with another provider (in other words, makes a referral). Consult-processing guidance does not include a metric for the time from file entry date to when a veteran attended their appointment (time to receive care), but the OIG assessed this measure to determine how long veterans waited to receive care.

manage consults as well as specialty care provider shortages. In addition, VISN 12 had 250 consults from the first quarter of FY 2024 (October 2023 through December 2023) still in an active, pending, or scheduled status as of November 2024—that is, the consult was not yet recorded as completed.[16]

Concerns have persisted about veterans' access to health care—whether in the community or within VA—and these concerns have become more focused in recent years on compliance with the MISSION Act. Until medical facility staff have the capability to effectively identify appointment availability not only across VA medical facilities but also within the community, VA will continue to miss opportunities to fully comply with the act and ensure veterans are informed of all their care options. Improving processes for documenting when veterans opt out of community care would also provide better visibility and assurances that veterans are receiving high-quality care when and where they need it.

What the OIG Recommended

The OIG made four recommendations to the VISN 12 director to improve the effectiveness of the community care program and ensure a veterans-first approach. The recommendations address establishing and using agreements with other VA medical facilities to help identify and schedule care at nearby facilities and clinics when services are unavailable at a veteran's local VA facility; routinely emphasizing to schedulers the proper use of codes to document when veterans opt out of community care; and requiring medical facility directors in VISN 12 to review and act on those consults the OIG identified that began in the first quarter of FY 2024 that have not resulted in an appointment. The OIG is also recommending the medical facility director at the Jesse Brown VA Medical Center in Chicago be required to ensure veterans requesting mental health services are assessed for community care and informed of all potential care options.

Additionally, the review team identified potential issues with VA-wide scheduling systems and conflicting guidance for assessing community care eligibility. Therefore, the OIG has begun two national audits to assess these potential issues and make any enterprise-wide recommendations warranted to improve timely, high-quality healthcare delivery to veterans. In the interim, VISNs across the nation can use the findings in this report as a road map to internally evaluate whether they have the same deficiencies and should proactively implement related recommendations.

VA Management Comments and OIG Response

The VISN 12 director concurred with all recommendations and submitted corrective action plans to address issues identified in the report. These steps include creating VISN-level service line

[16] This could be due to a variety of factors and is a very small percentage of the consults (250 of about 119,000 of the VA and community care consults the team reviewed). According to interviews with schedulers, some were outside VA's control, such as veteran no-shows or unresponsiveness to rescheduling.

agreements (for example, for cardiology or neurology), ensuring that schedulers take training at least annually, and requiring VISN 12 to review the consults the OIG identified that began in the first quarter of FY 2024 that had not resulted in an appointment. As to training, the Jesse Brown VA Medical Center has conducted several courses for mental health service line scheduling staff and clinical staff managing consults.

The OIG agrees to close recommendation 3 based on the actions taken and will close recommendations 1 and 2 when the VISN provides additional evidence that actions have fully addressed the identified issues. The VISN's targeted completion date for recommendation 4 is September 2025. The full text of the VISN director's comments can be found in appendix D.

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Contents

Abbreviations

FY	fiscal year
IVC	Office of Integrated Veteran Care
MISSION Act	VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Veterans Health Administration (VHA) provides care to patients in over 150 VA medical facilities that are organized into 18 Veterans Integrated Service Networks (VISNs), which oversee facilities in their respective regions and coordinate access to high-quality care.[17] In addition to providing direct care in a VHA facility or clinic, VA can authorize and pay for veterans to receive care from a community healthcare provider when certain criteria are met.[18] These criteria include that VA does not provide the requested services, a veteran lives in an area without a full-service VA medical facility, or there are long wait times or drive times to receive care at a VA facility.[19] It is critical that veterans be made aware of *all* care options and the timeliness of their availability so they can be actively engaged in deciding the most appropriate care for their distinct needs.

The VA Office of Inspector General (OIG) conducted this review to determine whether medical facilities in VISN 12 were appropriately identifying veterans eligible for community care, informing eligible veterans of their care options, and delivering such care in a timely manner.[20]

This review—which began in May 2024—focused on VISN 12's community care program because by September 2023, the VISN had completed the mandatory rollout of the Consult Toolbox (a web application that assists with documenting community care eligibility determinations, a veteran's decision on where to receive care, and the consult scheduling process).[21] VISN 12 was one of the first four VISNs to complete the rollout of the toolbox in that same month.[22] As of December 2023, use of the toolbox was required for all facilities across every VISN.[23] VISN 12's mandate that VHA staff use the toolbox gave the review team access to information needed to determine veterans' community care eligibility, to review

[17] VISNs are regional networks that manage day-to-day functions of medical centers and provide administrative and clinical oversight. VHA, "Veterans Integrated Services Networks (VISNs)," https://www.va.gov/HEALTH/visns.asp.

[18] Direct care is medical care provided at VHA medical facilities or at VHA community-based outpatient clinics.

[19] These criteria are detailed later in the discussion of the MISSION Act.

[20] The Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No. 118-210, § 110, 138 Stat. 2706 (2025), requires the OIG to assess VA's performance in appropriately identifying veterans eligible for care and services under the VA MISSION Act, informing veterans of their eligibility for such care and services, and delivering the care and services in a timely manner. The OIG is conducting two national audits subsequent to this review to fulfill this requirement, using the VISN 12 approach as a model. To assess whether VA was "appropriately identifying veterans for [community] care" in VISN 12, the review team tested the accuracy and consistency of VA's determinations of veterans' eligibility for care in the community.

[21] VA, *Consult Toolbox (CTB) User Guide*, September 2023.

[22] VISN 12 was selected also because it was the only one of the four networks that did not have related OIG oversight work being conducted, or recently completed, at that time.

[23] Acting assistant under secretary for health for integrated veteran care, "Mandatory Use of Consult Toolbox (CTB) For Consult Management (10796909)," memorandum to VISN directors, September 12, 2023.

documentation of what was shared with veterans about their eligibility, and to assess the timeliness of the care provided. The review was not a clinical assessment of the quality or type of health care provided to veterans.

Request for Care by Veterans Enrolled in VHA Health Care

Veterans enrolled in VA have three primary ways to ask for care: (1) a veteran-initiated appointment request, (2) a provider request for a follow-up appointment, and (3) a provider referral to specialty care. Veterans can also receive three types of care:

- **Primary care** covers wellness, prevention, and treatment for common illnesses in which providers can coordinate care with specialists. It provides long-term relationships between a patient and their provider, coordinates care across a range of health services, and offers disease prevention programs.[24]
- **Mental health care** includes inpatient and outpatient services at VA medical facilities; community-based outpatient treatment services; and individual and family services for posttraumatic stress disorder, military sexual trauma, depression, and readjustment.[25]
- **Specialty care** is advanced medical care that focuses on a specific disease or patient group. Specialty care includes services like dermatology, oncology, and cardiology.[26]

For a veteran to receive care, a VHA provider must create a consult: either through a request for care on a veteran's behalf or by scheduling a veteran for care through a "return to clinic order."[27] Once a request for healthcare services is made, VA staff apply legislative criteria (discussed below) to determine whether the veteran is eligible for community care.

[24] VA, "VA Primary Care" (web page), VA Patient Care Services, accessed March 4, 2025, https://www.patientcare.va.gov/primarycare/index.asp.

[25] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[26] VHA Directive 1159, *VHA Specialty Care Program Office and National Programs*, March 9, 2022.

[27] VHA Directive 1232(5), *Consult Processes and Procedures,* December 5, 2022. This directive defines a consult as "a request for clinical services on behalf of a patient." In VHA, consults are used to request care or seek an opinion, advice, or expertise from other VA or community providers to evaluate and manage care for patients. Veterans may also be scheduled for care through return to clinic orders, which are required to schedule follow-up appointments at VA medical facilities or clinics. VHA Office of Integrated Veteran Care, "National Return to Clinic Order" (standard operating procedure), September 7, 2022.

Community Care Eligibility

The VA MISSION Act of 2018 consolidated several community care initiatives into one permanent program, known as the Veterans Community Care Program.[28] Since the consolidation, VHA purchases care for veterans in their community through Community Care Network contracts or veterans care agreements.[29] The Community Care Network groups VA medical facilities into five regions managed by two third-party administrators to improve care coordination and make it easier for community providers and VA staff to deliver care to veterans.[30] Figure 1 outlines the general community care eligibility standards.

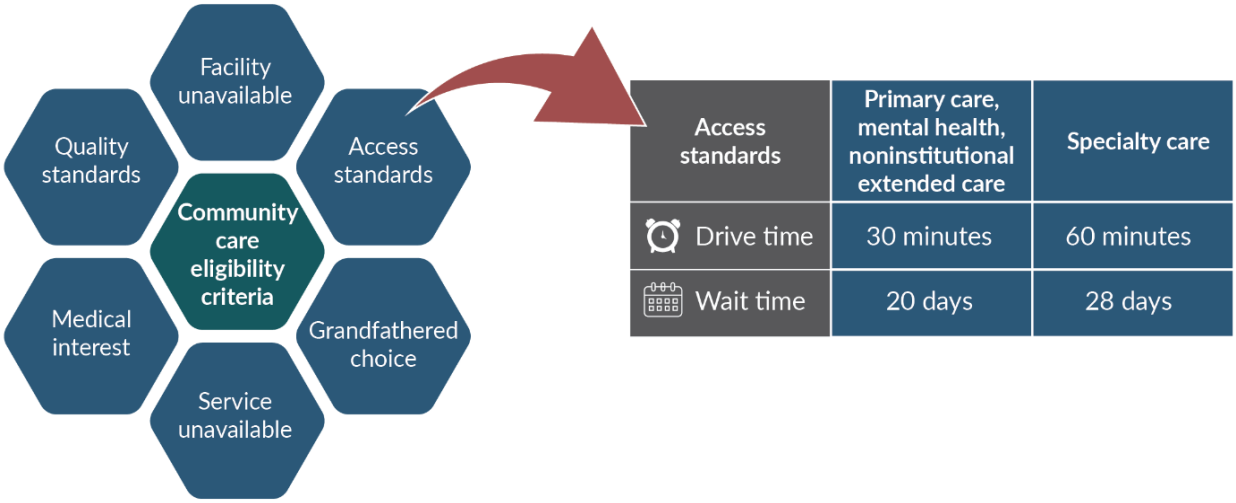

Figure 1. *Overview of community care eligibilty standards.*

Source: VA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

Under the MISSION Act and related regulations, veterans are eligible to receive community care in any of the following circumstances:[31]

- **Facility unavailable:** A veteran needs a service not available at a VA medical facility.

[28] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

[29] VA medical facilities may enter into veterans care agreements with community providers in limited situations when contracted services through the Community Care Network are either not provided or not sufficient to ensure veterans can get the care they need. VA, "Community Care" (web page), accessed June 19, 2024, https://www.va.gov/COMMUNITYCARE/providers/Veterans-Care-Agreements.asp.

[30] Third-party administrators are contracted entities that manage a network of providers for VHA community care programs. Each of the five contracts began with a base period of up to one year with seven renewable one-year options.

[31] MISSION Act; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

- **Quality standards:** The service at the VA medical facility does not meet specific quality standards.[32]
- **Medical interest:** A veteran's sending provider, with agreement from the veteran, determines community care is in the veteran's "best medical interest."
- **Service unavailable:** A veteran lives in a US state or territory without a full-service VA medical facility.
- **Grandfathered choice:** A veteran must both have lived more than 40 miles from the nearest VA facility on the day before June 6, 2018; *and* continues to reside in a location that would qualify them under that criterion.

  In addition to also living in Alaska, Montana, North Dakota, South Dakota, or Wyoming, *or* living in another state and received care between June 6, 2017, and June 6, 2018, and also required care before June 6, 2020.
- **Access standard:**
  - A veteran must drive an average of at least 30 minutes for primary care, mental health care, or noninstitutional services at a VA medical facility, or they must drive an average of at least 60 minutes for specialty care at a VA medical facility.
  - A veteran's wait time for an appointment at a VA medical facility is more than 20 days for primary care, mental health care, or noninstitutional services, or it is more than 28 days for specialty care.

According to VHA's Office of Integrated Veteran Care (IVC), IVC policy requires VA staff to check all eligibility criteria for new patients, but in practice, staff check only wait-time eligibility for an established patient—that is, a veteran who has completed an appointment within the same service line (for example, cardiology or neurology) in the past 36 months—unless otherwise requested by the established patient.[33] Considering past OIG work related to community care eligibility, this is a long-standing VHA practice.

Determining Eligibility

VA staff are required to follow a standard process to assess community care eligibility for a veteran that includes reviewing the criteria detailed in the MISSION Act. This assessment includes identifying wait times, drive times, and the available VA locations that provide the

[32] VHA policy requires VA medical facilities to maintain healthcare accreditation for ongoing compliance with regulatory standards and processes consistent with industry standards and community healthcare delivery. VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs,* July 19, 2022.

[33] A service line is a specific area of care (for example, podiatry).

requested services. This review focused specifically on two community care eligibility criteria: wait time and drive time. In addition, while VISN 12 had no states without full-service VA medical facilities, the team still tested this eligibility criteria to see whether it had been used inappropriately. The review team did not test the other community care eligibility criteria because

- services that could be offered only at VA or only in the community were excluded from the review population;
- VA has not implemented the criteria related to quality standards; and
- determinations of "best medical interest" are based on clinical decisions between providers and veterans.[34]

Wait Time

VHA uses the following terms when determining wait-time eligibility.[35]

- **The file entry date** is used to document the day a VHA provider requests a consult with another provider (in other words, makes a referral) or a veteran requests an appointment.[36]
- **The patient indicated date** is the day on which a healthcare provider and a veteran agree care is clinically indicated, or the date a patient would like to be seen, absent a provider's input. This date is established without considering availability at a facility or clinic.
- **The appointment date** is when a veteran is scheduled to receive care.[37]

To determine whether veterans meet the wait-time standard, schedulers should first compare the patient indicated date to the file entry date. If the patient indicated date is beyond the appropriate

[34] The review team implemented several testing criteria to make sure the analysis represented a fair comparison of care that could be provided by VA and community care services. The review team tested only wait-time and drive-time eligibility determinations because they could be replicated and assessed for accuracy. In contrast, the team did not assess the accuracy of "best medical interest" determinations because those are clinical in nature. Other criteria—such as service not offered by VA—did not need to be tested because the team reviewed only services that *could* be offered by VA or in the community. Others—such as service does not meet quality criteria—were not being used by VA at the time of this review. See appendix A for further detail on the scope and methodology and appendix B for additional exclusion criteria.

[35] "Standard MISSION Act Guidance: Patient Eligibility and Scheduling Reference Sheet" (fact sheet), February 26, 2023.

[36] IVC, *National Audit Findings Reference Sheet*, October 24, 2024.

[37] The review team calculated the average time to receive care by comparing the file entry date to the "best available appointment date." The team identified the best available date as the appointment date documented in the electronic health record or on the community care claim. For community care consults, the claim date represents the date a veteran received care; it is also the most reliable documentation to confirm an appointment occurred.

wait-time standard (of 20 or 28 days), the veteran is not wait-time eligible for community care because the veteran agreed to the appointment outside the wait-time standard. If the patient indicated date is within the wait-time standard, the scheduler must determine whether a VA appointment can be scheduled within 20 or 28 days of the file entry date. If no VA appointment is available within the appropriate time frame, the veteran is eligible for community care through the wait-time standard.[38] Figure 2 illustrates this process.

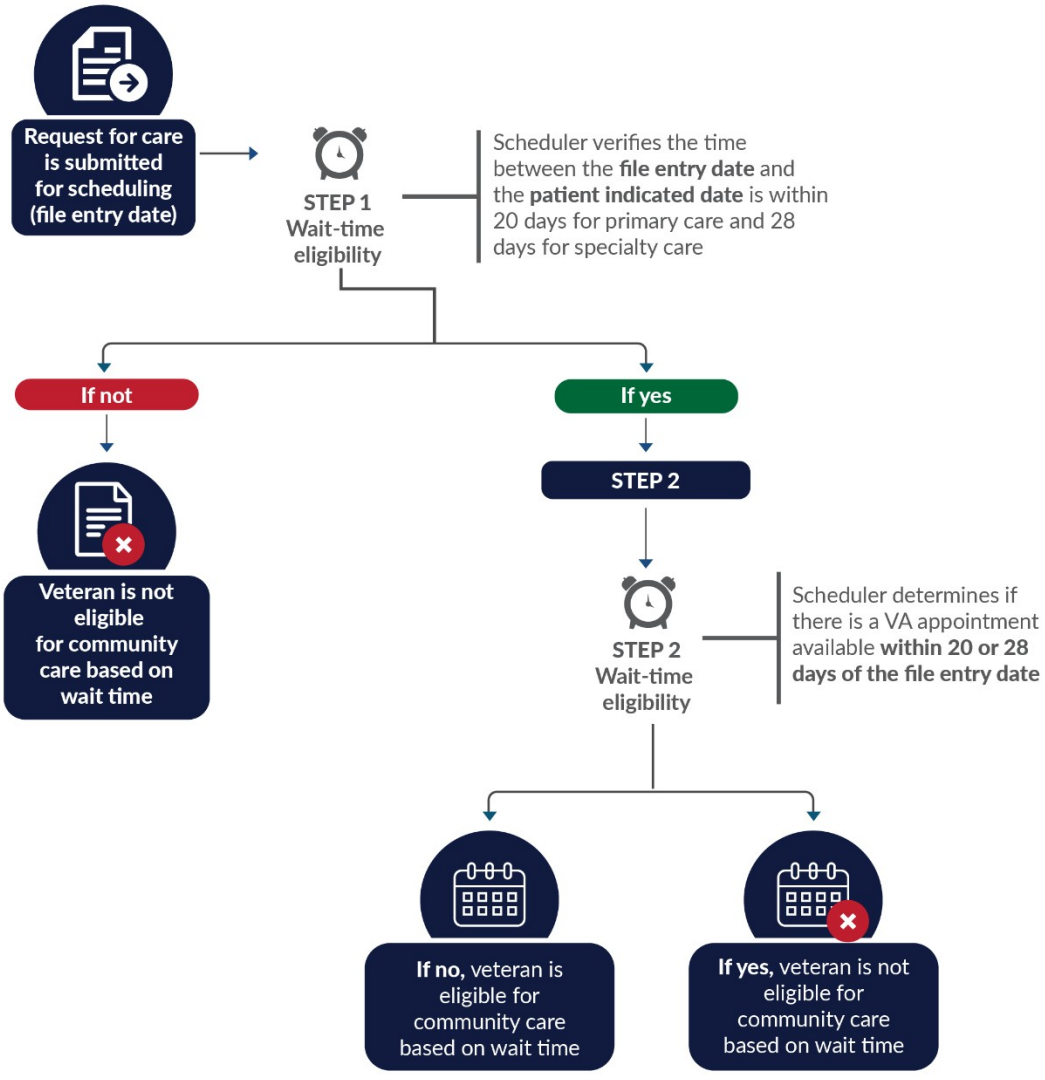

Figure 2. *Process for determining wait-time eligibility for community care.*

Source: OIG analysis of "Eligibility, Referral, and Scheduling," chap. 2 in Community Care Field Guidebook*, IVC, accessed October 25, 2024 (not publicly accessible).*

[38] VHA is not always able to provide veterans with the comparable wait time for community care as that for direct care, resulting in a veteran sometimes waiting longer for care in the community. How often this occurs will be assessed in a subsequent national OIG audit.

In addition to assessing veterans for community care by wait time, VHA developed a standard for the number of days within which appointments should occur in a VA facility for veterans who are not community care eligible or who choose to receive their care in VA. This standard, which took effect the first quarter of fiscal year (FY) 2023, specifies the number of days within which an appointment should occur:

- 20 days for primary care and mental health care
- 28 days for specialty care[39]

For community care, VHA's appointment-scheduling process includes several parameters to assess veterans' eligibility based on wait times (such as, is an appointment in VA available within 20 or 28 days of the file entry date?); however, VHA does not have a standard for the number of days from the file entry date within which community care appointments should occur.

Drive Time

The average drive time is determined by VHA staff using the Consult Toolbox to calculate the distance from a veteran's residence to the nearest VA facility that offers the service needed. The toolbox also considers inputs such as traffic to calculate the average drive time by drawing on navigational software. For a veteran to meet eligibility this way, the average drive time from home to a specific medical facility must be at least

- 30 minutes for primary care and mental health care, or
- 60 minutes for specialty care.

Informing Veterans of Care Options

If a veteran is not eligible for community care, VA staff will schedule the appointment or submit a consult referral to the applicable VA service line (for example, cardiology or neurology).

When a veteran is eligible for community care, VA staff are required to provide the veteran with the option of receiving care within VA (if VA provides it) or in the community; they must also provide key information, such as wait times at VA and in the community if available, to help the veteran decide which option to choose. VA staff should use the Consult Toolbox to document a specific code that indicates whether the veteran opted in or out of community care.[40] If a veteran chooses community care, VA staff should discuss any veteran preference for specific care providers and days, times, and locations for the appointment. Finally, VA staff should forward

[39] VHA, "Consult Timeliness *Standard Operating Procedure*" (standard operating procedure), December 1, 2022.
[40] IVC, *National Standardized Scheduling Audit Guidebook*, August 2023.

the consult to the facility's community care department for scheduling if the community care scheduler is not making the appointment while talking with the veteran.

Consult Toolbox

Consults go through several steps that must be tracked and documented for each veteran. As noted earlier, VHA started requiring the use of the Consult Toolbox nationally in September 2023; it concluded the rollout in December 2023. VISN 12 was one of the first four VISNs to complete the rollout in September 2023.

VHA staff are mandated to use the toolbox to document actions and track and manage each consult.[41] The toolbox is meant to make it easy for staff to document completed actions quickly and consistently. It uses uniform language to document steps, which allows for subsequent digital analyses of records, and eliminates the need for a second action or separate entry to track scheduling steps.

The toolbox helps standardize how VA staff decide the appropriate location for a veteran to receive care by showing available services within VA and information about the veteran's eligibility for community care. Additionally, it documents the outcomes of decisions by adding preformatted codes that help systematize comments for each consult.[42]

The toolbox captures veterans' preferences to opt in or out of community care. And it allows VHA healthcare providers to view relevant data to help guide conversations with veterans to decide whether a consult should be sent to a nearby VA facility or a community provider and considers

- drive-time standards associated with the requested consult service, and
- average wait times for the requested clinical service at VA facilities near the veteran's home and average wait times for community care appointments.

To be clear, average wait times are not used to determine wait-time eligibility. Eligibility is always based on the number of days from the file entry date to the next available appointment within VA (unless a veteran prefers a later appointment date). The toolbox merely provides average wait times in the community and within VA to help veterans decide where to receive care.

[41] VHA Directive 1232(5).

[42] The web-based interface uses buttons, drop-down options, and other mechanisms that help generate standardized codes (consult factors) that are recorded in a veteran's electronic health record, which facilitates reporting efforts. VA, *Consult Toolbox (CTB) User Guide*.

Veterans Integrated Service Network 12

VISN 12, also known as the VA Great Lakes Health Care System, includes eight medical facilities and more than 40 community clinics in northeastern Illinois, northwestern Indiana, Michigan's Upper Peninsula, and eastern Wisconsin. The VISN provided services to about one million veterans in FY 2024, with an operating budget of about $6.3 billion. Of that, about $1.3 billion was used for community care.[43] The medical facilities in VISN 12 are as follows:

- Jesse Brown VA Medical Center (Chicago, Illinois)
- Danville VA Medical Center (Danville, Illinois)
- Captain James A. Lovell Federal Health Care Center (North Chicago, Illinois)
- Edward Hines Jr. VA Hospital (Hines, Illinois)
- Oscar G. Johnson VA Medical Facility (Iron Mountain, Michigan)
- William S. Middleton Memorial Veterans Hospital (Madison, Wisconsin)
- Tomah VA Medical Center (Tomah, Wisconsin)
- Clement J. Zablocki VA Medical Center (Milwaukee, Wisconsin)

In FY 2024, VHA staff in VISN 12 processed more than 270,800 consults for community care and more than 668,300 consults for VA direct care.[44] Figure 3 shows each type of request for care at VISN 12 facilities that fiscal year. Of note, three of the eight medical facilities processed more requests for community care than for direct care: Danville, Iron Mountain, and Tomah.

[43] VA OIG Financial Analysis Tool, FY 2024 data.

[44] "Processed" means any consult in a complete or scheduled status. FY 2024 covers the period from October 1, 2023, through September 30, 2024. Data were provided by the VHA Support Service Center.

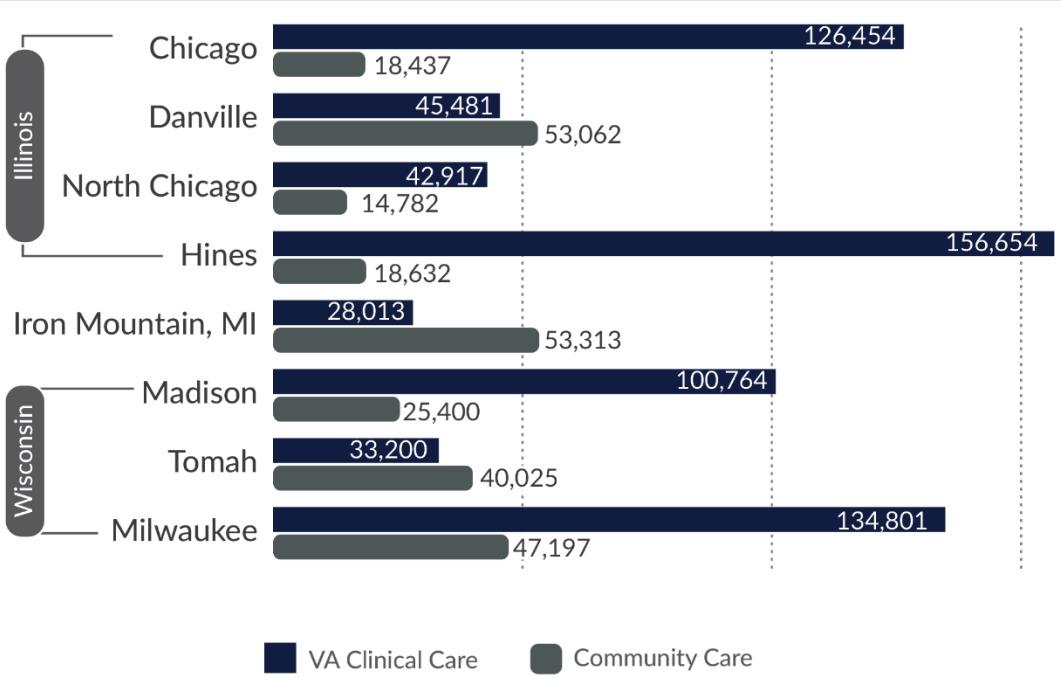

Figure 3. *VISN 12 community care and VA consults, by facility (October 1, 2023, through September 30, 2024).*

Source: Data are as of November 6, 2024, and were provided by IVC, which received the data from the VHA Support Services Center.

Consult requests for community care in VISN 12 increased about 36 percent from FY 2021 through FY 2024—from about 198,900 to about 270,800. All VISN 12 facilities saw an increase in requests for community care from FY 2021 through FY 2024, as shown in Figure 4 on the next page.

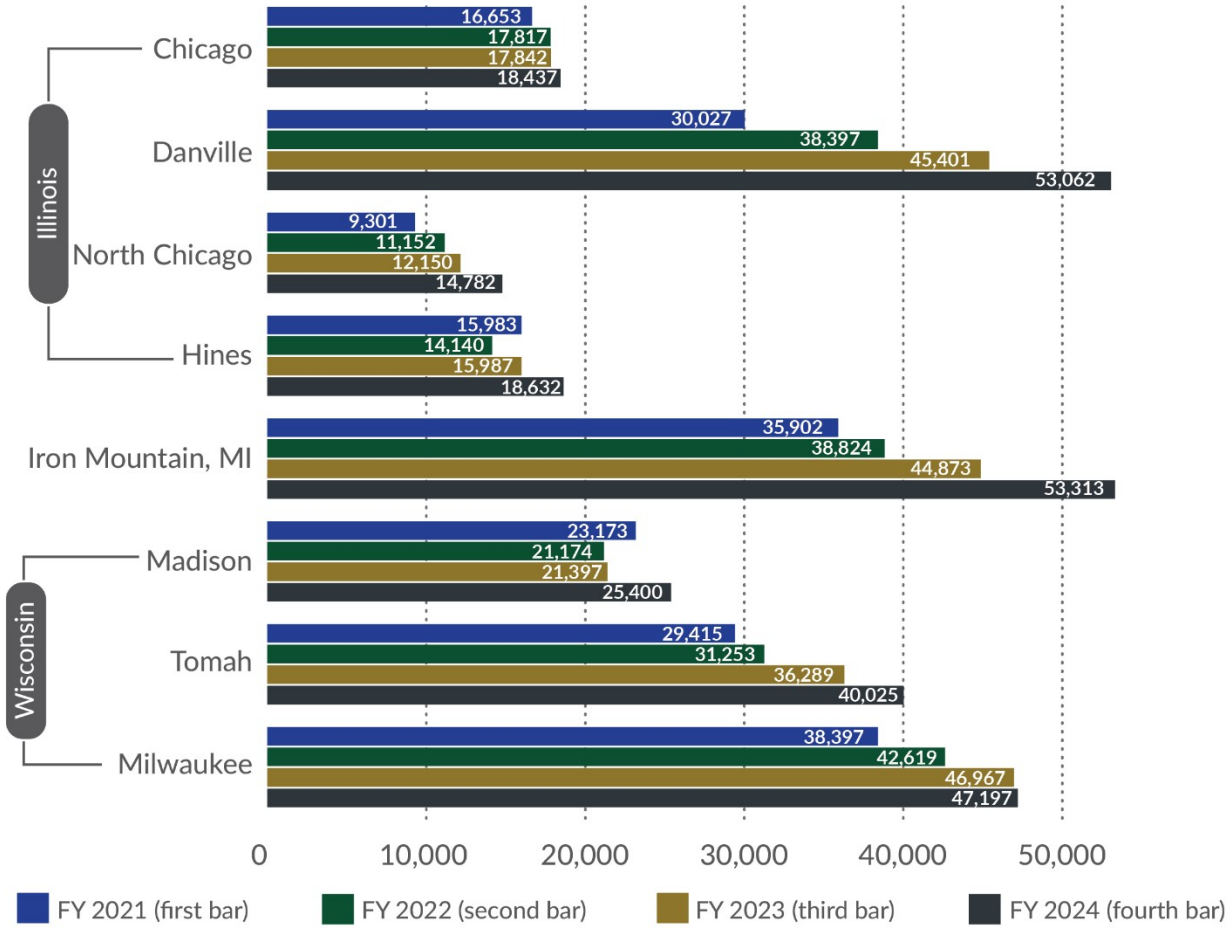

Figure 4. *VISN 12 community care requests by facility (October 1, 2021, through September 30, 2024).*
Source: Data are as of November 6, 2024, and were provided by IVC, which received the data from the VHA Support Services Center.

Consult Timeliness

To ensure compliance with VHA's directive on processing consults, IVC developed a standard operating procedure with timeliness standards, starting from the file entry date to the date an appointment is first scheduled.[45] Table 1 on the next page describes the specific metrics for the stages of consults: pending, active, and scheduled.

[45] VHA Directive 1232(5); VHA, "Consult Timeliness Standard Operating Procedure." As mentioned, a consult is considered complete when the requested healthcare services have been provided, according to the directive. VHA's Patient Eligibility and Scheduling Reference Sheet defines the patient indicated date as the appointment date a provider requested or the date a patient requests an appointment absent a provider's request.

Table 1. Metrics for Community Care and VHA Consult Scheduling

Consult status	Community care metric	VHA metric
Pending	A consult has been sent to the receiving service but not acted on	A consult has been sent to the receiving service but not acted on
Active	Within two business days from the file entry date or the date the consult was last placed in a pending status, the service is working to fulfill it	Within two business days from the file entry date or the date the consult was last placed in a pending status, the service is working to fulfill it
Scheduled	The appointment has been made within **seven** calendar days from the file entry date	The appointment has been made within **three** calendar days from the file entry date

Source: VHA Directive 1232(5), Consult Processes and Procedures*, December 5, 2022.*

Note: "Receiving service" refers to a facility's area of care or specific provider assigned to process the request for care.

The consult timeliness metrics are nearly identical for both community care and VHA care. The major difference relates to scheduling appointments, which is seven days for community care and three days for VHA care.

Although VHA has timelines for when appointments should be *scheduled*, there is no established timeliness standard for when community care appointments should *occur*. But VHA's network contracts include a wait-time goal for third-party administrators to make sure community providers respond to scheduling requests so that appointments occur within 24 hours for emergency care, 48 hours for urgent care, and 30 days for routine care.

Oversight Responsibilities

Various entities have oversight responsibilities for community care—including consult scheduling—at the national, regional, and local levels. Although this report focuses on VISN 12 and its facilities, the responsibilities for the VISN director and the medical facility director apply to all VISNs and all facility directors.

Office of Integrated Veteran Care

In 2022, VHA combined its Office of Veterans Access to Care and its Office of Community Care into a single Office of Integrated Care (IVC) to better coordinate services at VA facilities with those provided in the community. IVC is responsible for "allocating resources, developing training, and managing professional standards."[46]

In addition, VHA contracts with two third-party administrators to manage networks of providers for its community care program. The third-party administrators are responsible for making sure

[46] VHA Directive 1217, *VHA Operating Units*, August 14, 2024.

VA medical facilities have adequate community provider networks in size, scope, and capacity so veterans receive care in a timely manner.[47]

Veterans Integrated Service Network

In addition to the oversight IVC provides, the VISN director is responsible for the following:

- **Managing performance within the VISN.** The VISN's first duty is to make sure procedures and policies put forth by IVC are communicated to its medical facilities to identify risk, improve processes, and share best practices among facilities.
- **Assisting with oversight of policy implementation.** This includes regularly reviewing and applying corrective measures to address VISN data on consults and implementing standardized processes for consult management and reporting across the VISN.[48]

Medical Facility Director

Facility directors are responsible for monitoring compliance with VHA Directive 1230, *Outpatient Scheduling Management,* and reporting noncompliance to the VISN director. They are also charged with

- providing scheduling resources (including staff) to meet veterans' needs,
- making sure consults are scheduled in accordance with policy,
- creating a clearly defined local policy for managing and prioritizing consults, and
- following policy and guidance from IVC on community care coordination procedures.[49]

Schedulers

The following are among the facility-level schedulers responsible for consult management and consult timeliness:

[47] In accordance with the contract: To ensure an adequate and accessible provider network, drive-time and wait-time standards (ceilings) both vary by veteran location (such as urban, rural, and highly rural) that the third-party administrators must adhere to. Drive-time standards vary by type of care (such as primary care and general care), and wait-time standards also vary by emergency, urgent, and routine consults. For example, third-party administrators must keep drive times for general care below 45 minutes for veterans in an urban area and below three hours for veterans in a highly rural area. As stated earlier on wait times, appointments must occur within 24 hours for emergency care, 48 hours for urgent care, and 30 days for routine care.

[48] VHA Directive 1232(5); VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

[49] VHA Directive 1232(5).

- The facility **referral coordination team** receives, refers, and schedules consults in compliance with VHA consult-processing standards. The team provides care options that veterans are eligible for at VA medical facilities or with a community provider so patients can make informed healthcare decisions.
- The **consult sending service** or the **sending clinician** (where the care originates) is responsible for entering consults with a clinically appropriate date.
- The consult **receiving service** or the **receiving clinician** (where the care is requested from) is responsible for acting on consults received to provide timely scheduling information to veterans.
- **Receiving service administrative staff** are responsible for notifying veterans and promptly scheduling appointments from consults.[50]

The review team refers to these roles throughout the report collectively as "schedulers."

[50] VHA, "Consult Timeliness Standard Operating Procedure."

Results and Recommendations

Finding: VISN 12 Needs to Improve How It Administers the Veterans Community Care Program

From October 1 through December 31, 2023 (the first quarter of FY 2024), VHA staff in VISN 12 did not consistently offer all veterans required information about all their care options within and outside VA, based on OIG testing of wait-time and drive-time eligibility criteria.[51] Schedulers did not always accurately determine a veteran's eligibility for community care or inform veterans of their eligibility. An OIG analysis of wait-time and drive-time eligibility criteria found VHA staff sometimes incorrectly processed community care consults and VA appointments during these three months. Specifically, medical facility staff

- sent to community care about 23 percent of consults related to mental health care or specialty care although the veteran did not meet the wait-time and drive-time standards (6,900 of 30,300), partly due to scheduling system limitations;[52]
- sent to VA about 37 percent of appointments that *were* eligible for community care based on wait-time and drive-time standards without an indication that staff tested these veterans for eligibility (65,900 of 178,900); and
- scheduled within VA about 85 percent of primary care, mental health care, or specialty care appointments when a veteran qualified for community care based on wait times or drive times (65,900 of 77,600) without documenting the veteran's opt-in or opt-out decision in the consult or appointment notes or having other evidence of communicating all care options to the veteran before scheduling direct care (that is, care within VA).

Contributing to this noncompliance with guidance was schedulers' lack of an effective way to identify all available appointments that met wait-time and drive-time standards at other VA medical facilities, either within or outside VISN 12. Additionally, IVC guidance was uneven: It required schedulers to check all eligibility criteria for new patients but check only wait times for established patients.[53] Although prior OIG work suggests this is a long-standing VHA practice, it does not align with the plain language of the MISSION Act, and it hindered notifications to

[51] See appendix A for additional information on scope and methodology and appendix B for analyses performed.

[52] The review team analyzed consults that had at least 500 occurrences within a specific service line during the first quarter of FY 2024 to ensure a fair comparison between community care and VA direct care. As a result, primary care consults were not included in the team's testing because VHA sent only around 350 primary care consults to the community during the three months reviewed. Primary care was included, however, in further testing regardless of whether veterans were informed of all care options.

[53] Established patients accounted for about 33 percent of VA appointments meeting drive-time criteria in the first quarter of FY 2024 (21,800 of 65,900).

established patients about all care options that might ensure the soonest and best care. Neither the MISSION Act nor the implementing regulations distinguish between community care eligibility for new versus established patients. The MISSION Act sets forth the criteria under which the Secretary "shall, subject to the availability of appropriations, furnish hospital care, medical services, and extended care services to a covered veteran through [community] health care providers."[54] Pursuant to the law, veterans should be assessed and offered community care when the criteria apply and the decision to receive community care services "shall be at the election of the veteran."[55]

Furthermore, VHA staff in VISN 12 did not always provide timely care to veterans during the first quarter of FY 2024. From the initial request to the appointment date, veterans waited an average of 44 days to receive community care and an average of 35 days to receive care within VA.[56] More concerning, VISN 12 had roughly 250 VA and community care consults with a file entry date in the first quarter of FY 2024 that still had an active, pending, or scheduled status as of November 2024—a year later. These delays risked some veterans not receiving care when needed. When the team asked VA staff about these consults in a January 2025 briefing, they stated that some of the consults could be the result of the Captain James A. Lovell Federal Health Care Center going live with a new electronic health records system during the OIG's review period. They were unsure whether that was the cause for all 250 consults and said they would need to look into the matter further, which prompted the OIG's fourth recommendation in this report. Unless IVC implements processes to provide VA medical facilities with access to scheduling details across facilities, it will continue to be unable to identify all potential scheduling options.[57]

The following determinations support the OIG's finding that VISN 12 needs to improve how it administers the Veterans Community Care Program:

- VISN 12 lacked an effective process to accurately identify veterans' community care eligibility.
- VISN 12 staff did not always inform veterans of all available care options.
- Veterans received care sooner within VA when compared to community care.

[54] VA MISSION Act; 38 U.S.C. § 1703(d).

[55] VA MISSION Act; 38 U.S.C. § 1703(d)(4).

[56] Consult-processing guidance does not include a metric for the time from file entry date to when a veteran attended their appointment (time to receive care), but the OIG assessed this to determine how long veterans waited to receive care. The team acknowledges that circumstances outside schedulers' control can exist that extend wait times (for example, continually rescheduled appointments or challenges contacting community providers or veterans).

[57] The OIG is conducting two national audits subsequent to this review to fulfill a requirement of the Dole Act—using the VISN 12 approach as a model—to assess the performance of VA in appropriately identifying veterans eligible for care and services under the VA MISSION Act, informing veterans of their eligibility for such care and services, and delivering the care and services in a timely manner.

What the OIG Did

To assess whether VISN 12 staff determined community care eligibility in accordance with guidance and informed veterans of all their care options, the review team analyzed community care and VA consults with a file entry date (that is, when a request for care was made) and VA appointments that occurred during the first quarter of FY 2024. The team implemented several exclusion criteria to ensure the analysis represented a fair comparison of VA and community care services, such as including only services that were offered both in VA and in the community, disregarding emergency and walk-in services.

The team focused only on wait-time and drive-time criteria because they could be replicated and assessed for accuracy, and other community care eligibility criteria were not applicable or being used. In addition, while VISN 12 had no states without full-service VA medical facilities, the team still tested this eligibility criteria to see whether it had been used inappropriately. The team excluded from the testing population: services that could be offered only at VA or only in the community for comparison purposes; quality standards because VA had not implemented the criteria at the time of this review; and determinations of "best medical interest," which could not be assessed because they were based on clinical decisions between care providers and veterans.[58]

Table 2 details the number of appointments and consults that met the OIG's testing criteria for accuracy, evidence of informing veterans of eligibility, and timeliness.

Table 2. Number of VA Appointments and VA and Community Care Consults Tested for Accuracy, Evidence of Informing Veterans, and Timeliness

Testing category	Type of referral	Number tested
Accuracy of community care eligibility determination (wait time and drive time)	Community care consults with file entry dates from October 1 through December 31, 2023	30,300
Accuracy of VA eligibility determinations	VA appointments with appointment dates from October 1 through December 31, 2023	178,900
Evidence of informing veterans of community care eligibility	VA appointments among the 178,900 the OIG tested for accuracy identified as eligible for community care	77,600
Timeliness of community care	Community care consults with file entry dates from October 1 through December 31, 2023	35,000
Timeliness of VA direct care	VA consults with file entry dates from October 1 through December 31, 2023	84,000

Source: Data obtained on consults with a file entry date and appointments dated from October 1 through December 31, 2023, from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

[58] See appendix A for further detail on the scope and methodology and appendix B for more on exclusion criteria.

Note: The review team tested VA appointments for community care eligibility and whether there was evidence that veterans were informed because consults alone do not generally include this information, as the determination has not been made at the time a consult is placed. The team tested VA consults for timeliness because VA's standards for both VA and community care consults present a balanced comparison.

In addition to testing all appointments and consults in table 2, the team then selected and analyzed a judgmental sample of 60 community care consults—30 VA appointments and 30 VA consults to verify the data analysis results. This included verifying drive-time calculations and ensuring VA medical facilities provided requested services. The team also reviewed veterans' medical records for evidence that schedulers had reviewed community care eligibility criteria and communicated all potential care options. That review helped the team better understand what might be contributing to delays in consult processing.

The team interviewed IVC officials and VISN 12 facility staff responsible for overseeing or scheduling appointments within and outside VA. The team also judgmentally selected three VA medical facilities to analyze further—the Jesse Brown VA Medical Center, the Danville VA Medical Center, and the Clement J. Zablocki VA Medical Center.[59] For both the site selections and the sample, the team assessed a mix of mental health care, primary care, and specialty care services. The team interviewed staff to discuss how they process consults, conduct community care eligibility assessments, and inform veterans of their care options. Finally, the team analyzed IVC guidance and met with IVC leaders to discuss the OIG analysis, the review methodology, and any identified concerns related to VA's noncompliance or weaknesses with systems and processes. See appendix A for more on the review team's methodology.

VISN 12 Lacked an Effective Process to Accurately Identify Veterans' Community Care Eligibility

VHA staff in VISN 12 did not always accurately determine a veteran's eligibility for community care. This was due in part to limitations of the Consult Toolbox (such as inability to complete scheduling and consistently provide average wait times for community care) used by VA facilities to show all area VA medical facilities and help calculate wait and drive times for information purposes. VA also did not always comply with the plain language of the governing law because VA failed to require staff to routinely check drive times for established patients. As a result, some veterans received community care without meeting eligibility standards while others received direct care without being assessed for community care eligibility.

[59] The team considered medical facility complexity level, volume of consults, timeliness for veterans to receive care, and type of service.

VISN 12 Schedulers Did Not Always Identify All VA Direct Care Options for Determining Community Care Eligibility

VHA staff in VISN 12 did not accurately determine community care eligibility for about 28 percent of consults to community providers during the first quarter of FY 2024 (8,400 of 30,300). Specifically, based on OIG testing, the review team determined that veterans received care outside VA for mental health and specialty care when VA offered the same services within a veteran's drive time or wait time.[60] The schedulers did not always consider all in-house and community options because VISN 12 medical facilities lacked an effective scheduling system to identify available services at all VA medical facilities within veterans' wait times and drive times when that service was not available within the standards at veterans' home facilities. In addition, IVC does not have a process to validate eligibility determinations as part of its oversight.

Of the 30,300 consults the team tested for community care eligibility, the team verified wait-time and drive-time determinations for 21,900 of the consults (72 percent). However, the OIG's testing for community care eligibility identified a different eligibility designation for 1,500 consults than VHA had identified—for example, they recorded wait time rather than drive time or vice versa. For the other 6,900 consults, the team found surrounding VA medical facilities could have provided the requested services within veterans' drive times and wait times, making the veterans ineligible for community care. Table 3 details the results of these analyses.

Table 3. Results of VISN 12 Community Care Eligibility Determinations

Testing outcome	Number of community care consults	Percentage of community care consults
Confirmed eligibility for community care—that is, OIG testing matched VHA's decision	21,900	72%
Eligibility was based on different criteria—that is, OIG testing confirmed community care eligibility but on different criteria than VA's basis for its decision	1,500	5%
Did not confirm VA's finding of eligibility for community care	6,900	23%
Total	**30,300**	**100%**

Source: Data obtained on consults with a file entry date from October 1 through December 31, 2023, from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

[60] Under the MISSION Act and related VA regulations, a veteran is eligible to receive community care if the veteran must drive an average of at least 30 minutes for primary care, mental health care, or noninstitutional services at a VA facility or must drive an average of 60 minutes for specialty care at a VA facility. A veteran is also eligible if the wait time is more than 20 days for a primary care, mental health care, or noninstitutional services appointment at a VA facility or 28 days for a specialty care appointment at a VA facility.

To validate the OIG's data analysis, the team reviewed 30 of the 6,900 community care consults in which the team could not confirm VA's finding of eligibility for community care. The analysis focused on verifying drive-time calculations and confirming the availability of services within drive-time-eligible VA medical facilities. The team also reviewed VA appointment data to determine whether the wait-time calculations were reasonable compared to wait times at identified VA medical facilities that provided similar services.[61] Examples 1 and 2 reflect situations in which OIG testing found that a veteran did not meet community care eligibility criteria because VA could have provided the services in-house within the veterans' wait times or drive times.

Example 1

A patient at the Jesse Brown VA Medical Center in Chicago, Illinois, required physical therapy. A physician entered a consult on December 20, 2023, and documented the patient indicated date as December 20, 2023. At that time, the patient's eligibility for community care was not assessed. On January 4, 2024 (15 days later), the patient was found wait-time eligible for community care because the next available VA appointment was February 14, 2024—41 days from VA's initial contact with the veteran. Although it appeared the veteran would be eligible for community care, the OIG determined three other VA facilities were within the veteran's drive time and could have provided the care within the wait-time standard of 28 days. The average wait time at these facilities was between 15 and 21 days. The OIG found no evidence that VHA staff had considered any other VA facilities to provide care to the patient. Instead, the patient was sent to a community provider.

Example 2

A veteran that receives care from two VA facilities—the Clement J. Zablocki VA Medical Center in Milwaukee and the Union Grove (Wisconsin) VA Outpatient Clinic—required acupuncture treatment. The veteran lives about 47 minutes away from the Zablocki VA Medical Center and around 38 minutes from the outpatient clinic. In May 2021, the veteran's Union Grove primary care provider referred the veteran to community care based on drive-time eligibility. The veteran received regular acupuncture care in the community until around March 2024. But the OIG confirmed the Zablocki VA Medical Center offered acupuncture services during this time. Despite the facility offering acupuncture services, the Union Grove primary care provider did not consider sending the veteran to

[61] Though appointment data did not provide a past record of available appointments at the time of scheduling, the team could use scheduling data to identify scheduling occurrences for the specific services at the medical facility, which provided reasonable assurance that an appointment could have been scheduled.

Milwaukee for care. Because Milwaukee is within 60 minutes from the veteran's home address, the veteran was ineligible to receive acupuncture services in the community based on wait times and drive times.

Weaknesses in VHA's scheduling process meant veterans in VISN 12 may not have been aware of all their care options within VA during the first quarter of FY 2024. VHA's Consult Toolbox can identify other medical facilities within a veteran's drive time and wait time (even outside a VISN) and can also provide the average wait time for appointments at those facilities.[62] But schedulers cannot see the available appointments or schedule care at these other facilities. Schedulers can access the scheduling systems only for *their* facility and its associated clinics. This is because the toolbox and the scheduling system are separate systems. For community care, the toolbox does not identify drive times, and it only sporadically provides average wait times for care in the community.[63]

The Consult Toolbox Identifies Direct Care Facilities Without Allowing Scheduling

The Consult Toolbox uses geographic data to show all VA medical facilities within a 90-minute drive of a veteran's home address that may offer the clinical service requested in a consult. Drive times appear in 10-minute ranges, starting at 0–10 minutes and going up to 80–90 minutes (well beyond the 30-minute or 60-minute standards set by the MISSION Act and related VA regulations). The system also calculates average drive time based on past traffic patterns. Figure 5 illustrates how the system portrays drive-time, wait-time, and average community care wait-time information (discussed in the next section).

[62] Average wait time is calculated as the rolling average of wait times (the time between the file entry date and appointment date) for completed appointments for new patients with the selected clinical services within the last 30 days. The average wait time is displayed only as a reference. Eligibility for community care, based on wait time, is determined at the time of scheduling.

[63] For the toolbox to show the average community care wait time, an appointment in that same service must have been scheduled with a community provider within the past 90 days.

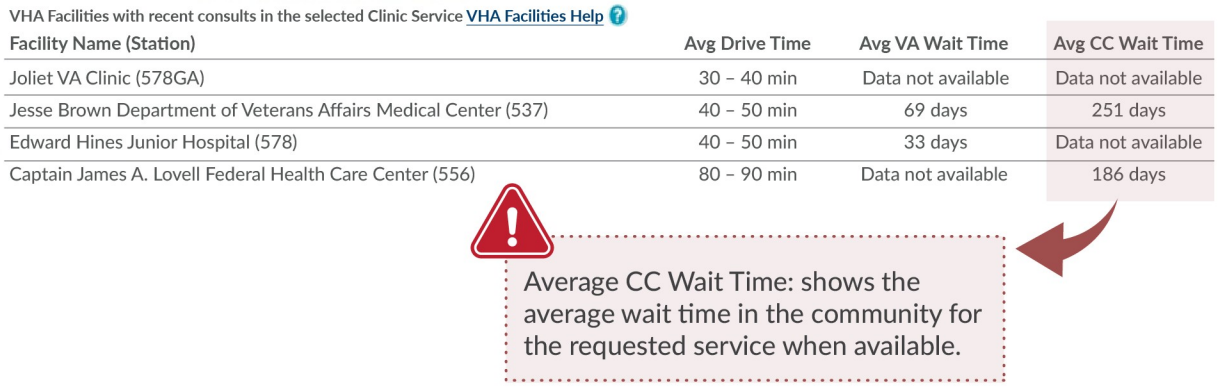

Figure 5. *Snapshot of the Consult Toolbox's drive-time identification.**

Source: OIG analysis of "How to Determine Clinical Service Availability within VAMC [VA Medical Center] or Sister Facility," chap. 2 in Community Care Field Guidebook*, IVC, accessed October 25, 2024 (not publicly accessible).*

** For accessibility, the OIG re-created the image based on a screenshot from the Consult Toolbox.*

Showing VA medical facilities close to a veteran is where the toolbox's capability ends. VHA staff who use the Consult Toolbox told the review team they cannot access or even see these other medical facilities' calendars, so they cannot schedule veterans at those facilities. Some schedulers noted they have established relationships with local facilities to request scheduling information, but this is not the case for all schedulers.

As a result of these limitations, VHA was not able to identify all opportunities when VA facilities—even some outside VISN 12—could have provided services. As of August 2024, IVC leaders were aware of these challenges and said they were planning a fix for scheduling direct care. Once this solution is fully implemented, IVC intends to provide the following capabilities, which should help schedulers and allow veterans to make better-informed decisions about their care:

- Multiple scheduling applications consolidated into a single platform—such as the ability to have provider-based scheduling and different appointment types (such as telehealth), compare available VA and community care appointments, and directly schedule available community care appointments
- The ability to identify available virtual and in-person appointments and schedule across medical facilities
- More online scheduling options for veterans' direct care

The Consult Toolbox Does Not Consistently Provide Average Wait Times for Community Care

IVC debuted the Consult Toolbox in September 2023 with the intent that it would eventually display average community care wait times. Providers, schedulers, and veterans could then

compare VA and community wait times and make informed decisions. But, at the time of this review, average community care wait times were not always available in the toolbox.

The toolbox shows the *average* wait times of all appointments booked or completed under specific care categories related to the requested clinical service, based on the previous 90 days of data.[64] The community care wait-time data shown are for community care appointments associated with a facility and the specific type of care requested under a selected clinical service. As noted earlier, for the toolbox to show the average community care wait time, an appointment in that service must have been scheduled with a community provider within the past 90 days.

Although adding the community care average wait time to the Consult Toolbox helps schedulers work with veterans on their VA and community care options, expanding the function to show appointment availability and enable scheduling would make the process more efficient. But due to system limitations, VA schedulers were not always able to inform veterans of what the wait times would be if they opted for community care. Consequently, VA schedulers sent consults to community care without having assurance that the wait time in the community would be shorter than at a VA facility.

The team identified significant issues related to eligibility determinations that were reported in this section, as well as the contributing factors. These include an ineffective scheduling system and limitations within the Consult Toolbox to fully identify community care wait times. Accordingly, the OIG is conducting two national audits subsequent to this review. The first will more closely examine how VISNs determine eligibility and inform veterans of care options. The second will compare the timeliness of care received at VA with the care provided in the community. Because these national audits will include recommendations for corrective action that must be implemented at a systems level higher than VISN 12 has the authority to make, no recommendations related to these broader concerns are offered in this report.

In the interim, recommendation 1 calls on the VISN 12 director to establish and use agreements with other VA medical facilities to help identify and schedule direct care when local services are unavailable.

VISN 12 Schedulers Did Not Always Identify Community Care Eligibility for VA Appointments

VHA staff in VISN 12 sent to VA about 37 percent of appointments that were eligible for community care during the first quarter of FY 2024 (65,900 of 178,900) based on wait-time and drive-time standards. For these appointments, the OIG's testing did not find any indication that these veterans were tested for, or informed of, their eligibility. This was partly due to schedulers

[64] The toolbox provides the average wait time rather than the exact wait time. The exact wait time is determined at the time of scheduling when actual appointment times are available.

not accurately identifying or documenting that veterans were eligible for community care. Schedulers also did not appropriately document when veterans opted out of community care.

The review team's testing of wait times and drive times also identified 113,100 of the about 178,900 VA appointments (63 percent) that either did not meet community care eligibility (about 101,400) or met eligibility but the veteran chose to receive care within VA (11,700). For the latter group of appointments, the team assumed VA had identified the veterans as eligible for community care and discussed care options and then the veterans decided to stay in VA.

VHA's Assessments of Community Care Eligibility Were Inconsistent With the Plain Language of the MISSION Act

IVC guidance required schedulers to check all eligibility criteria for new patients but check only the wait times for established patients.[65] Because schedulers also did not always complete required documentation of veterans' decisions to opt out of community care, VHA lacks assurances that they were provided all available options, especially veterans who were drive-time eligible for community care (shaded in table 4). Table 4 breaks down the eligibility standard the team identified for these VA appointments that the OIG's testing identified as eligible for community care without any indication that VA identified or informed veterans of their care options.

Table 4. Community Care Eligibility Standard Met with No Evidence of Opt-Out

Eligibility standard	Number of VA appointments (new patient)	Number of VA appointments (established patient)
Wait time	7,400	28,600
Drive time	2,200	21,800
Wait time and drive time	850	5,100
Total*	**10,500**	**55,500**

Source: OIG analysis of VA appointments that occurred from October 1 through December 31, 2023. Data obtained in January 2025 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

** Numbers will not total due to rounding.*

Thirty-three percent of VA appointments that actually met community care eligibility criteria based on the OIG's testing were not assessed for community care eligibility because they were for established patients (21,800 of 65,900). For these 21,800 consults, schedulers would not have fully checked for community care eligibility because IVC's guidance is not in accordance with the plain language of the MISSION Act. As discussed, IVC guidance required schedulers to check all eligibility criteria for new patients but check only wait times for established patients.[66]

[65] IVC, *National Standardized Scheduling Audit Guidebook*.

[66] IVC, *National Standardized Scheduling Audit Guidebook*.

Although this has been a long-standing VHA practice, the OIG maintains that it is inconsistent with the plain language of the MISSION Act and, based on prior OIG audits, it hindered veterans' awareness of all care options to ensure their soonest and best care.

The team could not identify any support for this practice in the plain language of the MISSION Act or the regulations governing implementation, as neither distinguish between community care eligibility for new patients versus established patients. The MISSION Act sets forth the criteria under which the Secretary "shall, subject to the availability of appropriations, furnish hospital care, medical services, and extended care services to a covered veteran through [community] health care providers."[67] Pursuant to the law, veterans should be assessed and offered community care when the criteria apply and the decision to receive community care services "shall be at the election of the veteran."[68] IVC leaders agreed with the OIG's assessment and told the review team in January 2025 that they intended to request legislative changes to this process (so they do not have to check drive time or distance eligibility criteria for existing patients) to align with the IVC guidance for established patients; this effort was on hold as of January 2025.

VISN 12 Staff Did Not Always Inform Veterans of All Available Care Options

For VA appointments that the OIG's testing identified as eligible for community care based on wait-time or drive-time standards, the review team could not confirm that VISN 12 staff assessed—and therefore informed—veterans of their community care eligibility for about 85 percent of these appointments for primary care, mental health care, or specialty care (65,900 of 77,600) during the first quarter of FY 2024.[69] While the OIG's analysis of wait-time and drive-time criteria determined these veterans were eligible to receive community care, the veterans' electronic health records lacked the required evidence showing schedulers had assessed these veterans for community care and subsequently communicated these options to each veteran.

The IVC schedulers handbook requires that veterans have an opportunity to schedule an appointment either in a VA medical facility or, when eligible, in the community.[70] The guidance further says that before scheduling a VA appointment, a scheduler must review community care eligibility and discuss all care options with a veteran. All appointments have three potential outcomes for a veteran:

[67] VA MISSION Act; 38 U.S.C. § 1703(d).

[68] VA MISSION Act; 38 U.S.C. § 1703(d).

[69] The review team focused on VA appointment data to determine whether a veteran met wait-time and drive-time eligibility criteria. When an appointment was associated with a VA consult, the team also reviewed the consult for evidence that the veteran was assessed for community care and informed of all care options.

[70] IVC, *National Standardized Scheduling Audit Guidebook*.

- **The veteran is not eligible** for community care and is scheduled for an appointment in the desired service at a VA facility.
- **The veteran is eligible for community care but opts out** and, therefore, is scheduled for an appointment in the desired service at a VA facility. In the appointment comments, the scheduler must include the opt-out code "#COO#" to document that the veteran is eligible for community care but has declined.[71]
- **The veteran is eligible for community care and opts in.** The scheduler must use the Consult Toolbox to capture the veteran's opt-in decision and to document the reason for eligibility. The scheduler then discusses any preferences the veteran has, such as specific care providers and days, times, and locations for the appointment, and then sends the consult to the community care department for scheduling.[72]

But schedulers told the review team they use the opt-out code even when it does not apply; they acknowledged confusion about using the code correctly. For example, staff reported adding the opt-out code even when a veteran is not eligible for community care and therefore is not actually given an opportunity to opt out. The schedulers also said they were instructed to use the code but did not receive training on how, when, and what support to include when they used it. Inaccurately using the opt-out code can skew the data VA leaders use to measure the number of veterans eligible for community care based on wait time. Further, it incorrectly implies a veteran declined care outside VA.

Veterans Who Were Eligible for Community Care Were Not Always Marked as "Opt-Out"

Not all appointments for direct care within VA that the OIG's testing identified as eligible for community care had documentation of a veteran opting out of community care. Table 5 breaks down the VA appointments the team identified as eligible for community care during the review period because of wait-time or drive-time criteria being met. These were reviewed to determine whether veterans were informed of their eligibility for community care. About 85 percent of these appointments (those in the bottom shaded and bolded row) did not include required documentation that the veterans opted out of community care.

[71] IVC, *National Standardized Scheduling Audit Guidebook*.
[72] VA, *Consult Toolbox (CTB) User Guide*.

Table 5. Results of Analysis on Whether VISN 12 Staff Informed Veterans of Their Community Care Eligibility

Outcome	Number and percentage of VA appointments	Number of VA appointments (new patient)	Number of VA appointments (established patient)
Identified by OIG as wait-time or drive-time eligible for community care	77,600 (100%)	14,800	62,800
Evidence the veteran had opted out	11,700 (15%)	4,400	7,300
No evidence the veteran had opted out	**65,900 (85%)**	**10,500**	**55,500***

Source: Data obtained in January 2025 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

** Numbers will not total due to rounding.*

This could have occurred because schedulers inaccurately identified community care eligibility for these appointments (as discussed previously) or because they did not appropriately document when veterans opted out of community care. To verify the results of the OIG's analysis, the team reviewed a sample of 30 of the 65,900 VA appointments that appeared eligible for community care services but had no documentation in the Consult Toolbox or in appointment notes that veterans were informed of their eligibility. The team reviewed each veteran's medical records and determined these appointments lacked evidence of having been assessed for community care eligibility. Without such evidence, VA has no assurance a conversation about community care eligibility occurred.

Veterans Who Were Not Eligible for Community Care Were Sometimes Marked as "Opt-Out"

The team also identified 7,200 veterans in VISN 12 who were not eligible for community care during the review period, yet their appointment notes included the opt-out code. More concerning, during a visit to the Jesse Brown facility in Chicago, the team determined that a mental health department used the opt-out code incorrectly when veterans *were* eligible for community care. Specifically, a mental health scheduler there had used the code to indicate when a VA appointment was scheduled more than 21 days out. This scheduler said speaking with veterans about their eligibility for community care was unnecessary because wait times in the community exceeded the more-than-20-day wait-time standards within VA for the specific mental health services requested. As a result, the scheduler arranged for services within VA without documenting that eligibility in the Consult Toolbox. Although the review team did not

find any ill intent on the scheduler's part, these veterans should have been told of their eligibility for community care. In addition, the review team identified 1,400 appointments—across different services—at the Jesse Brown facility that were not eligible for community care but the appointment notes erroneously included the opt-out code.

Regardless of a veteran's eligibility, it is imperative that schedulers provide veterans with all necessary information to make informed decisions about their care. Whether the decision is to stay with VA or use community care, schedulers should accurately document those discussions and veterans' decisions.

Recommendation 2 is for the VISN 12 director to emphasize, at least annually, to schedulers the proper methods (including the use of appropriate codes) to document when veterans opt out of community care. Further, recommendation 3 calls on the VISN 12 director to require that the medical facility director at the Jesse Brown VA Medical Center in Chicago ensure veterans requesting mental health services are assessed for community care and informed of all potential care options.

Veterans Received Care Sooner Within VA When Compared to Community Care

The team reviewed about 84,000 VA consults and 35,000 community care consults that had a file entry date between October 1 and December 31, 2023.[73] The OIG's analysis determined that veterans in VISN 12 waited an average of about 44 days to receive community care and 35 days to receive care within VA from the date they requested an appointment to when they attended their appointment during the first quarter of FY 2024.[74] Much of that wait time—for both VA and community care—represents challenges with scheduling appointments. These include ineffective processes that VHA used to manage consults and shortages in specialty care providers.

The review team determined that VISN 12 medical facilities did not always meet processing timeliness standards for community care or VA direct care. Figure 6 illustrates the timeliness comparison for each consult-processing metric. VA's processing goal is to move consults from pending to active status within two days of the file entry date and then schedule an appointment within three days for VA and within seven days for community care.

[73] See appendix B for additional information on the consults tested for timeliness.

[74] The review team calculated the average time to receive care by comparing the file entry date to the best available appointment date. The best available date is the appointment date documented in the electronic health record or on the community care claim. For community care consults, the claim date represents the date a veteran received care; it is also the most reliable documentation to confirm an appointment occurred.

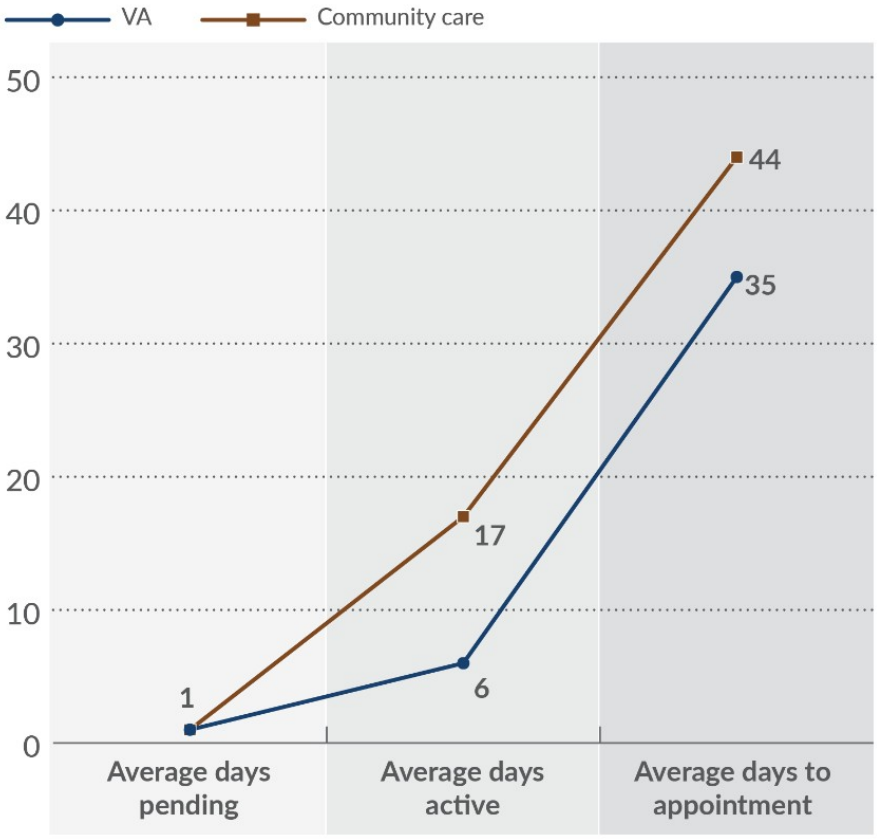

Figure 6. *VISN 12 timeliness comparison of consult processing between community care and VA direct care.*

Source: VHA Corporate Data Warehouse consults data, as of November 4, 2024.

VISN 12 generally met consult-processing expectations when moving a consult from pending to active status within two days—meaning the service receiving the consult accepted it and started the scheduling process. But on average, no medical facility in VISN 12 met consult-processing expectations for scheduling community care appointments within seven days; only three of the eight facilities met consult-processing expectations for scheduling VA consults within three days. Appendix C provides timeliness measures by medical facility.

Beginning on the next page, figure 7 compares VA and community care consults by days in pending status, figure 8 compares VA and community care days to schedule, and figure 9 compares VA and community care by days to appointment and the number of days consults remained in each phase.

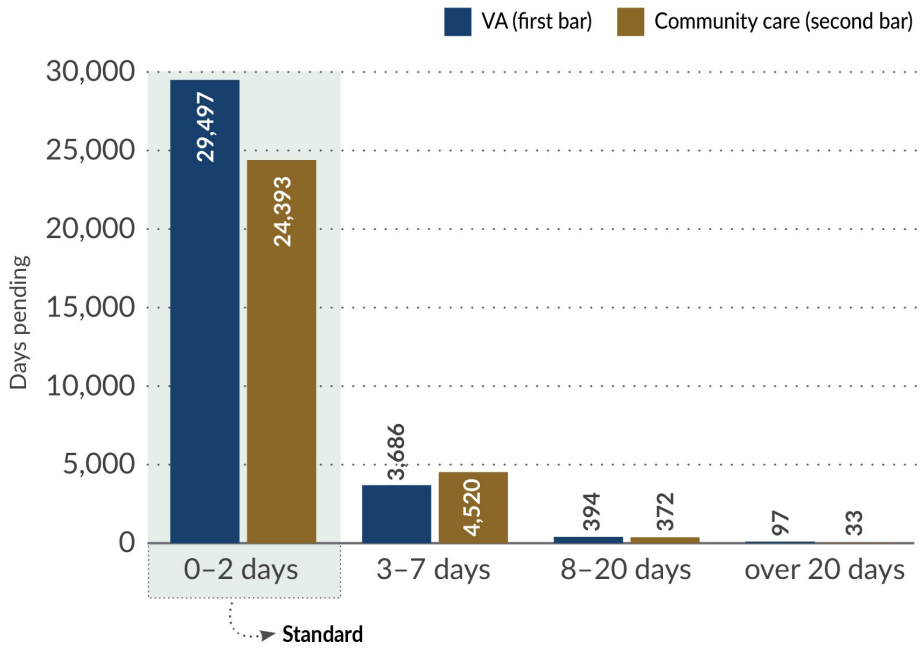

Figure 7. *VISN 12 timeliness comparison of consults in a pending status between community care and direct care.*

Source: VHA Corporate Data Warehouse consults data, as of November 4, 2024.

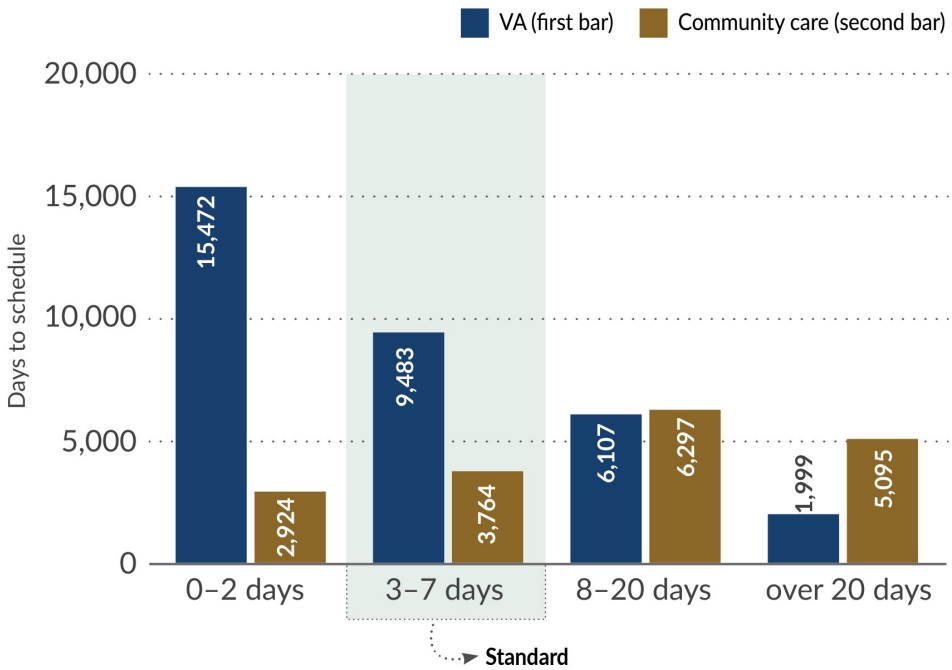

Figure 8. *VISN 12 timeliness comparison of consults in an active status between community care and direct care.*

Source: VHA Corporate Data Warehouse consults data, as of November 4, 2024.

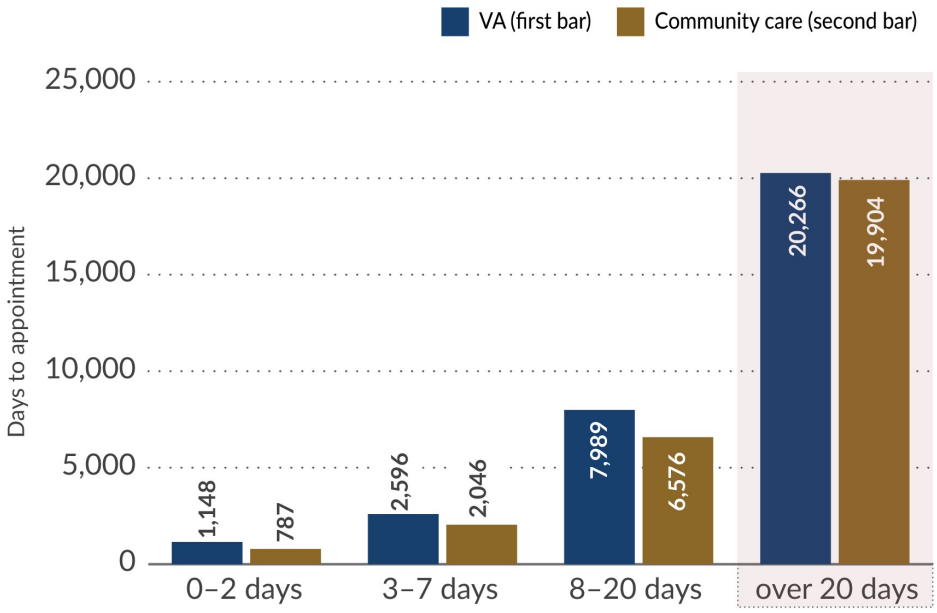

Figure 9. *VISN 12 timeliness comparison of the time to receive care between community care and direct care.*

Source: VHA Corporate Data Warehouse consults data, as of Novermber 4, 2024.

For VA direct care, schedulers told the review team the biggest challenges meeting processing metrics are providers' availability and contacting veterans. Schedulers also attributed delays in scheduling to the high volume of consults and the multiple other tasks they must complete.[75]

It may take more time to schedule a patient with a community provider due to factors beyond VA's control. For example, some community providers require a veteran's medical records before scheduling an appointment. Once the community provider is ready to offer an appointment, the scheduler may have difficulty reaching the veteran—particularly in cases when the veteran has chosen to self-schedule. Additionally, the community provider may be scheduling further out than VA or may cancel a veteran's appointment due to a lack of availability. In some cases, a veteran cancels or does not show up to the appointment, which may add to delays. Example 3 shows how the additional steps in the process contribute to the time a veteran may wait to receive care in the community.

Example 3

A veteran at the medical facility in Danville, Illinois, was informed of their eligibility for community care for mental health services on October 20, 2023. The first contact between a VA scheduler and the veteran was 11 days later, on

[75] Other duties include answering phones, greeting patients, canceling and rescheduling patient appointments and consults, entering no-show information, monitoring appointment requests from multiple electronic sources, participating in team meetings, and verifying providers' orders.

October 31. As of November 22, the veteran had not responded to the community provider's attempts to schedule an appointment. On December 13, the provider informed VA the veteran was scheduled for December 19. However, the community provider canceled this appointment and rescheduled it for January 2, 2024—totaling 74 days to schedule the appointment. However, the veteran did not show up on January 2. On January 11, the community care scheduler spoke with the veteran, who no longer wanted the care. The consult was canceled and then automatically discontinued 60 days later on March 11.

A Milwaukee community care leader said scheduling delays occurred because of staffing challenges and heavy workloads, adding that the delays decreased significantly after VHA hired additional community care staff. For example, the time to schedule previously took about 30 days, and at the time of the OIG's review, it was down to about 20 days. The review team also learned about several other issues during site visits:[76]

- Schedulers reported challenges at one site with following consult-processing requirements due to a union preventing community care staff from implementing process changes without subjecting them to bargaining provisions.
- Timeliness issues also occurred because of differing goals. Community care staff in one facility had a goal to move consults from active to scheduled within 21 days, even though the consult timeliness goal is seven days, and that was not always achieved. For example, the Clement J. Zablocki VA Medical Center in Milwaukee had an average time to schedule of 36 days during the review period.[77]
- At all three facilities the review team visited, community care schedulers are assigned consults based on veterans' last names rather than by service area. Schedulers suggested to the review team that organizing community care schedulers into service lines could lead to more efficient processes.

The team reviewed 43 consults that did not meet processing-time metrics (23 community care consults and 20 VA consults) to identify where the breakdown in scheduling typically occurred.[78] The main reasons veterans sometimes experienced longer wait times was because schedulers did not consistently make the first attempt to contact a veteran in time to meet the seven-day scheduling requirement, providers lacked availability for appointments or canceled appointments, or veterans did not respond to schedulers' attempted contacts. In an egregious

[76] The team judgmentally selected three VISN 12 medical facilities to visit in June and September 2024: the Jesse Brown VA Medical Center in Chicago; the Danville VA Medical Center in Danville, Illinois; and the Clement J. Zablocki Veterans' Administration Medical Center in Milwaukee.

[77] Appendix C provides details on the timeliness metrics for VISN 12 facilities.

[78] The team selected consults based on timeliness results and a distribution of statuses (pending, active, and scheduled).

example, a community care scheduler did not initiate action on a dental consult with a file entry date in November 2023 until June 2024 because of a miscommunication between the scheduler and the community provider about who would schedule the appointment and when.

The OIG confirmed these consult management issues occurred because staff did not always contact patients to schedule their appointments for consults within the required time. VISN and medical facility staff said they monitored consults through various reports. However, the OIG found service line staff did not always act on the consults quickly enough or the services experienced challenges obtaining appointments with community providers due to their need for VA medical records and a lack of availability. Providing timely care to veterans in the community and within VA is not a new challenge; VA consistently encounters barriers to meeting service goals. Prior OIG work found that scheduling delays occurred because of weaknesses in community care management processes. Contributing factors included unclear policies for coordinating care with community providers, inadequate controls to ensure managers' accountability for consult timeliness, and shortages in specialty care providers.[79]

Scheduling obstacles also resulted in delays completing consults. As of November 2024 (in the first quarter of FY 2025), VISN 12 had roughly 250 consults with file entry dates from the first quarter of FY 2024 that still had an active, pending, or scheduled status. As noted, IVC staff stated these consults could be the result of a medical facility going live with an electronic health records system, and these consults remained stuck in their respective statuses. Table 6 details the status of the community care and VA consults, based on the OIG's analysis.

Table 6. VISN 12 Status of the 250 Consults from First Quarter FY 2024

Consult status	Community care	VA direct care
Pending	0	20
Active	10	20
Scheduled	90	110
Total	**100**	**150**

Source: Data obtained in November 2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

[79] VA OIG, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, Report No. 16-026-18-424, March 2, 2017; VA OIG, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15*, Report No. 17-00481-117, March 13, 2018; VA OIG, *Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities*, Report No. 18-05121-36, January 16, 2020; VA OIG, *Management and Oversight of the Electronic Wait List for Healthcare Services*, Report No. 19-09161-02, December 1, 2020; VA OIG, *Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, Report No. 21-02326-233, September 12, 2022; VA OIG, *Delays in Community Care Consult Processing and Scheduling at the Martinsburg VA Medical Center in West Virginia*, Report No. 23-02020-85, May 2, 2024.

Recommendation 4 calls on the VISN 12 director to require that medical facility directors in VISN 12 review and process consults that began in the first quarter of FY 2024 and that remain in a pending, active, or scheduled status.

Conclusion

VISN 12 staff experienced challenges with ensuring veterans were correctly identified as eligible for community care, afforded opportunities to schedule appointments either within VA or in the community, or received care within established time frames. Until medical facility staff have the capability to effectively identify appointment availability—not only across VA facilities but also in the community—VA's efforts to ensure veterans are fully informed of their care options will be hindered. Finally, improving processes to assess, inform, and document veterans' community care eligibility will provide better visibility and assurances to VA that veterans are receiving the high-quality care they need when they need it.

Based on the results of this examination of VISN 12, the OIG is conducting two national audits: One is a deeper dive into how VISNs determine eligibility and inform veterans of their care options, and the other is comparing the timeliness of care received at VA versus in the community.

Recommendations 1–4

The OIG made the following recommendations to the VISN 12 director:

1. Establish and use agreements with other VA medical facilities to help identify and schedule direct care when services are unavailable at a veteran's local VA facility.
2. At least annually, emphasize to schedulers the proper methods (including the use of codes) to document when veterans opt out of community care.
3. Require the medical facility director at the Jesse Brown VA Medical Center in Chicago to make sure veterans who request mental health services are assessed for community care and informed of all potential care options.
4. Require medical facility directors in Veterans Integrated Service Network 12 to review and process consults initiated in the first quarter of fiscal year 2024 that remain in a pending, active, or scheduled status.

VA Management Comments

The VISN 12 director concurred with all recommendations and submitted corrective action plans to address issues identified in the report. VISN 12 requested closure of recommendations 1, 2, and 3. Appendix D includes the full text of the comments, which are summarized here.

Recommendation 1. The director stated that as part of the FY 2024 VHA Senior Executive Performance Appraisal Plan, the VISN created service line agreements, triaging tools, and standardized consults for the following eight services: cardiology, dermatology, gastroenterology, neurology, oncology, orthopedics, pain, and urology.

Recommendation 2. The director noted that the VISN 12 Business Implementation Manager and Group Practice Manager will ensure training is conducted at least annually. He also noted that in FY 2024, all schedulers completed annual online training and the VISN complies with the national scheduling audit program.

Recommendation 3. The director noted that, since the conclusion of the OIG review, the Jesse Brown VA Medical Center has conducted several training courses for mental health service line scheduling staff and clinical staff managing consults. Specifically, in January 2025, scheduling supervisors provided virtual training that focused on the proper use of opt-out codes and comments when scheduling appointments associated with consult requests. In February 2025, consult schedulers also received individualized training on using the Consult Toolbox, how to read the Decision Support Tool, and when to use opt-out codes. In addition, all providers in VHA were required to complete online training related to consult management, which "includes information relevant to the accurate dispositioning of consults and appointments that would be community care eligible." As of March 20, 2025, 95 percent of Jesse Brown clinical staff in mental health had completed the training. The group practice manager also reviewed audit findings over six months that are reported as exceeding the accuracy rate goal.

Recommendation 4. The director stated that as of May 2025, the VISN had 17 open direct care consults from the first quarter of FY 2024 that were still in active, pending, or scheduled status and the director had reached out to those facilities. In addition, 355 direct care consults from the Captain James A. Lovell Federal Health Care Center (North Chicago, Illinois) that originated in the legacy electronic health records system were being reviewed because they may not have transferred to the new electronic health records system (Oracle Health). The chief medical officer will oversee full compliance of this review and any appropriate corrective actions. The target completion date is September 2025.

OIG Response

VISN 12's comments and corrective action plans are responsive to the intent of the recommendations. As to VISN 12's requests to close recommendations 1, 2, and 3 as implemented, the OIG agrees to close recommendation 3 based on the documentation provided. The OIG will close recommendation 1 when additional evidence is provided that the service agreements are being used and recommendation 2 when sufficient information is presented that additional steps, beyond those in place at the time of the audit, have been taken to emphasize to schedulers the proper methods (including the use of codes) to document when veterans opt out of

community care. Recommendation 4 will be closed when the OIG receives adequate evidence that actions have been completed to address identified issues.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) review team conducted its work from May 2024 through May 2025. The scope of the review included Veterans Integrated Service Network (VISN) 12 community care consults and VA appointments, as well as consults during the first quarter of fiscal year (FY) 2024 (October 1 through December 31, 2023). Table A.1 details the number of community care consults, VA appointments, and VA consults—referrals to a specialty service or other facility within VA—during the time frame of the OIG's review as well as the number that met the team's testing criteria (see appendix table B.1 for information on the exclusions used).

Table A.1. Scope of Community Care and VA Consults and Appointments in VISN 12

Scope of analysis	Community care consults	VA appointments	VA consults
VISN 12 total	80,282	1,010,831	218,356
Count that met criteria for testing	30,316	178,883	84,161

Source: Data obtained in September2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Methodology

To address the review objective, the team completed the following:

- Obtained community care consult data and VA appointment information and applied exclusion criteria detailed in appendix B to identify a population for analysis
- Tested the data to determine how well VISN 12 assessed and informed veterans of their community care eligibility and provided timely care to veterans
- Interviewed Office of Integrated Veteran Care (IVC), VISN, and VA medical facility leaders and staff involved with implementing the community care program—including clinical and administrative referral coordination team members, community care staff, and medical support assistants

- Visited three judgmentally selected VISN 12 medical facilities: the Jesse Brown VA Medical Center, the Danville VA Medical Center, and the Clement J. Zablocki VA Medical Center[80]
- Validated OIG findings from the population tested by reviewing a sample of veterans' medical records with community care consults and VA appointments to verify VHA staff errors and determine whether there was documented evidence of veterans' being informed of community care options, including opt-out codes ("#COO#")
- Developed a standardized tool with preloaded sample information, key data points to examine, and uniform interview questions to ensure consistent medical record reviews and data collection at each site
- Identified risks and barriers related to veterans' access and use of both direct care and community care

Internal Controls

The review team assessed IVC's internal controls that are significant to the review objective. This included an assessment of the five internal control components of (1) control environment, (2) risk assessment, (3) control activities, (4) information and communication, and (5) monitoring.[81] In addition, the team reviewed the principles of internal controls associated with the objective. The team identified two components and two principles as significant to the objective.[82] The team identified internal control weaknesses during this review and proposed recommendations to address the following control deficiencies:

- Component 4: Information and Communication
    - Principle 13: Use quality information
- Component 5: Monitoring
    - Principle 16: Perform monitoring activities

[80] The team selected two sites that had a high number of errors and one site that had a low number of errors. The team considered errors as (1) eligibility for community care was inaccurate, (2) the eligibility type was inaccurate, (3) a veteran was not informed of the community care option or such a conversation was not documented, and (4) community or VA direct care exceeded processing-time standards.

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

[82] Because the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this review.

Data Reliability

The review team relied on computer-processed data to support the finding, conclusion, and recommendations of this review. The team used electronic data retrieved from the Veterans Health Administration's (VHA) Corporate Data Warehouse and Palantir (a web application that allows for real-time access to data across systems) to evaluate community care consults, VA appointments, and VA consults. The team evaluated the completeness and accuracy of the data from these systems by checking for missing or duplicate entries and text and the accuracy of number formats. The team then tested consult records' data entries against source consult documentation in Veterans Health Information System Technology Architecture electronic medical records. The review team's assessment determined the electronic data the team relied on were complete, accurate, and relevant for supporting the review objective and results.

Government Standards

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

Appendix B: Identification of Testing Population

To address the review objective, the team performed several types of analyses on VISN 12 consults with a file entry date or VA appointment date during the first quarter of fiscal year (FY) 2024 to identify the testing population.[83]

- **The accuracy and type of community care eligibility based on the type of consult or appointment**
    - For all community care consults, the team determined whether it could replicate the eligibility determination.
    - For VA appointments, the team assessed whether the veteran met community care eligibility criteria.
- **Whether VA informed eligible veterans of their choice between VA and community care based on the type of consult or appointment**
    - For all VA appointments, the team determined whether documentation existed in the appointment notes (#COO# code) indicating a veteran's preference to opt out of community care.
    - For VA consults, the team determined whether documentation existed in the consult (the OPT-OUT code) indicating a veteran's preference to opt out of community care.
- **Whether veterans received community care and VA direct care within established timelines based on the type of consult or appointment**.

  For all community care consults and VA appointments and consults—which are referrals to a specialty service or other facility within VA—the team calculated how quickly staff moved the consults through the stages of completion (that is, pending, active, scheduled, and appointment date).

The team applied several criteria to ensure the analysis represented a fair comparison of VA and community care services. For example, the team removed appointments and consults for services that were administrative in nature or were offered only by VA or only within the community.[84] Additionally, the team removed appointments and consults for each service type that had fewer than 500 consults.

[83] The file entry date is when the request for care was made.

[84] An example of VA-paid care provided only within VA is geriatrics and extended care, while an example of care available only in the community is maternity services.

The team analyzed data on all consults and appointments that met the criteria for testing to identify noncompliance with guidance. The team classified the following errors:

- **Community care eligibility error:** OIG testing of wait-time and drive-time criteria identified nearby VA facilities that could provide the service within the accepted wait time or drive time for consults approved for community care within the population tested.[85] The review verified that the service was available at the identified facilities and so a determination of community care eligibility was in error.
- **Lack of documentation informing veterans of options:** OIG testing of wait-time and drive-time criteria for scheduled VA direct care appointments determined veterans met the community care eligibility standard, but no documentation was found that the veteran had opted out of community care.
- **Timeliness goal nonadherence:** Consult-processing times exceeded VHA standards.

Tables B.1 through B.4 detail the review team's testing criteria for assessing the accuracy of community care eligibility determinations, how well veterans were informed of their eligibility, and the timeliness of care. Specific to table B.1 and B.2 for the testable address review, the team had the enrollment file as of June 30, 2023, and the daily updated patient demographic file (the best data available at the time). It is likely that formatting differences between the enrollment file and the patient demographic file data resulted in excluding some consults.

[85] The review team also tested consults determined to be eligible based on no full-service VA near where a veteran lived, but these accounted for less than 1 percent of the population.

Table B.1. Exclusions for Accuracy Testing for Community Care Consults (Cumulative Counts After Each Filter Is Applied)

Filter	Community care consult count after filter	Filter description
Scope	80,282	Include community care consults with a file entry date in the first quarter of FY 2024 in VISN 12
Basic	67,253	Exclude consults with any of the following conditions: • Backdated appointments—when care occurred before the consult was created • Desired appointment date exceeds wait time threshold—the patient's preferred date is later than the file entry date (the date the provider requested) • Test patients—consults are created only for data testing and not real patients • Same day—the consult was created on the date the appointment occurred
Tested eligibility reason documented to approve consult for community care	52,732	Keep consults only if the eligibility reason is drive time, wait time, and no full-service VA facility
Excluded stop codes and services	52,697	Exclude consults for emergency and urgent care and for services that are unique to community care or to VA
Keywords	50,675	Exclude services specific to community care that are not provided by VA direct care based on a list provided by VHA on March 26, 2024
Minimum use services	36,660	Keep services with at least 500 VA appointments and 500 community care consults (that meet the above criteria) within VISN 12 during the first quarter of FY 2024
Valid address information	35,178	Keep consults only if VHA would have had valid veteran residential address data in its enrollment file that the OIG could test
Testable address	30,316	Keep consults only if the patient's address data matched before and after the period under review
Testable consults total	**30,316**	**Scope of consults tested**

Source: Data obtained in November 2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: Rows shaded in gray with bold reflect the total testing population used. Numbers are rounded in the report narrative.

Table B.2. Exclusions for Informing Testing for VA Appointments (Cumulative Counts After Each Filter Is Applied)

Filter	VA appointment count after filter	Filter description
Scope	1,010,831	Include appointments with a relevant date in the first quarter of FY 2024 in VISN 12
Basic	385,827	Exclude appointments with any of the following conditions: • Desired appointment date exceeds wait-time threshold—the patient indicated date is later than the appointment creation date plus the wait-time threshold • Test patients—appointments are created only for data testing and not real patients • Same day—appointments were created on the date the appointment occurred or were walk-in appointments • Emergency or urgent care appointments • Virtual appointments, such as telehealth
Excluded stop codes and services	317,244	Exclude appointments for services that are unique to community care or to VA (not offered by both)
Keywords	311,609	Exclude services specific to VA direct care that are not provided through community care based on a list provided by VHA on March 26, 2024
Minimum use services	230,852	Keep services with at least 500 VA appointments (that meet the above criteria) and 500 community care consults within VISN 12 during the first quarter of FY 2024
Valid address information	178,883	Keep appointments only if VHA would have had valid veteran residential address data in its enrollment file that the OIG could test and the patient's address data matched before and after the review period
Testable appointments total	**178,883**	**Scope of VA appointments tested**

Source: Data obtained in January 2025 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: Rows shaded in gray with bold reflect the total testing population used. Numbers are rounded in the report narrative.

Table B.3. Exclusions for Timeliness Testing of Community Care Consult (Cumulative Counts After Each Filter Is Applied)

Filter	Community care consult count after filter	Filter description
Scope	80,282	Include community care consults with a file entry date in the first quarter of FY 2024 in VISN 12
Basic*	65,913	Exclude consults with any of the following conditions: • Backdated appointments—care occurred before the consult was created • Desired appointment date exceeds wait-time threshold—the patient indicated date is later than the file entry date or the appointment creation date plus wait-time threshold • Test patients—consults were created only for data testing and not real patients • Same day—the consult was created on the date the appointment occurred
Tested eligibility reasons	51,269	Keep consults only if eligibility factor is drive time, wait time, and no full-service VA in area
Excluded stop codes and services	51,231	Exclude consults for emergency and urgent care and for services that are unique to community care or to VA direct care (using the most recent consult stop code for each consult)
Keywords	50,087	Exclude services that are specific to community care and are not provided by VA direct care based on a list provided by VHA on March 26, 2024
Minimum use services	35,017	Keep services with at least 500 VA appointments and 500 community care consults (that meet the above criteria) within VISN 12 during the first quarter of FY 2024
Testable consults total	**35,017**	**Scope of community care consults tested**

Source: Data obtained in September 2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: Rows shaded in gray with bold reflect the total testing population used. Numbers are rounded in the report narrative.

** The date the team obtained community care consult data for the timeliness testing resulted in slight variances among the community care consult populations described in table B.1.*

Table B.4. Exclusions for Timeliness Testing of VA Consults (Cumulative Counts After Each Filter Is Applied)

Filter	VA consult count after filter	Filter description
Scope	218,356	Include VA consults with a file entry date in the first quarter of FY 2024 in VISN 12
Basic	191,068	Exclude consults with any of the following conditions: • Desired appointment date exceeds wait time threshold—care occurred before the consult was created • Future care—the patient indicated date was later than the file entry date or the appointment creation date plus wait-time threshold • Test patients—consults created only for data testing and not real patients • Same day—where the consult was created on the date the appointment occurred
Excluded stop codes and services	159,019	Exclude consults for emergency and urgent care and for services that are unique to community care or to VA direct care. (using the most recent consult stop code for each consult)
Keywords	146,128	Exclude services that are specific to community care and are not provided by VA direct care based on a list provided by VHA on March 26, 2024
Minimum use services	84,161	Keep services with at least 500 VA appointments and 500 community care consults (that meet the above criteria) within VISN 12 during the first quarter of FY 2024
Testable Consults Total	**84,161**	**Scope of VA consults tested**

Source: Data obtained in December 2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: Rows shaded in gray with bold reflect the total testing population used. Numbers are rounded in the report narrative.

Appendix C: Timeliness Metrics by Medical Facility

Veterans in VISN 12 waited an average of about 44 days to receive community care and waited about 35 days to receive direct care within VA from the date they requested an appointment to when they attended their appointment during the first quarter of FY 2024. The review team determined that VISN 12 medical facilities did not always meet processing timeliness standards for community care or direct care.

Table C.1 details the average days it took VISN 12 medical facilities to process community care consults for each timeliness metric during the first quarter of FY 2024.

Table C.1. Average Days by Facility to Process Community Care Consults

Medical facility	Number of consults	Days pending	Days active	Average days to appointment
William S. Middleton Memorial Veterans Hospital	2,500	1	32	61
Edward Hines Jr. VA Hospital	1,200	2	27	49
Jesse Brown VA Medical Center	1,000	1	19	46
Tomah VA Medical Center	5,000	1	19	45
Clement J. Zablocki VA Medical Center	7,000	1	36	45
Danville VA Medical Center	5,700	2	10	40
Oscar G. Johnson VA Medical Facility	6,200	0	13	40
Captain James A. Lovell Federal Health Care Center	780	1	12	31
Total across VISN 12	**29,380**	**1**	**16**	**44**

Source: Data obtained in November 2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: Total number of consults is a rounded number.

Table C.2 on the next page details the average days it took VISN 12 to process VA consults for each timeliness metric by medical facility.

Table C.2. Average Days to Process VA Consults (Referral for Specialty Care at Another VA Service or Facility)

Medical facility	Number of consults	Days pending	Days active	Days to appointment
Jesse Brown VA Medical Center	13,200	1	9	42
Oscar G. Johnson VA Medical Facility	2,300	1	3	38
William S. Middleton Memorial Veterans Hospital	7,000	2	8	37
Tomah VA Medical Center	2,200	1	7	34
Edward Hines Jr. VA Hospital	10,100	1	5	35
Clement J. Zablocki VA Medical Center	14,400	1	3	35
Danville VA Medical Center	2,400	1	3	32
Captain. James A. Lovell Federal Health Care Center	6,200	1	3	25
Total across VISN 12	**57,800**	**1**	**5**	**35**

Source: Data obtained in November 2024 from VHA's Corporate Data Warehouse and VA's Integrated Care Workspace database.

Note: Total number of consults is a rounded number.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 8, 2025

From: Director, Department of Veterans Affairs (VA) Great Lakes Health Care System (10N12)

Subj: Office of Inspector General (OIG) Draft Report, Veterans Integrated Service Network (VISN) 12 Needs to Improve How It Administers the Veterans Community Care Program (VIEWS 13239659)

To: Assistant Inspector General for Audits and Evaluations (52)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the OIG as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring that Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report's findings and recommendations and have provided an action plan in the attachment.

2. Should you need further information, contact the VISN Quality Management Officer.

The OIG removed point of contact information prior to publication.

(Original signed by)

Daniel S. Zomchek, PhD, FACHE
Network Director, VISN 12

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report – VA OIG Draft Report, Review of VHA's Implementation of Veterans Community Care Program in VISN 12

(2024-01757-AE-0072)

Recommendation 1: Establish and use agreements with other VA medical facilities to help identify and schedule direct care when services are unavailable at a veteran's local VA facility.

VHA Comments: Concur. As part of the fiscal year (FY) 2024 VHA Senior Executive Performance Appraisal Plan, Veterans Integrated Service Network (VISN) 12 created VISN-level Service Line Agreements, triaging tools, and standardized consults for the following services: Cardiology, Dermatology, Gastroenterology, Neurology, Oncology, Orthopedics, Pain, and Urology. These VISN-level Service Line Agreements are used to facilitate care at other Department of Veterans Affairs (VA) medical facilities when resources are unavailable at the Veteran's local facility, or it is in the best interest for the Veteran's care. VHA requests closure on this recommendation.

Status: Completed Completion Date: May 2025

Recommendation 2: At least annually, emphasize to schedulers the proper methods (including the use of codes) to document when veterans opt out of community care.

VHA Comments: Concur. The VISN 12 Business Implementation Manager and Group Practice Manager will continue to work with the facilities to ensure that training is being conducted at least annually as required by VHA Directive 1230, Outpatient Scheduling Management, published June 1, 2022. In FY 2024, the annual training was accomplished through Talent Management System (TMS) course 4652140 with 100% compliance for all schedulers. In addition to the annual refresher training, the VISN complies with the national scheduling audit program required by VHA Directive 1230. The audits look at several measures, which include community care eligibility documentation and Veterans opting out of community care. For the past six months, VISN 12 has met the 93% goal for scheduling accuracy. VHA requests closure on this recommendation.

Status: Completed Completion Date: May 2025

Recommendation 3: Require the medical facility director at the Jesse Brown VA Medical Center in Chicago to make sure veterans who request mental health services are assessed for community care and informed of all potential care options.

VHA Comments: Concur. Since the conclusion of the OIG review, the Jesse Brown VA Medical Center (VAMC) conducted several trainings for Mental Health Service Line (MHSL) scheduling staff and clinical staff managing consults. In January 2025, the Medical Support Assistant (MSA) Supervisors provided four group trainings to the MHSL MSA staff via Microsoft Teams. The training included a focus on when to use the #COO# opt-out code along with proper comments when scheduling appointments associated with consult requests. MSA leadership provided one-on-one, over-the-shoulder training in February to any MHSL scheduler who handles consults. This training focused on the use of the consult toolbox, how to read the Decision Support Tool, and when to use the #COO# code.

In FY 2025, all providers in VHA were required to complete TMS course 4667068 VHA Directive 1232, Consult Management Recertification, Mandatory Training for Licensed Independent Practitioners. This training includes information relevant to the accurate dispositioning of consults and appointments that would be community care eligible. As of March 20, 2025, Jesse Brown VAMC clinical staff in MHSL are at 95% (166/174) completion compliance.

The VISN 12 Group Practice Manager has reviewed the results of the national scheduling audit for Jesse Brown VAMC MHSL for the six-month period from November 2024 to April 2025, which shows an accuracy rate of 94.05% (goal of 93%). Of the 185 audits performed, 11 had audit findings and 6 of those were related to #COO# code comments either missing or used incorrectly. This is an error rate of 3.24% with regard to correct documentation of the #COO# code. The VISN 12 Group Practice Manager will continue to provide oversight of scheduling audits. VHA requests closure on this recommendation.

Status: Completed Completion Date: May 2025

Recommendation 4: Require medical facility directors in Veterans Integrated Service Network 12 to review and process consults initiated in the first quarter of fiscal year 2024 that remain in a pending, active, or scheduled status.

VHA Comments: Concur. As of May 2025, the VHA Support Service Center Consult Patient Details report shows VISN 12 has 17 open direct care consults from FY 2024, Quarter 1 that are not future care and are still in active pending and scheduled status. VISN 12 issued a suspense action to those facilities and is awaiting completion. In addition, 355 direct care consults from North Chicago VA are from the legacy Computerized Patient Record System (CPRS). A separate suspense has been issued to review these consults that may not have been transferred to the Oracle electronic health record during the go-live period, but they will continue to reflect their current status in CPRS until scheduled. Reporting on this action will occur through the Access Committee where the Chief Medical Officer will oversee compliance. Compliance is defined as 100% of consults that are designated as “scheduled future appointments” or are closed. Compliance for consults assigned to Lovell is defined as 100% of consults have been reviewed and appropriate action taken in Oracle electronic health record as needed.

VISN 12 Community Care has ensured all consults were managed appropriately in the Oracle electronic health record.

Status: In Progress Target Completion Date: September 2025

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

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