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VETERANS HEALTH ADMINISTRATION

Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the VA Boston Healthcare System in Massachusetts, Fiscal Year 2024

National Review | **25-02447-08** | **November 18, 2025**

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Report Overview

With the passage of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in 2018, veterans have greater choice for health care through VA direct care (provided by VA facilities) or community care (paid for by VA). The VA Office of Inspector General (OIG) initiated this review to assess some of the important aspects of the community care program, in comparison to VA direct care, at the VA Boston Healthcare System (system) for fiscal year 2024 (October 1, 2023, through September 30, 2024) using data that were current as of April 14, 2025. Specifically, the OIG reviewed

- community care utilization for both inpatient and outpatient care;
- the reasons for utilizing community care;
- the quality of care; including
    - timeliness of referral coordination,
    - appointment wait times, and
    - disqualified community providers.[1]

The system, part of Veterans Integrated Service Network (VISN) 1, is located in Jamaica Plain, a neighborhood in Boston, Massachusetts, and provides a range of inpatient and outpatient medical, surgical, and mental health services. The system includes three VA medical centers in the greater Boston area and community-based outpatient clinics in Framingham, Lowell, Plymouth, and Quincy, Massachusetts.

This report focuses on utilization and timeliness of VA direct and community care provided through an urban healthcare system in contrast to an earlier report focusing on the Montana VA Healthcare System, located in a particularly rural area.[2]

[1] The term *disqualified* refers to providers who have had an adverse action taken against them and are ineligible to provide community care to veterans.

[2] VA OIG, *Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022*, Report No. 24-02106-80, March 19, 2025.

Inspection Results

Patient Demographics

The patient population consists of 58,324 patients who received medical care at the system or through community care paid for by the system during fiscal year 2024. Almost 73 percent of the patient population were known to reside in Massachusetts, and 12 percent in adjacent states. Less than 15 percent of patients were known to live further away than an adjacent state.

Community Care Utilization

VA health care includes both VA direct care (provided at a VA facility) and VA community care (delivered by providers in the community who are paid by VA). The OIG determined the number of patients who utilized only VA direct care, only VA community care, or both VA and community care for primary, mental health, emergency/urgent, and specialty medical care in fiscal year 2024. Among patients who received primary care, all did so exclusively through VA direct care. Similarly, 99.5 percent of patients who received mental health care did so exclusively through VA direct care. The OIG determined that approximately 97 percent of patients received specialty care services exclusively through VA direct care.

According to VA, in fiscal year 2024, the system operated a total of 517 beds and offered inpatient domiciliary, community living center, medical, mental health, neurological, rehabilitation medicine, residential rehabilitation, spinal cord injury, and surgical services.[3] The OIG determined that inpatient community care accounted for approximately 12 percent of the overall acute care bed-days of care provided in fiscal year 2024.

The OIG also examined the documented reasons for community care referrals made in fiscal year 2024.[4] Most community care referrals were requested due to patients' associated drive times to access needed care.

Quality of Community Care

For the purposes of this report, the OIG assessed certain indicators of quality care: whether the system (1) coordinated the referral processes timely, (2) met timeliness goals for providing

[3] "Workload Profile Report," VHA Support Service Center (VSSC), accessed April 29, 2025, https://app.powerbigov.us/groups/me/apps/b8d12242-6dea-48c7-86c0-92de7a5e1710/rdlreports/44027efd-9f92-4baf-bcd9-2585b1a659e3?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (This website is not publicly accessible.); "Geriatrics and Extended Care," VA, accessed July 29, 2025, https://www.va.gov/GERIATRICS/pages/VA_Community_Living_Centers.asp. "A Community Living Center (CLC) is a VA Nursing Home."

[4] The terms "consult" and "referral" are used synonymously in this report.

quality direct and community care, and (3) used disqualified providers for community care services.

The OIG assessed the timeliness of referral's first activation guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies two business days for VA staff to complete any necessary pre-work steps and activate both direct and community care referrals.[5] The OIG found that VA staff activated approximately 83 and 84 percent of direct and community care referrals, respectively, within two days.

The OIG also assessed the timeliness of appointment setting, guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*. The OIG found that approximately one in two effective (not canceled or discontinued) referrals had an associated appointment set within the established timeliness: 55 percent of VA direct care referrals had an associated appointment set within three business days, and 53 percent of community care referrals had an associated appointment set within seven calendar days.

The OIG assessed the timeliness of referral completion. VA guidelines give facilities 90 days from the requested date to complete both direct and community care referrals.[6] The OIG found that VA staff completed more than 90 percent of referrals within 90 days of the requested date: approximately 94 and 93 percent of direct and community care referrals, respectively.

While reviewing referral completion, the OIG noticed that some completed VA direct care referrals did not document the scheduled status on the referral, despite the appointment being set. The OIG further analyzed referrals for specialty care that generally require appointments to be set prior to the visit, such as for ophthalmology. However, the OIG noticed that the date the appointment was set was not documented on the referral.

Veterans become eligible for community care when appointment wait times for VA direct care cannot be met within 20 days of the referral date for primary and mental health care. The OIG found no community care referrals for primary care and less than 3 percent were for mental health in fiscal year 2024. The OIG found that approximately 66 percent of patients were given a community care appointment for mental health within 20 days of the requested date.

Similarly, veterans become eligible for community care for specialty visits when an appointment for VA direct care cannot be made within 28 days from the referral date. The OIG found that approximately 97 percent of all community referrals were for specialty care. OIG analysis indicates that approximately 61 percent of patients received a community care appointment for specialty care within 28 days of the requested date.

[5] VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)," updated December 1, 2022; VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)" updated July 8, 2024.

[6] The requested date is the date the clinician, in collaboration with the patient, determines is clinically indicated for care.

The OIG also assessed whether providers who were removed from VA employment due to conduct that violated VA policy related to the delivery of safe and appropriate health care, continued to furnish community care to patients. The OIG did not find any paid community care claims for services provided by potentially disqualified providers.

The information presented in this report is intended to provide VA leaders and stakeholders with an overall view of utilization, delivery of timely care, and provider qualifications associated with community care provided through the system. The OIG made three recommendations for improvement to the System Director related to appointment scheduling, the proper use of consults, and wait times.

VA Comments and OIG Response

The Veterans Integrated Service Network and System Directors concurred with recommendations 1 and 3 and concurred in principle with recommendation 2. The System Director reported enhancing reporting of metrics related to scheduling, completed appointments, wait times, and facility access and identifying opportunities to improve and refine practices. The System Director concurred in principle with one recommendation and committed to educating staff on consult documentation practices (see appendixes G and H). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Abbreviations

OIG	Office of Inspector General
MISSION	Maintaining Internal Systems and Strengthening Integrated Outside Networks
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated this review to characterize the impact of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act on patient use of community care. The OIG reviewed patient demographics, utilization, and selected elements of quality of care associated with VA's community care program (paid for by VA) in comparison to direct care (provided by VA facilities) at the VA Boston Healthcare System (system) for fiscal year 2024 (October 1, 2023, through September 30, 2024) using data that were current as of April 14, 2025.

The OIG chose to review the system because of its urban location and ability to provide a wide range of services, after the OIG's seminal review of a healthcare system in a rural area providing comparably fewer services in fiscal year 2022.[1]

Specifically, the OIG reviewed

- community care utilization for both inpatient and outpatient care;
- the reasons for utilizing community care;
- the quality of care; including
    - timeliness of referral coordination,
    - appointment wait times, and
    - disqualified community providers.[2]

Community care programs work "to ensure every Veteran and beneficiary can access high-value care when and where they need it."[3] Lawmakers enacted the Veterans Access, Choice, and Accountability Act of 2014, establishing the Veterans Choice Program.[4] This program allowed "eligible Veterans to receive care from non-VA facilities, connecting them to timely and

[1] VA OIG, *Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022*, Report No. 24-02106-80, March 19, 2025.

[2] The term *disqualified* refers to providers who have had an adverse action taken against them and are ineligible to provide community care to veterans.

[3] "Veterans Health Administration Office of Integrated Veteran Care," VHA, accessed July 29, 2025, https://vaww.va.gov/communitycare/. (This site is not publicly accessible.)

[4] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1754.

convenient access to health care, instead of waiting for a VA appointment or traveling long distances to a VA facility."[5]

In June 2018, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act was established to give veterans "better access and greater choice in health care either at VA or a community provider through improved eligibility criteria."[6] The Veterans Health Administration's (VHA's) overall community care expenditures were over $36 billion in fiscal year 2024.[7]

The OIG's seminal review of VA direct and community care utilization and referral coordination focused on a healthcare system in a particularly rural area in fiscal year 2022. Conclusions included the challenges of operating a VA medical facility, especially in a rural environment in which many patients qualify for community care based solely on where they live. The OIG made five recommendations, which remain open as of June 17, 2025.

This report, in contrast, focuses on utilization and timeliness of VA direct and community care provided through an urban healthcare system.

Facility Background

The system, part of Veterans Integrated Service Network (VISN) 1, is located in Jamaica Plain, a neighborhood in Boston, Massachusetts. It provided a range of inpatient and outpatient medical, surgical, and mental health services to over 58,000 patients in fiscal year 2024. The system includes three VA medical centers in the greater Boston area and community-based outpatient clinics in Framingham, Lowell, Plymouth, and Quincy, Massachusetts. See appendix A for additional facility information.[8]

[5] "Using the Veterans Choice Program," VA, accessed July 9, 2024, https://www.publichealth.va.gov/exposures/publications/oef-oif-ond/post-9-11-vet-fall-2015/veterans-choice-program.asp.

[6] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

[7] OIG analysis; expenditures are not adjusted for inflation.

[8] The underlined terms are hyperlinks to appendixes. To return from the appendix, press and hold the "alt" and "left arrow" keys together.

Scope and Methodology

Data Source

VA care includes both VA direct care (provided at a VA facility) and VA community care (delivered by providers in the community and paid for by VA). All data analyzed in this report were for fiscal year 2024 and compiled from VA administrative data sources. The OIG utilized VA direct care and VA community care data, which are dynamic in nature, as of April 14, 2025.

Patient Population and Demographics

The OIG identified the population of patients with an outpatient visit (excluding dental visits) or an inpatient stay during fiscal year 2024.

Community Care Utilization

Outpatient

The OIG characterized each outpatient visit into one of four types of medical services (primary care, mental health care, emergency/urgent care, and specialty care) using clinical stop codes and grouped them into VA direct care visits and community care visits.[9] The OIG further categorized specialty care into the subcategories of cardiology, dermatology, gynecology, ophthalmology, urology, and other specialty visits. The other specialty visits subcategory captured a broad range of visit types from audiology to neurology.

The OIG defines utilization for each of the four medical types as the number of days in which a patient had one or more qualifying outpatient visits through either VA direct care or VA community care during fiscal year 2024. Qualifying outpatient visits exclude visits related to dental care, laboratory tests, dialysis not assisted by a physician, pharmacy, hospice care, homemaker services, adult day care, residential-based care, chaplain services, and other visit types that the OIG determined are often nonclinical in nature, such as the Veterans Justice Outreach and Social Work Services.

The OIG's analysis highlights VA community care utilization, in comparison with VA direct care. A patient may choose to receive community care over VA direct care for many reasons. The OIG further excluded those visits that do not readily allow patients to choose between VA direct care and community care. This results in the exclusion of home-based care and care provided in a homeless shelter or correctional facility.

[9] VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019. VHA uses stop codes to classify encounters into workload types.

The OIG also provided a separate analysis of outpatient utilization that includes visits for which the patient cannot readily choose between VA direct care and VA community care in appendix C.

Inpatient

VA Direct Care Inpatient

VA direct care inpatient data contain records for acute inpatient stays, non-acute (short- and long-term) stays, and observation stays. The OIG classified VA direct care inpatient records based on the length of stay and treating specialty at admission:

- Acute inpatient stays—stays with an acute treating specialty at admission, regardless of the number of days spent in the hospital
- Non-acute inpatient stays (short- and long-term stays)—stays with a non-acute treating specialty such as hospice, nursing home, domiciliary, and spinal cord injury at admission
- Observation stays—stays that were less than or equal to 48 hours in which the patient was admitted under observation treating specialty.[10] The OIG excluded observation stays when computing inpatient utilization.

For VA acute inpatient stays, the OIG identified the top five most frequently used discharge codes responsible for patient stays.[11]

Community Care Inpatient

The OIG identified acute and non-acute inpatient stays using the bill type codes associated with the claims (see table 1).[12] The OIG excluded stays with the same admission and discharge dates since they are considered observation stays. The OIG also excluded any community care inpatients discharged on October 1, 2023, or admitted on September 30, 2024, from further analysis. For community care acute inpatient stays, the OIG determined the top five most frequently used discharge codes responsible for patient stays.

[10] VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, January 13, 2020, rescinded and replaced by VHA Directive 1036(1), *Standards for Observation in VA Medical Facilities,* December 18, 2024, amended March 10, 2025.

[11] For purposes of this report, ICD-10 refers to ICD-10-CM, in which CM references Clinical Modification. According to the Centers for Disease Control and Prevention, "The International Classification of Diseases, Clinical Modification (ICD-CM) is a standardized system used to code diseases and medical conditions (morbidity) data." "Classification of Diseases, Functioning, and Disability," Centers for Disease Control National Center for Health Statistics, accessed May 7, 2025, https://www.cdc.gov/nchs/icd/?CDC_AAref_Val=https://www.cdc.gov/nchs/icd/index.htm.

[12] A bill type code is a four-digit code that identifies the type of facility (2nd digit) and the type of care provided (3rd digit). The first digit is always zero and the 4th digit specifies the billing frequency for a claim.

Table 1. Community Care Inpatient Type of Care Included in the Analysis

Type of Inpatient Care	Bill Type Codes
Acute Inpatient	011, 012
Non-acute Inpatient	
Hospice	081, 082
Nursing Home	018, 021, 022, 061, 062, 065, 066, 068
Residential Facility	086

Source: OIG analysis of bill type codes. "Bill Type Code," Research Data Assistance Center, https://resdac.org/cms-data/variables/bill-type-code.

Inpatient Bed-Days

The OIG measured inpatient utilization based on bed-days. The OIG calculated inpatient bed-days from admission date to the discharge date over days that occurred in fiscal year 2024, even if the stay extended beyond the study period.

Reasons for Utilizing Community Care

The OIG examined routine outpatient referrals to determine the reasons for utilizing community care.[13] The reasons were classified into the following categories based on the eligibility criteria under the VA MISSION Act that can qualify a veteran to receive community care:[14]

1. Average Drive Time—Veterans driving to a VA medical facility for at least 30 minutes for primary care, mental health, and noninstitutional services, or driving at least 60 minutes for specialty care services.
2. Grandfathered—Veterans are considered grandfathered if they were eligible under the 40-mile criterion under the Veterans Choice Program and continue to reside in a location that would qualify them under this criterion.
3. Service Not Available—Veterans need a specific type of service that is not available at a VA medical facility.

[13] The terms "consult" and "referral" are used synonymously. A referral, which VHA calls a consult, is a request for services on behalf of a patient. One provider requests an opinion, advice, or expertise regarding the evaluation or management of a patient-specific problem, and another provider responds to the request. The referral process provides a method of coordinating patient care among different services. VHA policy sets timeliness standards for each step of the referral process.

[14] VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

4. Best Medical Interest—The referring clinician and the veteran determine that it is in the best interest of the veteran to see a community provider.
5. Wait Time—Veterans have to wait for 20 days or more for primary care, mental health care, and noninstitutional extended care services, or 28 days for specialty care from the date of referral request.
6. No Full-Service—Veterans live in a US state or territory without a full-service VA facility.

Quality of Care

The OIG assessed timeliness of referral coordination and appointment wait times for routine outpatient referrals. Therefore, referrals for dental, inpatient, geriatrics and extended care, e-consults (chart reviews), prosthetics, administrative in nature activities, referrals for which the appointment was expected to occur more than 90 days from the referral date, emergency/urgent care, and laboratory work were excluded (see appendix F). Referrals that were not canceled or discontinued are referred to as effective referrals in this report.

Timeliness of Referral Coordination

The OIG examined direct and community care referrals for routine outpatient care written by system providers during fiscal year 2024. For referrals that were canceled or discontinued, the OIG analyzed the time VA took to cancel the referral and if an appointment should have been scheduled prior to the cancellation.

Timeliness of Referral's First Activation

The OIG evaluated timeliness of a referral's first activation guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies two business days for VA staff to complete any necessary pre-work steps and activate the direct and community care referrals, which changes the referral status from "pending" to "active."[15] Timeliness of a referral's first activation was calculated as the number of business days from the date the referral was written to the date the referral was first changed from a pending to an active status.

Timeliness of Appointment Setting

Timeliness of appointment setting was calculated as the number of days from the date the referral was written to the date the appointment was first set. The OIG excluded community care

[15] VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)," updated December 1, 2022; VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)," updated July 8, 2024.

referrals scheduled by the patient and referrals exempted from scheduling requirements, such as those for e-consults, inpatient consults, and clinical procedures.[16]

Additionally, the OIG assessed timeliness of appointment setting, which includes canceled referrals if an appointment should have been scheduled prior to the cancellation.

Timeliness of Referral Completion

The OIG calculated the number of days from the requested date to the date of completion to evaluate the timeliness of routine outpatient referrals. The requested date is the date the clinician, in collaboration with the veteran, determines is clinically indicated for care.

Appointment Wait Times

The OIG assessed appointment wait times for routine outpatient referrals. The OIG measured appointment wait time as the days from the requested date to the appointment date. The OIG included effective, routine, outpatient referrals that required an appointment, and excluded referrals that are exempt from scheduling requirements. The OIG also excluded community care referrals for which the associated appointment was self-scheduled by the patient.

Disqualified Community Care Providers

The OIG used the VA Human Resources Information System to identify potentially disqualified providers, based on removals utilizing combinations of nature of action code and legal authority code, from the enactment of the VA MISSION Act on June 6, 2018, through the end of fiscal year 2024. VHA clinical providers who had an adverse action, identified using a combination of nature of action codes and legal authority codes, taken against them related to the delivery of safe and appropriate health care are disqualified from providing community care to veterans, and thus should not have any paid community care claims during their disqualification period.[17] The OIG defined the disqualification period as beginning from the date of separation. For cases in which the adverse action was rescinded at a later date, the disqualification period was calculated from the separation date to the rescinded date of the adverse action.

Authorities

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews

[16] VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)," updated December 1, 2022; VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)," updated July 8, 2024.

[17] United States Government Accountability Office, "Veterans Community Care Program–Immediate Actions Needed to Ensure Health Providers Associated with Poor Quality Care Are Excluded," GAO-21-71, February 2021. Adverse actions include resignation or retirement in lieu of involuntary action; removal; termination during probation period; demotion; termination; indefinite suspension; and suspension.

available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

Inspection Results

Patient Enrollment Priority and Residency

Priority Groups

VA defines enrollment as "the acceptance of an eligible Veteran into the VA health care system and assignment to a Priority Group for the purpose of receiving the full medical benefits package as defined in 38 C.F.R. § 17.38." To manage the provision of care, VA assigns veterans to one of eight priority groups when applying for VA health care, which reflects veterans' level of service-connected disability and income. Veterans are placed in the highest priority group for which they qualify (see appendix B for priority group definitions).[18] Figure 1 describes the number and percent of patients in the patient population by priority group. During fiscal year 2024, over 46 percent of the patient population was in Priority Group 1, the highest priority group.

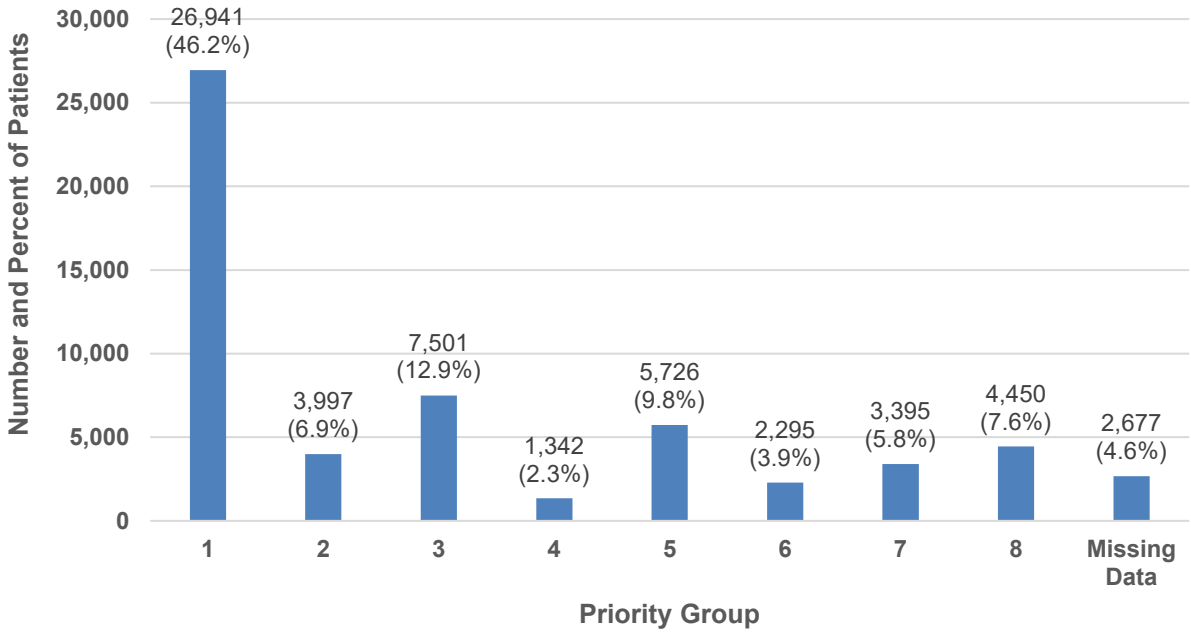

Figure 1. *Number and percent of patients by priority group.*
Source: OIG analysis of VA administrative data.

[18] VHA Directive 1601A.01(3), *Registration and Enrollment*, July 7, 2020, amended April 4, 2024.

States of Residence

The OIG identified the patient population of 58,324 veterans who received medical care from the system during fiscal year 2024. Almost 73 percent of the patient population were known to reside in Massachusetts (see figure 2), and 12 percent of the patient population were known to reside in a bordering state. Less than 15 percent of patients were known to live further away than an adjacent state.

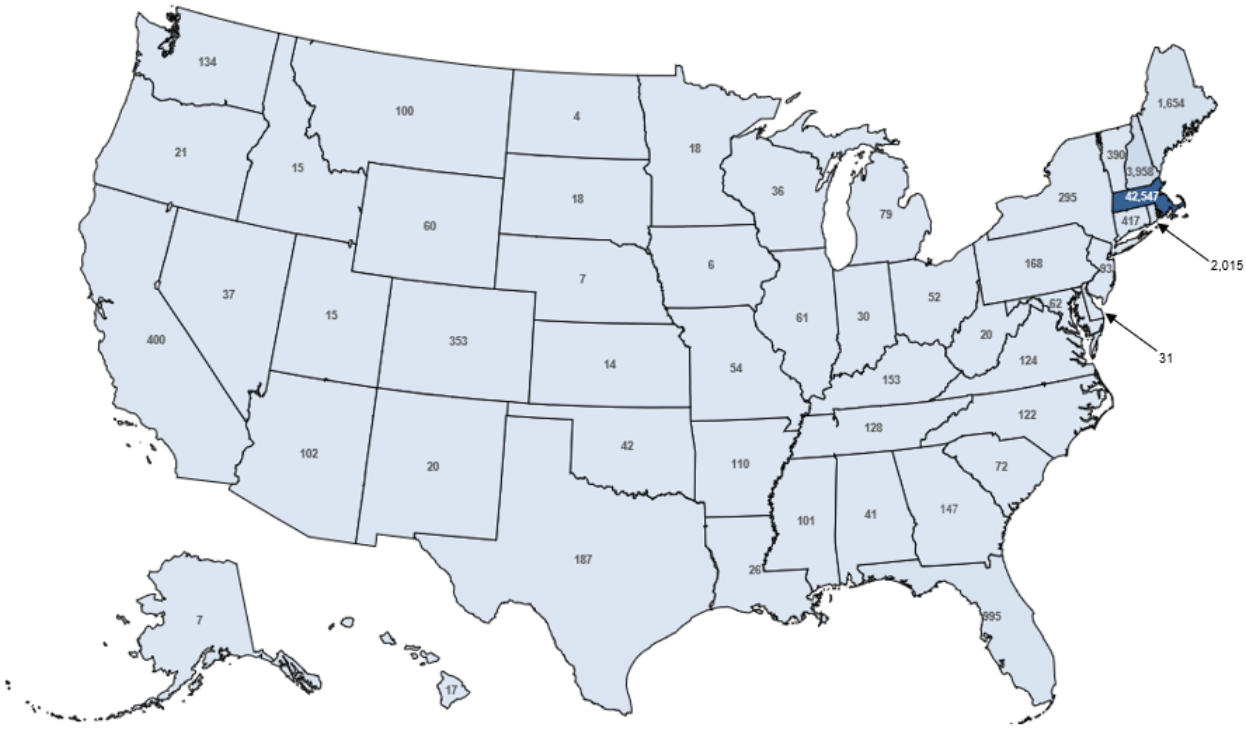

Figure 2. *States of residence for fiscal year 2024 system patients.*
Source: OIG analysis of VA administrative data.
Note: Figure data are limited to the 48 contiguous states, Alaska, and Hawaii.

Community Care Utilization

Outpatient

VA care includes both VA direct care (provided at a VA facility) and VA community care (paid by VA). The OIG determined the number of patients who utilized only VA direct care, only VA community care, or both VA direct care and VA community care for primary, mental health, emergency/urgent care, and specialty medical care in fiscal year 2024. All (100 percent) patients received primary care, and almost all (99.5 percent) patients received mental health care only through VA direct care.[19] Most patients (77.7 percent) who sought emergency/urgent care did so

[19] The percents presented here are based on the number of patients who sought the type of medical care stated.

through direct care. The OIG determined that approximately 97 percent of patients received specialty care services exclusively through VA direct care (see table 2).

These findings demonstrate that the system provided most primary, mental health, emergency/urgent, and specialty care through VA direct care. This is in contrast to those observed in the OIG's review of a system serving patients in a particularly rural area, where the rural system relied heavily on community care for emergency/urgent and specialty care services.[20]

Table 2. Patients Receiving Outpatient Care by Medical Care Type

Medical Care Type	Number (%) of Patients with ONLY VA Direct Care Visit-Days	Number (%) of Patients with ONLY Community Care Visit-Days	Number (%) of Patients with Both VA Direct Care and Community Care Visit-Days	Total Patients
Primary Care	**29,975 (100)**	**0 (0)**	**0 (0)**	**29,975**
Mental Health	**12,721 (99.5)**	**23 (0.2)**	**41 (0.3)**	**12,785**
Emergency/Urgent Care	**11,635 (77.7)**	**2,337 (15.6)**	**1,007 (6.7)**	**14,979**
All Specialties*	**47,386 (96.7)**	**57 (0.1)**	**1,561 (3.2)**	**49,004**
Cardiology	13,990 (99.6)	19 (0.1)	37 (0.3)	14,046
Dermatology	8,088 (99.8)	‡	11 (0.1)	8,104
Gynecology	644 (99.4)	‡	‡	648
Ophthalmology	5,803 (99.4)	16 (0.3)	20 (0.3)	5,839
Urology	4,829 (99.5)	13 (0.3)	10 (0.2)	4,852
Other specialties	43,234 (96.6)	67 (0.1)	1,450 (3.2)	44,751

Source: OIG analysis of VA administrative data.
Note: Table data reflect only visits for patients who could choose either the VA or community care and who had at least one visit by medical care type. Each row of table 2 is calculated independently. For example, there are 43,234 patients whose visits to other specialties (i.e., other than cardiology, dermatology, gynecology, ophthalmology, and urology) were only through VA direct care. If one of those patients also had a community care visit to a cardiologist, then that patient would not be included in the 13,990 patients whose visits to specialists were only through VA direct care, because the All Specialties row includes both cardiology and any specialty in Other specialties.
** Five selected specialties are disaggregated from All Specialties.*
‡ Less than 10 patients.

[20] VA OIG, *Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022*. Comparisons between the system and the Montana VA Healthcare System are limited due to the different time frames of the respective OIG reviews.

The OIG determined outpatient utilization for patients who could choose either the VA direct or community care based on visit-days.[21] VA direct care provided almost all care for patients who could choose either the VA or community care: 100 percent of primary care, 99 percent of mental health care, and 97.6 percent of specialty care services. In addition, VA direct care provided 81 percent of emergency/urgent care in fiscal year 2024 (see table 3).

Appendix C provides outpatient utilization data that includes visits for patients who could not readily choose between VA direct care and community care (see tables C.1–C.11).

Table 3. Outpatient Utilization by Direct and Community Care

Medical Care Type	VA Direct Care Visit-Days	Visit-Days by Medical Care Type (%)	Community Care Visit-Days	Visit-Days by Medical Care Type (%)
Primary Care	**106,177**	**100**	**0**	**0**
Mental Health	**107,214**	**99.0**	**1,095**	**1.0**
Emergency/Urgent Care	**26,366**	**81.1**	**6,140**	**18.9**
All Specialties*	**396,610**	**97.6**	**9,772**	**2.4**
Cardiology	34,612	99.4	213	0.6
Dermatology	14,026	99.0	136	1.0
Gynecology	1,331	99.3	10	0.7
Ophthalmology	16,207	99.3	122	0.7
Urology	9,512	99.2	73	0.8
Total	**636,367**	**97.4**	**17,007**	**2.6**

Source: OIG analysis of VA administrative data.
**Only five selected specialties are disaggregated from All Specialties, so they do not total to All Specialties.*

Top Five Primary Diagnoses for Outpatient Care

The OIG assessed the five most common primary outpatient diagnoses among VA direct care visits and community care visits by sex.[22] A diagnosis for a patient with an outpatient visit was counted once, regardless of the number of visits that patient may have had with that diagnosis.

[21] The OIG defines a visit-day as a day in which the patient received care in one of the listed medical care types. If a patient received care in multiple medical types on the same day, then the patient is counted as having a visit-day in each of the medical-type categories. While there are only 593,086 distinct patient visit-days, allowing for multiple medical types on the same calendar day means that there were 653,374 total patient visit-days.

[22] The International Classification of Diseases, 10th revision, (ICD-10) codes identify the diagnoses.

Male and female patients shared three of the top five primary outpatient diagnoses: essential (primary) hypertension, chronic post-traumatic stress disorder, and low back pain (see table 4).[23]

The OIG observed similar findings in its review of a system serving patients in a particularly rural area of the country that relied heavily on community care.[24] Male patients in both the urban and rural systems shared four of the top five diagnoses for outpatient care (essential hypertension, bilateral sensorineural hearing loss, type 2 diabetes, and low back pain). Female patients shared three of the top five diagnoses for outpatient care (chronic post-traumatic stress disorder, low back pain, and essential hypertension).

Table 4. Top Five Primary Diagnoses for Outpatient Care by Sex

Male			Female		
ICD10 Diagnosis (Code)	**Number of Patients**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients**	**Patients (%)**
Essential (primary) hypertension (I10)	6,723	13.2	Post-traumatic stress disorder, chronic (F43.12)	601	12.6
Post-traumatic stress disorder, chronic (F43.12)	4,010	7.9	Low back pain (M54.50)	433	9.1
Sensorineural hearing loss, bilateral (H90.3)	3,961	7.8	Post-traumatic stress disorder, unspecified (F43.10)	363	7.6
Type 2 diabetes mellitus, without complications (E11.9)	3,923	7.7	Obesity, unspecified (E66.9)	353	7.4
Low back pain (M54.50)	3,358	6.6	Essential (primary) hypertension (I10)	330	6.9

Source: OIG analysis of VA administrative data.

Further, the OIG determined the five most common primary diagnoses for outpatient care associated with patients who had at least one visit for primary care, mental health care, or emergency/urgent care during fiscal year 2024 (see appendix D, tables D.1–D.3).

Appendix E provides the OIG's determination of the five most common primary outpatient diagnoses from cardiology, dermatology, ophthalmology, gynecology, and urology visits. The OIG noted that patients seen through VA direct and community care for the selected specialties shared at least one of the top five primary diagnoses (see appendix E, tables E.1–E.5).

[23] For the purposes of this report, OIG considers the first ICD-10 code as the primary diagnosis.

[24] VA OIG, *Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022*.

Inpatient

According to VA, in fiscal year 2024, the system operated a total of 517 beds and offered inpatient domiciliary, community living center, medical, mental health, neurological, rehabilitation medicine, residential rehabilitation, spinal cord injury, and surgical services.[25] The OIG determined that community care accounted for 28 percent of the system inpatient bed-days in fiscal year 2024. Additionally, community care accounted for approximately 12 percent of the system's overall acute inpatient bed-days of care in fiscal year 2024. Community care provided 7 and 67 percent of system's inpatient bed-days utilization for hospice and nursing home care, respectively. VA direct care provided all domiciliary and spinal cord injury care, while VA community care covered all the system's residential care (see table 5).

There is a noteworthy difference when comparing the urban and rural systems' utilization of VA direct care and community care for inpatient services. Whereas the urban system discussed in this report utilized community care for approximately 12 percent of acute inpatient care, the rural system relied heavily on community care services for acute inpatient care (83 percent).

Table 5. Inpatient Utilization

Type of Inpatient Care	VA Direct Care Bed-Days	Community Care Bed-Days	Total Bed-Days Provided by Community Care (%)
Acute Inpatient Care	79,394	10,406	11.6
Non-Acute Care	47,690	39,947	45.6
Domiciliary	20,191	0	0
Hospice	3,625	268	6.9
Nursing Home	19,320	38,425	66.5
Residential Facility	0	1,254	100
Spinal Cord Injury	4,554	0	0
Total	**127,084**	**50,353**	**28.4**

Source: OIG analysis of VA administrative data.

[25] "Workload Profile Report," VHA Support Service Center (VSSC), accessed April 29, 2025, https://app.powerbigov.us/groups/me/apps/b8d12242-6dea-48c7-86c0-92de7a5e1710/rdlreports/44027efd-9f92-4baf-bcd9-2585b1a659e3?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (This website is not publicly accessible.) "Geriatrics and Extended Care," VA, accessed July 29, 2025, https://www.va.gov/GERIATRICS/pages/VA_Community_Living_Centers.asp. "A Community Living Center (CLC) is a VA Nursing Home."

The OIG did not observe noticeable differences in acute inpatient bed-days between VA direct and community care (see table 6). The median inpatient bed-days was four days for both VA direct care (ranged from 1 to 365 days) and community care (ranged from 1 to 299 days).

Table 6. Acute Inpatient Utilization

Measure	VA Direct Care (bed-days)	Community Care (bed-days)
Range (min-max)	1–365	1–299
Range of middle 50% (25–75% quartiles)	2–8	2–7
Median	4	4
Mean (standard deviation)	10.4 (28.6) days	6.3 (11.2) days

Source: OIG analysis of VA administrative data.
Note: There were 7,656 VA direct care acute inpatient stays and 1,661 community care acute inpatient stays.

Top Five Primary Diagnoses Responsible for Acute Inpatient Stays

The OIG determined the top five most common primary diagnoses responsible for acute inpatient stays at the system and community hospitals (see table 7). Hypertensive heart disease with heart failure (I11.0) and hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (I13.0) are the two diagnoses among the top five primary diagnoses responsible for acute inpatient stays in both VA direct care and community care.

Table 7. Top Five Diagnoses Among Acute Inpatient Stays

VA Direct Care*			Community Care†		
ICD10 Diagnosis (Code)	Number of Patients	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients	Patients (%)
Alcohol use, unspecified, uncomplicated (F10.90)	167	2.4	Sepsis, unspecified organism (A41.9)	99	6.3
Hypertensive heart disease with heart failure (I11.0)	133	1.9	Acute kidney failure, unspecified (N17.9)	42	2.7
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified	113	1.6	Pneumonia, unspecified organism (J18.9)	41	2.6

VA Direct Care*			Community Care†		
ICD10 Diagnosis (Code)	Number of Patients	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients	Patients (%)
chronic kidney disease (I13.0)					
Chronic obstructive pulmonary disease w (acute) exacerbation (J44.1)	106	1.5	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (I13.0)	38	2.4
COVID-19 (U07.1)	100	1.4	Hypertensive heart disease with heart failure (I11.0)	37	2.3

Source: OIG analysis of VA administrative data.

**In fiscal year 2024, 6,942 patients had an acute inpatient stay at the system.*

†In fiscal year 2024, 1,581 patients had an acute inpatient stay at a community hospital.

Reasons for Utilizing Community Care

Approximately 7 percent of the 49,622 patients in the patient population with a Massachusetts or bordering state (Rhode Island, Connecticut, New Hampshire, New York, and Vermont) address live in rural or highly rural areas.

With the passage of the VA MISSION Act, the two designated access standards for obtaining care in the community are average drive times and appointment wait times:[26]

- Average drive time
    - "30-minute average drive time for primary care, mental health, and noninstitutional extended care services"
    - "60-minute average drive time for specialty care"
- Appointment wait time
    - "20 days for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with their VA healthcare provider"

[26] VHA Office of Community Care, "Veteran Community Care Eligibility."

- "28 days for specialty care from the date of request, unless the veteran agrees to a later date in consultation with a VA healthcare provider"

Tables 8 and 9 present the number of patients with geocoded residential addresses in Massachusetts or bordering states by rurality whose drive time to the nearest VA site for primary and secondary care exceeds the 30-minute and 60-minute community care eligibility thresholds for primary and specialty care, respectively.[27] Secondary care sites provide specialty care. Since a high percentage of the patient population lives in urban areas, a low percentage of the population meets VA MISSION Act eligibility for community care based on drive-time thresholds alone. This is notably different from the findings in OIG's first review of the Montana VA Healthcare System where 92 percent of primary care patients living in highly rural areas and 71 percent and 88 percent of secondary care patients living in rural and highly rural areas, respectively, were eligible for community care based on drive time alone.[28]

Table 8. Patient Drive Time to VA Primary Care Facility by Rurality

Rurality	Total Number of Patients	Median Drive Time (minutes)	Patients Exceeding Drive Time Threshold (%)
Urban	46,219	16	3.3
Rural	2,911	25	30.9
Highly Rural	492	36	64.2

Source: OIG analysis of VA administrative data.

Table 9. Patient Drive Time to VA Secondary Care Facility by Rurality

Rurality	Total Number of Patients	Median Drive Time (minutes)	Patients Exceeding Drive Time Threshold (%)
Urban	46,219	23	1.5
Rural	2,911	37	13.3
Highly Rural	492	61	50.2

Source: OIG analysis of VA administrative data.
Note: The median drive times presented are those to VA secondary care facilities that provide specialty care.

The OIG examined the documented reason for community care referrals, including referrals that were subsequently canceled or discontinued. A referral can include multiple documented reasons for utilizing community care. Table 10 shows that VA providers made over half of the community care routine outpatient referrals due to patients' associated drive time. The OIG

[27] The VA's Geospatial Service Support Center provides the driving distance and drive time data based on patient addresses.

[28] VA OIG, *Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the Montana VA Healthcare System in Fort Harrison, Fiscal Year 2022*.

noted that the use of the "No Full-Service" reason is reserved for veterans who live in a US state or territory without a full-service VA medical center, which does not apply to the state of Massachusetts. However, patients who reside in New Hampshire but use the Boston Healthcare System will be eligible for community care because New Hampshire does not have a full-service VA medical center. About 3 percent of requested referrals did not give a reason for community care.

Table 10. Reasons for Using Community Care for Outpatient Referrals

Reason	Number of Referrals	Referrals (%)
All Consults	4,188	100
Drive time	2,255	53.8
Grandfathered*	3	0.07
Service not available	334	8.0
Wait time	543	13.0
Best medical interest	773	18.5
No full-service	232	5.5
Not reported	129	3.1

Source: OIG analysis of VA administrative data.
**Veterans are considered grandfathered if they were eligible under the 40-mile criterion under the Veterans Choice Program and continue to reside in a location that would qualify them under this criterion.*

The OIG also examined the documented reasons for effective referrals for community care placed in fiscal year 2024. As noted above, effective referrals are referrals that were not canceled or discontinued. About 61 percent of effective referrals documented "drive time" as the reason for placing the referral (see table 11).

Despite the urban system discussed in this report having far fewer effective consults entered in fiscal year 2024 (2,864) than the rural system in fiscal year 2022 (67,180), providers at both systems made most of the community care routine outpatient referrals due to patients' associated drive time.

Table 11. Reasons for Using Community Care for Effective Outpatient Referrals

Reason	Number of Effective Referrals*	Effective Referrals (%)
Effective Consults (N)	2,864	100
Drive time	1,754	61.2
Grandfathered‡	0	0
Service not available	47	1.6
Wait time	398	13.9
Best medical interest	554	19.3
No full-service	153	5.3
Not reported	26	0.9

Source: OIG analysis of VA administrative data.
**Effective referrals exclude canceled and discontinued referrals.*
‡Veterans are considered grandfathered if they were eligible under the 40-mile criterion under the Veterans Choice Program and continue to reside in a location that would qualify them under this criterion.

Quality of Care

The Institute of Medicine has provided six objectives to address the delivery of improved quality of care, one of which being that it is provided "*timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care."[29] The OIG assessed whether the system (1) coordinated the referral processes in a timely manner, (2) met timeliness goals for providing direct and community care, and (3) used ineligible community care providers for community care services.

Timeliness of Referral Coordination

The referral process both for VA direct and community care begins when a VA provider writes a referral for a patient. VA staff then review the referral and receive it for further action if appropriate, including for community care.

The next step in the referral process is scheduling the appointment.

[29] Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*, (National Academies Press, 2001).

Timeliness of referral coordination is essential to avoid extended wait times for patients to receive appointments.[30] The OIG measured timeliness of referral coordination for both direct and community care referrals that were not later canceled or discontinued as the following:

- The number of business days elapsed from the date the referral was written to the date the referral was first changed from a pending to active status (timeliness of referral's first activation).
- The number of days elapsed from the referral being written to the setting of the appointment (timeliness of appointment setting).
- The number of days elapsed from the requested date through the date of completion (timeliness of referral completion).

Timeliness of Referral's First Activation

The OIG assessed the timeliness of a referral's first activation guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies two business days for VA staff to complete any necessary pre-work steps and activate the direct and community care referrals.

The OIG found that VA staff activated approximately 83 and 84 percent of non-excluded direct and community care referrals, respectively, within two business days, indicating potential opportunities to improve the timeliness of referral receipt for both types of referrals (see figure 3).

[30] VHA Office of Integrated Veteran Care (IVC) Community Care, "Consult Completion and Medical Records Management Metrics," chap. 4 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook,* updated July 30, 2024. https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000226164/FGB-Chapter-4-050408-How-to-Evaluate-Referral-Management-Timeliness%3FarticleViewContext=article_view_related_article.(This site is not publicly accessible.)

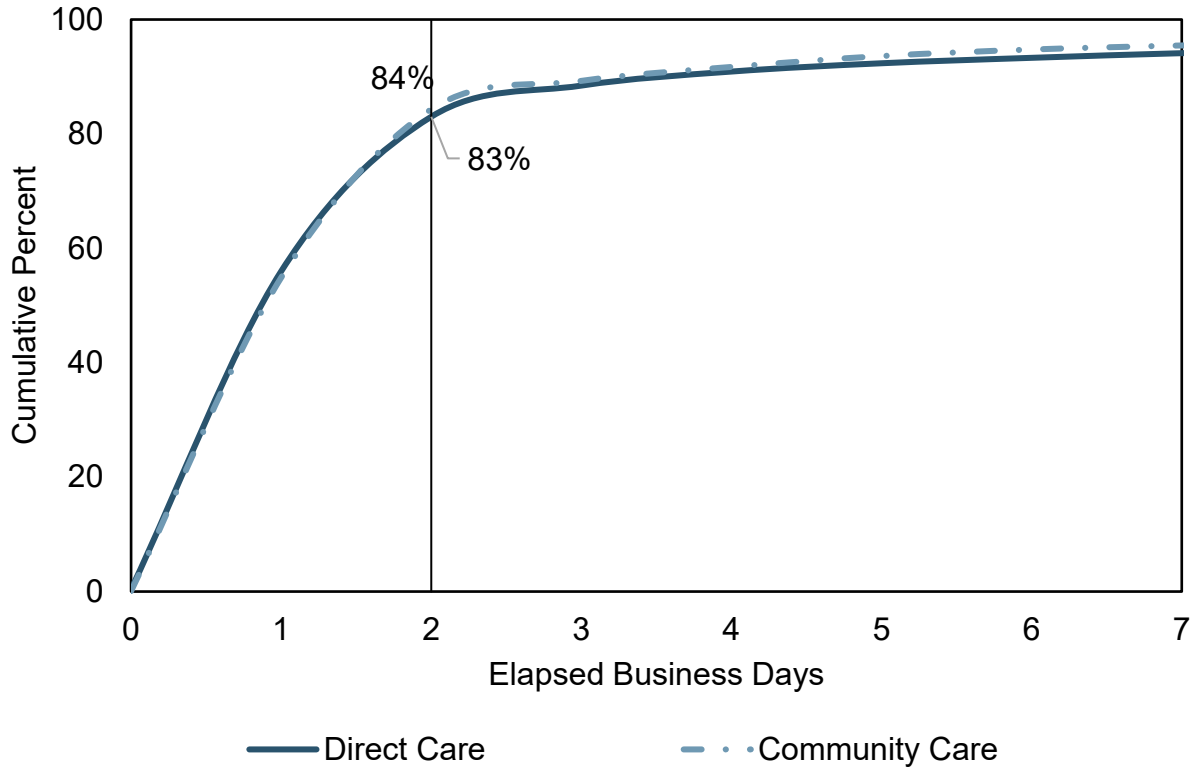

Figure 3. *Percentage of activated referrals by elapsed business days.*
Source: OIG analysis of VA administrative data.

Timeliness of Appointment Setting

The OIG assessed the timeliness of appointment setting guided by standards outlined in the *Consult Timeliness Standard Operating Procedure*, which specifies:[31]

- Three business days to set an appointment to occur at a VA facility; and
- Seven calendar days to set a community care appointment.

Figure 4 shows the distribution of days to appointment setting from the day the referral was written. The OIG found that within 3 business days, VA staff completed appointment setting for approximately 55 percent of effective VA direct care referrals. Within seven days of the referral written date, VA staff completed approximately 53 percent of appointment setting for community care referrals, indicating that appointments were often not set within the timelines outlined in the standard operating procedure.

[31] VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)," updated December 1, 2022.

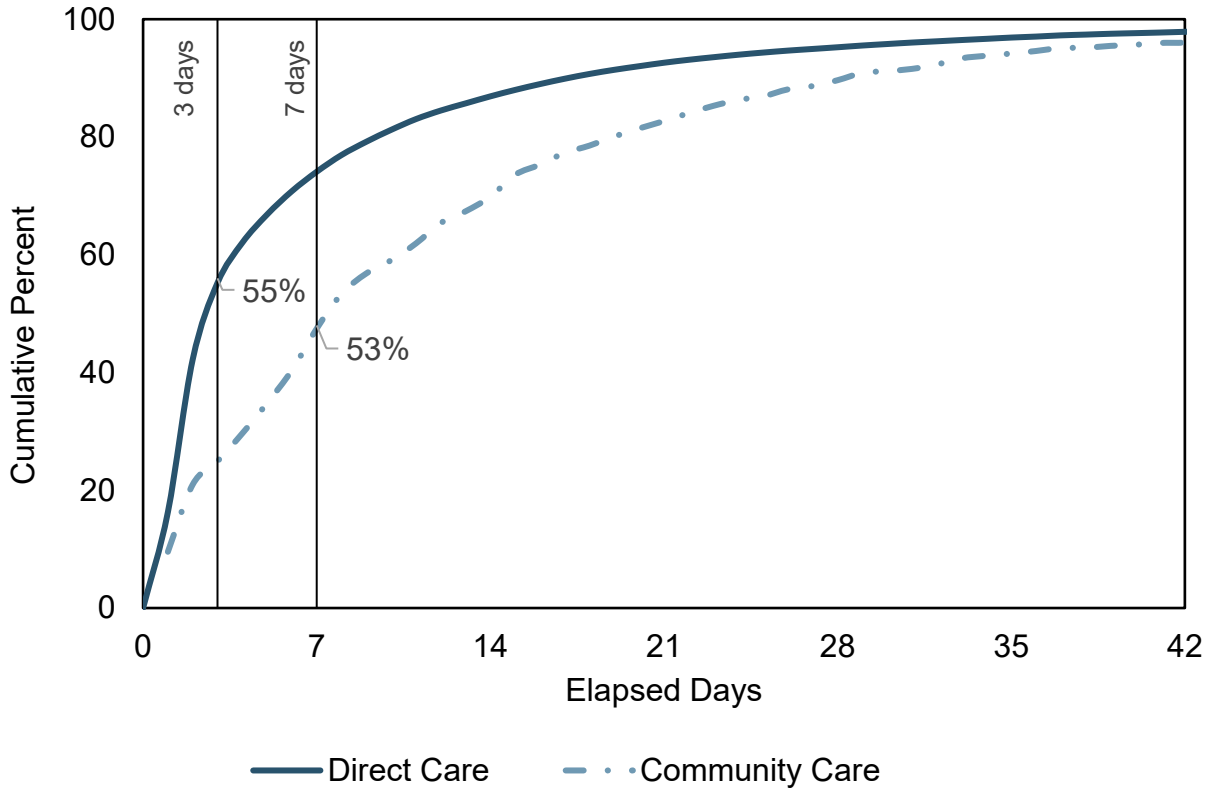

Figure 4. *Percentage of effective referrals having appointments set by elapsed days. Direct care referrals expressed in business days; community care expressed in calendar days.*
Source: OIG analysis of VA administrative data.

The OIG found that VA staff canceled 28 percent of VA direct care referrals and 65 percent of community care referrals before the specified time frame to set the appointments. Of those that were canceled after the required time frame to set the appointment, one out of five (20 percent of VA direct care referrals and 21 percent of community care referrals) had appointments set within the established timeline of three business days or seven calendar days, respectively.

The OIG recommends an assessment of the timeliness of appointment setting for direct and community care referrals to ensure facility staff establish appointments within required time frames.

Timeliness of Referral Completion

When assessing the timeliness of referral completion, the standards outlined in the *Consult Timeliness Standard Operating Procedure* guided the OIG's analysis.[32] Those guidelines give 90 days from the requested date to complete both direct and community care referrals.

After excluding canceled referrals and discontinued referrals 111,852 VA direct care and 2,864 community care referrals remained. The OIG found that VA staff completed over 90 percent (approximately 94 and 93 percent of VA direct and community care referrals, respectively), within 90 days of the requested date.

Completed Referrals Without Documentation of an Appointment Being Set

While reviewing referral completion, the OIG noticed that some completed VA direct care referrals did not document the scheduled status on the referral, despite the appointment being set. The OIG further analyzed referrals for specialty care that generally require appointments to be set prior to the visit, such as for ophthalmology. However, the OIG noticed that the date the appointment was set was not documented on the referral. Based on the OIG's limited review of the specialty referrals, it appeared the referrals were initiated by specialty providers after patients presented for subsequent care.

The OIG recommends the System Director reviews consult management practices and ensures the proper use of consults for VA direct care referrals.

Appointment Wait Time

The OIG classified referrals into the following categories: mental health and specialty care. The wait-time standards outlined by the Veterans Community Care Program for timeliness are[33]

- VA cannot schedule an appointment within 20 days of the referral request date for primary care, mental health care, and noninstitutional extended care services, unless the veteran agrees to a later date in consultation with a VA healthcare provider; and
- VA cannot schedule an appointment within 28 days of the referral request date for specialty care, unless the veteran agrees to a later date in consultation with a VA healthcare provider.

The OIG determined the number of days patients waited for an appointment after the requested date for routine outpatient community care referrals. The OIG found that less than 3 percent of referrals were for mental health in fiscal year 2024. Approximately 51 and 66 percent of mental

[32] VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)" updated December 1, 2022; VHA Office of Integrated Veteran Care (IVC), "Consult Timeliness Standard Operating Procedure (SOP)" updated July,8, 2024.

[33] Veterans Community Care Program, 38 C.F.R. § 17.4040 (2024).

health appointments were within 20 days of the requested date for VA direct care and community care, respectively. The OIG found that approximately 97 percent of all community care referrals were for specialty care. Approximately 68 and 61 percent of specialty care appointments were within 28 days of the requested date for VA direct care and community care, respectively (see figure 5)

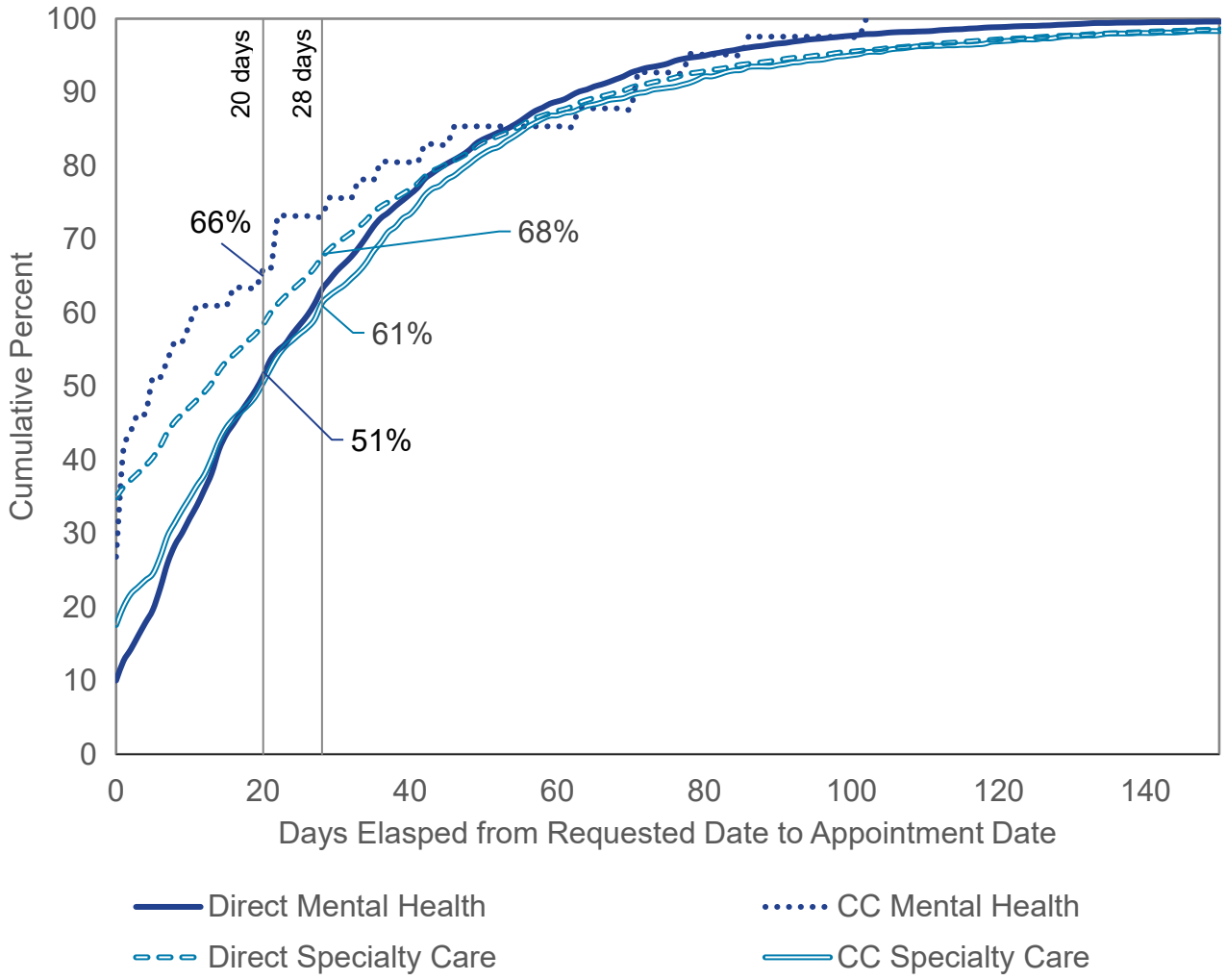

Figure 5. *Distribution of direct and community care wait times for mental health and specialty care referrals. Source: OIG analysis of VA administrative data.*

The OIG recommends that the System Director reviews appointment wait times and acts on identified opportunities for improvement.

Disqualified Community Care Providers

The OIG assessed whether providers who were removed from VA employment potentially due to conduct that violated VA policy related to the delivery of safe and appropriate health care furnished community care through the system in fiscal year 2024. The OIG used the VA Human

Resources Information System to identify potentially disqualified providers, based on removals utilizing combinations of nature of action code and legal authority code, from the enactment of the VA MISSION Act on June 6, 2018, through the end of fiscal year 2024. The OIG then determined whether the system had paid community care claims in fiscal year 2024 for services provided by the identified, potentially disqualified, providers.

The OIG did not find any paid community care claims for services provided by potentially disqualified providers.

Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, where patients may qualify for community care based solely on where they live. In the system, that amounted to approximately 7 percent of the 49,622 patients in the patient population with a Massachusetts or bordering state address living in rural or highly rural areas. Since 93 percent of the patient population lives in urban areas, the system did not rely heavily upon community care as found in OIG's initial review of the Montana VA Healthcare System. In particular, the OIG noticed the system performed equally well with both VA community and direct care in terms of timeliness of referral completion. However, the OIG's review identified opportunities for improvement.

The OIG made three recommendations. In response to the recommendations, the System Director reported enhancing reporting of metrics related to scheduling, completed appointments, wait times, and facility access and identifying opportunities to improve and refine practices. The System Director concurred in principle with one recommendation and committed to educating staff on consult documentation practices (see appendixes G and H).

Recommendations 1–3

1. The VA Boston Healthcare System Director assesses the timeliness of appointment setting for VA direct and community care referrals and ensures facility staff establish appointments within required time frames.
2. The VA Boston Healthcare System Director reviews consult management practices and ensures the proper use of consults for VA direct care referrals.
3. The VA Boston Healthcare System Director reviews appointment wait times and acts on identified opportunities for improvement.

Appendix A: VA Boston Healthcare System Profile

The table below provides general background information for this high complexity (Level 1a) VA healthcare system reporting to VISN 1.[34] To return to the narrative, press and hold the "alt" and "left arrow" keys together.

Table A.1. Profile for VA Boston Healthcare System (523) (October 1, 2021, through September 30, 2024)

Profile Element	Fiscal Year 2022*	Fiscal Year 2023‡	Fiscal Year 2024§
Total medical care budget	$1,072,710,284	$1,216,749,736	$1,298,447,701
Number of:			
• Unique patients	61,529	60,173	64,384
• Outpatient visits	733,029	722,757	770,184
Type and number of operating beds:			
• Community living center	80	80	77
• Compensated Work Therapy/ Transitional Residence	33	33	33
• Domiciliary	98	98	98
• Hospital	328	316	309
Average daily census:			
• Community living center	67	69	61
• Compensated Work Therapy/ Transitional Residence	15	20	18
• Domiciliary	33	39	38
• Hospital	230	241	225

Source: VA Support Service Center.
**October 1, 2021, through September 30, 2022.*
‡October 1, 2022, through September 30, 2023.
§October 1, 2023, through September 30, 2024.

[34] VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," accessed July 24, 2024, https://dvagov.sharepoint.com/sites/VHAOPES/SitePages/Facility-Complexity-Model-and-Patient-Level-Risk-Adjustment-Models.aspx. (This website is not publicly accessible.) VHA medical centers are classified according to a facility complexity model; a designation of "1a" indicates a facility with "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs."

Appendix B: Priority Group Definitions

Table B.1. Priority Group Definitions

Priority Group	Definition
1	(1) Veterans with a combined rating of 50 percent or greater based on one or more service-connected (SC) disabilities. (2) Veterans determined by VA to be unemployable due to SC conditions. (3) Veterans who have been awarded the Medal of Honor.
2	Veterans with a combined rating of 30 percent or 40 percent based on one or more service-connected disabilities.
3	(1) Veterans who are former prisoners of war. (2) Veterans awarded the Purple Heart medal. (3) Veterans awarded a combined rating of 10 percent or 20 percent based on one or more service-connected disabilities. (4) Veterans who were discharged or released from active military, naval, air, or space service for a disability incurred or aggravated in the line of duty. (5) Veterans who receive disability compensation under 38 U.S.C. § 1151, which provides benefits for individuals disabled by treatment or vocational rehabilitation. (6) Veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay. (7) Veterans receiving compensation at the 10 percent rating level based on multiple non-compensable service-connected disabilities that clearly interfere with normal employability.
4	(1) Veterans who receive aid and attendance or housebound pension benefits from VA. (2) Veterans who are determined to be Catastrophically Disabled (CD) by the Chief of Staff (or equivalent clinical official) at the VA medical facility where they were examined, unless the Veteran qualifies for placement in a higher Priority Group.
5	(1) Nonservice-connected Veterans and non-compensable 0 percent service-connected Veterans with annual income below the MT [VA Means Test] and GMT [Geographic Means Test] thresholds. (2) Veterans who receive VA pension benefits. (3) Veterans who are eligible for Medicaid programs.

Priority Group	Definition
6	(1) Toxic-exposed Veterans under 38 U.S.C. § 1710(e)(1): (a) Vietnam-era herbicide-exposed Veterans. (b) Radiation-exposed Veterans. (c) Veterans in Southwest Asia during the Persian Gulf War. (d) Combat Veterans who served in a theater of combat operations after the Persian Gulf War and those Veterans who served in combat against a hostile force during a period of hostilities after November 11, 1998. **NOTE:** *After their enhanced eligibility period and enrollment in Priority Group 6 ends, combat Veterans will remain enrolled and placed into Priority Group 8, unless they are otherwise eligible for a higher priority group.* (e) Project 112/SHAD Veterans. (f) Camp Lejeune Veterans. (g) Toxic-exposure risk activity Veterans. (h) "Covered Veterans" under 38 U.S.C. § 1119(c). (i) Veterans who deployed in support of a named contingency operation (Operation Enduring Freedom, Operation Freedom's Sentinel, Operation Iraqi Freedom, Operation New Dawn, Operation Inherent Resolve, and Resolute Support Mission). (2) World War II (WWII) Veterans. NOTE: Guidance on determining WWII eligibility, can be found at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001046/content/554400000223534/VAMC-Enroll-Elig-VES-Cleland-Dole-Act-Add-a-Person-AAP-JA. *This is an internal VA website that is not available to the public.* (3) Veterans with a compensable zero percent service-connected disability rating(s). **NOTE:** All Veterans in Priority Group 6 may be charged copayments for care received to treat illnesses and medical conditions not related to their military service. Additional information on special eligibility factors can be found at: https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001046/content/554400000136015/VAMC-Enroll-Elig-VES-Special-Eligibility-Factors-Review-and-Updates-JA?query=special%20eligibilities. *This is an internal VA Web site that is not available to the public.*
7	Veterans who agree to pay the VA the applicable copayment (under 38 U.S.C. § 1710(f) and (g)) if their income (including income of their spouse and dependents) for the previous year constitutes low income under the geographical income limits established by HUD [Housing and Urban Development] for the fiscal year that ended on September 30th, of the previous calendar year. To avoid hardship to a Veteran, VA may use the projected income for the current year of the Veteran, spouse, and dependent children if their projected income is below the low-income limit referenced in 38 C.F.R. § 17.36(b)(7).
8	Veterans with gross household income above the MT threshold and GMT income threshold who agree to pay the applicable copayments under 38 U.S.C. §§ 1719(f) and 1710(g).

Source: Reproduced from VHA Directive 1601A.01(3), Registration and Enrollment, July 7, 2020 (amended April 4, 2024).

Appendix C: All Outpatient Visits–Direct and Community Care

In the main body of this report, the reported outpatient visit data exclude visits for which the patient could not readily choose between VA direct care and community care. Appendix C tables provide outpatient utilization data that includes visits for patients who could not readily choose between VA direct care and community care. This is a broader measure of the clinical visits provided by the system. The results are similar to those in the body of the report.

Table C.1. Patients with an Outpatient Visit-Day by Medical Care Type

Medical Care Type	Number (%) of Patients with Only VA Direct Care Visit-Days	Number (%) of Patients with Only Community Care Visit-Days	Number (%) of Patients with Both VA Direct and Community Care Visit-Days	Total Patients
Primary Care	**30,568 (100)**	**0 (0)**	**0 (0)**	**30,568**
Mental Health	**13,493 (99.5)**	**21 (0.2)**	**43 (0.3)**	**13,557**
Emergency/Urgent Care	**11,635 (77.7)**	**2,336 (15.6)**	**1,008 (6.7)**	**14,979**
All Specialties*	**47,794 (96.4)**	**54 (0.1)**	**1,748 (3.5)**	**49,596**
Cardiology	13,990 (99.6)	19 (0.1)	37 (0.3)	14,046
Dermatology	8,088 (99.8)	‡	11 (0.1)	8,104
Gynecology	644 (99.4)	‡	‡	648
Ophthalmology	5,803 (99.4)	16 (0.3)	20 (0.3)	5,839
Urology	4,816 (99.1)	20 (0.4)	23 (0.5)	4,859
Other specialties	43,703 (96.3)	67 (0.1)	1,617 (3.6)	45,387

Source: OIG analysis of VA administrative data for fiscal year 2024.
Note: Each row of table C.1 is calculated independently, so comparisons across rows must be done carefully. For example, there are 43,703 patients whose visits to other specialties (i.e., other than cardiology, dermatology, gynecology, ophthalmology, and urology) were only through VA direct care. If one of those patients also had a community care visit to a cardiologist, then that patient would not be included in the 13,990 patients whose visits to specialists were only through VA direct care, because the All Specialties row includes both cardiology and any specialty in Other specialties.
**This is the number of patients whose only visits to specialists were through VA direct care, the number of patients whose only visits to specialists were to community care specialists, and the number of patients who had a visit to both a VA direct care and a community care specialist in fiscal year 2024.*
‡Less than 10 patients.

Table C.2. Outpatient Utilization by Medical Care Type

Medical Care Type	VA Direct Care Visit-Days	Percent of Visit-Days by Medical Care Type	Community Care Visit-Days	Percent of Visit-Days by Medical Care Type
Primary Care	**117,352**	**100**	**0**	**0**
Mental Health	**109,612**	**99.0**	**1,095**	**1.0**
Emergency/Urgent Care	**26,367**	**81.1**	**6,140**	**18.9**
All Specialties*	**407,029**	**96.9**	**12,893**	**3.1**
Cardiology	34,612	99.4	213	0.6
Dermatology	14,026	99.0	136	1.0
Gynecology	1,331	99.3	10	0.7
Ophthalmology	16,207	99.2	123	0.8
Urology	9,512	92.9	727	7.1
Total	**660,360**	**97.0**	**20,128**	**3.0**

Source: OIG analysis of VA administrative data for fiscal year 2024.

**Only five selected specialties are disaggregated from All Specialties, so they do not total to All Specialties.*

Table C.3. Outpatient Utilization by Medical Care Type–Overall Visit-Days

Medical Care Type	VA Direct Care Visit-Days	Overall Visit-Days (%)	Community Care Visit-Days	Overall Visit-Days (%)
Primary Care	**117,352**	**17.2**	**0**	**0**
Mental Health	**109,612**	**16.1**	**1,095**	**0.2**
Emergency/Urgent Care	**26,367**	**3.9**	**6,140**	**0.9**
All Specialties*	**407,029**	**59.8**	**12,893**	**1.9**
Cardiology	34,612	5.1	213	0
Dermatology	14,026	2.1	136	0
Gynecology	1,331	0.2	10	0
Ophthalmology	16,207	2.4	123	0
Urology	9,512	1.4	727	0.1
Total	**660,360**	**97.0**	**20,128**	**3.0**

Source: OIG analysis of VA administrative data for fiscal year 2024.

**Only five selected specialties are disaggregated from All Specialties, so they do not total to All Specialties.*

Table C.4. Top Five Primary Diagnoses for Primary Care Outpatient Visits

VA Direct and Community Care			VA Direct Care		
ICD10 Diagnosis (Code)	**Number of Patients (30,568)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (30,568)**	**Patients (%)**
Essential (primary) hypertension (I10)	6,093	19.9	Essential (primary) hypertension (I10)	6,093	19.9
Type 2 diabetes mellitus without complications (E11.9)	2,457	8.0	Type 2 diabetes mellitus without complications (E11.9)	2,457	8.0
Hyperlipidemia, unspecified (E78.5)	1,780	5.8	Hyperlipidemia, unspecified (E78.5)	1,780	5.8
Low back pain (M54.50)	1,241	4.1	Low back pain (M54.50)	1,241	4.1
Tinea unguium (B35.1)	1,093	3.6	Tinea unguium (B35.1)	1,093	3.6

Source: OIG analysis of VA administrative data for fiscal year 2024.

Table C.5. Top Five Primary Diagnoses for Mental Health Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (13,557)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (13,536)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (64)	Patients (%)
Post-traumatic stress disorder, chronic (F43.12)	4,263	31.4	Post-traumatic stress disorder, chronic (F43.12)	4,254	31.4	Post-traumatic stress disorder, unspecified (F43.10)	12	18.8
Post-traumatic stress disorder, unspecified (F43.10)	2,277	16.8	Post-traumatic stress disorder, unspecified (F43.10)	2,265	16.7	Opioid dependence, uncomplicated (F11.20)	10	15.6
Anxiety disorder, unspecified (F41.9)	1,439	10.6	Anxiety disorder, unspecified (F41.9)	1,436	10.6	Post-traumatic stress disorder, chronic (F43.12)	‡	14.1
Major depressive disorder, single episode, unspecified (F32.A)	1,084	8.0	Major depressive disorder, single episode, unspecified (F32.A)	1,083	8.0	Generalized anxiety disorder (F41.1)	‡	10.9
Major depressive disorder, recurrent, moderate (F33.1)	865	6.4	Major depressive disorder, recurrent, moderate (F33.1)	860	6.4	Adjustment disorder with mixed anxiety and depressed mood (F43.23)	‡	9.4

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Table C.6. Top Five Primary Diagnoses for Emergency/Urgent Care Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (14,979)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (12,643)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (3,344)	Patients (%)
Covid-19 (U07.1)	792	5.3	Covid-19 (U07.1)	696	5.5	Chest pain, unspecified (R07.9)	297	8.9
Low back pain, unspecified (M54.50)	693	4.6	Low back pain, unspecified (M54.50)	628	5.0	Shortness of breath (R06.02)	237	7.1
Chest pain, unspecified (R07.9)	644	4.3	Acute upper respiratory infection, unspecified (J06.9)	587	4.6	Altered mental status, unspecified (R41.82)	184	5.5
Acute upper respiratory infection, unspecified (J06.9)	613	4.1	Acute bronchitis, unspecified (J20.9)	397	3.1	Unspecified injury of head, initial encounter (S09.90XA)	163	4.9
Cough, unspecified (R05.9)	444	3.0	Urinary tract infection, site not specified (N39.0)	381	3.0	Other chest pain (R07.89)	138	4.1

Source: OIG analysis of VA administrative data for fiscal year 2024.

Table C.7. Top Five Primary Diagnoses for Cardiology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (14,046)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (14,027)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (56)	Patients (%)
Abnormal electrocardiogram [ECG] [EKG] (R94.31)	2,759	19.6	Abnormal electrocardiogram [ECG] [EKG] (R94.31)	2,757	19.7	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	11	19.6
Bradycardia, unspecified (R00.1)	2,187	15.6	Bradycardia, unspecified (R00.1)	2,184	15.6	Cardiomyopathy, unspecified (I42.9)	‡	8.9
Unspecified atrial fibrillation (I48.91)	1,305	9.3	Unspecified atrial fibrillation (I48.91)	1,303	9.3	Heart failure, unspecified (I50.9)	‡	7.1
Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,137	8.1	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,126	8.0	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris (I25.118)	‡	5.4
Essential (primary) hypertension (I10)	996	7.1	Essential (primary) hypertension (I10)	993	7.1	Bradycardia, unspecified (R00.1)	‡	5.4

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡*Less than 10 patients.*

Table C.8. Top Five Primary Diagnoses for Dermatology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (8,104)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (8,099)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (16)	Patients (%)
Actinic keratosis (L57.0)	2,055	25.4	Actinic keratosis (L57.0)	2,053	25.3	Actinic keratosis (L57.0)	‡	12.5
Neoplasm of uncertain behavior of skin (D48.5)	922	11.4	Neoplasm of uncertain behavior of skin (D48.5)	921	11.4	Body dysmorphic disorder (F45.22)	‡	12.5
Other seborrheic keratosis (L82.1)	860	10.6	Other seborrheic keratosis (L82.1)	859	10.6	Other specified dermatitis (L30.8)	‡	12.5
Dermatitis, unspecified (L30.9)	298	3.7	Dermatitis, unspecified (L30.9)	297	3.7	Psoriasis vulgaris (L40.0)	‡	12.5
Nevus, non-neoplastic (I78.1)	244	3.0	Nevus, non-neoplastic (I78.1)	244	3.0	Squamous cell carcinoma of skin of scalp and neck (C44.42)	‡	12.5

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡*Less than 10 patients.*

Table C.9. Top Five Primary Diagnoses for Gynecology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (648)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (645)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (4)	Patients (%)
Abnormal uterine and vaginal bleeding, unspecified (N93.9)	91	14.0	Abnormal uterine and vaginal bleeding, unspecified (N93.9)	91	14.1	Female infertility, unspecified (N97.9)	‡	75.0
Leiomyoma of uterus, unspecified (D25.9)	44	6.8	Leiomyoma of uterus, unspecified (D25.9)	44	6.8	Female infertility of other origin (N97.8)	‡	50.0
Other specified abnormal uterine and vaginal bleeding (N93.8)	41	6.3	Other specified abnormal uterine and vaginal bleeding (N93.8)	41	6.4	Hemorrhage, not elsewhere classified (R58)	‡	25.0
Female infertility, unspecified (N97.9)	21	3.2	Female infertility, unspecified (N97.9)	18	2.8			
Endometriosis, unspecified (N80.9)	14	2.2	Endometriosis, unspecified (N80.9)	14	2.2			

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Table C.10. Top Five Primary Diagnoses for Ophthalmology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (5,839)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (5,823)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (36)	Patients (%)
Unspecified retinal disorder (H35.9)	904	15.5	Unspecified retinal disorder (H35.9)	904	15.5	Combined forms of age-related cataract, left eye (H25.812)	‡	13.9
Unspecified glaucoma (H40.9)	798	13.7	Unspecified glaucoma (H40.9)	797	13.7	Combined forms of age-related cataract, bilateral (H25.813)	‡	8.3
Unspecified cataract (H26.9)	372	6.4	Unspecified cataract (H26.9)	371	6.4	Combined forms of age-related cataract, right eye (H25.811)	‡	8.3
Combined forms of age-related cataract, bilateral (H25.813)	269	4.6	Combined forms of age-related cataract, bilateral (H25.813)	266	4.6	Age-related nuclear cataract, left eye (H25.12)	‡	5.6
Age-related nuclear cataract, bilateral (H25.13)	239	4.1	Age-related nuclear cataract, bilateral (H25.13)	239	4.1	Dry eye syndrome of bilateral lacrimal glands (H04.123)	‡	5.6

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Table C.11. Top Five Primary Diagnoses for Urology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (4,859)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (4,839)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (43)	Patients (%)
Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	838	17.3	Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	837	17.3	Quadriplegia, unspecified (G82.50)	11	25.6
Elevated prostate specific antigen [PSA] (R97.20)	403	8.3	Elevated prostate specific antigen [PSA] (R97.20)	403	8.3	Malignant neoplasm of prostate (C61)	10	23.3
Malignant neoplasm of prostate (C61)	337	6.9	Malignant neoplasm of prostate (C61)	327	6.8	Calculus of kidney (N20.0)	‡	7.0
Other retention of urine (R33.8)	323	6.6	Other retention of urine (R33.8)	322	6.7	Paraplegia, unspecified (G82.20)	‡	7.0
Male erectile dysfunction, unspecified (N52.9)	297	6.1	Male erectile dysfunction, unspecified (N52.9)	297	6.1	Calculus of ureter (N20.1)	‡	4.7

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Appendix D: Top Five Outpatient Diagnoses for Primary Care, Mental Health, and Emergency/Urgent Care Visits

Appendix D includes outpatient diagnoses for outpatient primary care, mental health, and emergency/urgent care visits not included in the body of the report. These also exclude visit types for which the patient could not readily choose between direct care and community care.

Table D.1. Top Five Primary Diagnoses for Primary Care Outpatient Visits

VA Direct and Community Care			VA Direct Care		
ICD10 Diagnosis (Code)	**Number of Patients (29,975)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (29,975)**	**Patients (%)**
Essential (primary) hypertension (I10)	5,948	19.8	Essential (primary) hypertension (I10)	5,948	19.8
Type 2 diabetes mellitus without complications (E11.9)	2,405	8.0	Type 2 diabetes mellitus without complications (E11.9)	2,405	8.0
Hyperlipidemia, unspecified (E78.5)	1,769	5.9	Hyperlipidemia, unspecified (E78.5)	1,769	5.9
Low back pain (M54.50)	1,228	4.1	Low back pain (M54.50)	1,228	4.1
Tinea unguium (B35.1)	1,084	3.6	Tinea unguium (B35.1)	1,084	3.6

Source: OIG analysis of VA administrative data for fiscal year 2024.

Table D.2. Top Five Primary Diagnoses for Mental Health Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (12,785)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (12,762)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (64)	Patients (%)
Post-traumatic stress disorder, chronic (F43.12)	4,241	33.2	Post-traumatic stress disorder, chronic (F43.12)	4,232	33.2	Post-traumatic stress disorder, unspecified (F43.10)	12	18.8
Post-traumatic stress disorder, unspecified (F43.10)	2,232	17.5	Post-traumatic stress disorder, unspecified (F43.10)	2,220	17.4	Opioid dependence, uncomplicated (F11.20)	10	15.6
Anxiety disorder, unspecified (F41.9)	1,423	11.1	Anxiety disorder, unspecified (F41.9)	1,420	11.1	Post-traumatic stress disorder, chronic (F43.12)	‡	14.1
Major depressive disorder, single episode, unspecified (F32.A)	1,065	8.3	Major depressive disorder, single episode, unspecified (F32.A)	1,064	8.3	Generalized anxiety disorder (F41.1)	‡	10.9
Major depressive disorder, recurrent, moderate (F33.1)	854	6.7	Major depressive disorder, recurrent, moderate (F33.1)	849	6.7	Adjustment disorder with mixed anxiety and depressed mood (F43.23)	‡	9.4

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Table D.3. Top Five Primary Diagnoses for Emergency/Urgent Care Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (14,979)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (12,642)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (3,344)	Patients (%)
Covid-19 (U07.1)	792	5.3	Covid-19 (U07.1)	696	5.5	Chest pain, unspecified (R07.9)	297	8.9
Low back pain, unspecified (M54.50)	693	4.6	Low back pain, unspecified (M54.50)	628	5.0	Shortness of breath (R06.02)	237	7.1
Chest pain, unspecified (R07.9)	644	4.3	Acute upper respiratory infection, unspecified (J06.9)	587	4.6	Altered mental status, unspecified (R41.82)	184	5.5
Acute upper respiratory infection, unspecified (J06.9)	613	4.1	Acute bronchitis, unspecified (J20.9)	397	3.1	Unspecified injury of head, initial encounter (S09.90XA)	163	4.9
Cough, unspecified (R05.9)	444	3.0	Urinary tract infection, site not specified (N39.0)	381	3.0	Other chest pain (R07.89)	138	4.1

Source: OIG analysis of VA administrative data for fiscal year 2024.

Appendix E: Top Five Outpatient Diagnoses for Selected Specialty Care Visits

Appendix E includes outpatient diagnoses for outpatient specialty visits not included in the body of the report. These also exclude visit types for which the patient could not readily choose between direct care and community care.

Table E.1. Top Five Primary Diagnoses for Cardiology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (14,046)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (14,027)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (56)	Patients (%)
Abnormal electrocardiogram [ECG] [EKG] (R94.31)	2,759	19.6	Abnormal electrocardiogram [ECG] [EKG] (R94.31)	2,757	19.7	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	11	19.6
Bradycardia, unspecified (R00.1)	2,187	15.6	Bradycardia, unspecified (R00.1)	2,184	15.6	Cardiomyopathy, unspecified (I42.9)	‡	8.9
Unspecified atrial fibrillation (I48.91)	1,305	9.3	Unspecified atrial fibrillation (I48.91)	1,303	9.3	Heart failure, unspecified (I50.9)	‡	7.1
Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,137	8.1	Atherosclerotic heart disease of native coronary artery without angina pectoris (I25.10)	1,126	8.0	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris (I25.118)	‡	5.4

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	**Number of Patients (14,046)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (14,027)**	**Patients (%)**	**ICD10 Diagnosis (Code)**	**Number of Patients (56)**	**Patients (%)**
Essential (primary) hypertension (I10)	996	7.1	Essential (primary) hypertension (I10)	993	7.1	Bradycardia, unspecified (R00.1)	‡	5.4

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Table E.2. Top Five Primary Diagnoses for Dermatology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (8,104)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (8,099)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (16)	Patients (%)
Actinic keratosis (L57.0)	2,055	25.4	Actinic keratosis (L57.0)	2,053	25.3	Actinic keratosis (L57.0)	‡	12.5
Neoplasm of uncertain behavior of skin (D48.5)	922	11.4	Neoplasm of uncertain behavior of skin (D48.5)	921	11.4	Body dysmorphic disorder (F45.22)	‡	12.5
Other seborrheic keratosis (L82.1)	860	10.6	Other seborrheic keratosis (L82.1)	859	10.6	Other specified dermatitis (L30.8)	‡	12.5
Dermatitis, unspecified (L30.9)	298	3.7	Dermatitis, unspecified (L30.9)	297	3.7	Psoriasis vulgaris (L40.0)	‡	12.5
Nevus, non-neoplastic (I78.1)	244	3.0	Nevus, non-neoplastic (I78.1)	244	3.0	Squamous cell carcinoma of skin of scalp and neck (C44.42)	‡	12.5

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡*Less than 10 patients.*

Table E.3. Top Five Primary Diagnoses for Gynecology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (648)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (645)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (4)	Patients (%)
Abnormal uterine and vaginal bleeding, unspecified (N93.9)	91	14.0	Abnormal uterine and vaginal bleeding, unspecified (N93.9)	91	14.1	Female infertility, unspecified (N97.9)	‡	75.0
Leiomyoma of uterus, unspecified (D25.9)	44	6.8	Leiomyoma of uterus, unspecified (D25.9)	44	6.8	Female infertility of other origin (N97.8)	‡	50.0
Other specified abnormal uterine and vaginal bleeding (N93.8)	41	6.3	Other specified abnormal uterine and vaginal bleeding (N93.8)	41	6.4	Hemorrhage, not elsewhere classified (R58)	‡	25.0
Female infertility, unspecified (N97.9)	21	3.2	Female infertility, unspecified (N97.9)	18	2.8			
Endometriosis, unspecified (N80.9)	14	2.2	Endometriosis, unspecified (N80.9)	14	2.2			

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Table E.4. Top Five Primary Diagnoses for Ophthalmology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (5,839)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (5,823)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (36)	Patients (%)
Unspecified retinal disorder (H35.9)	904	15.5	Unspecified retinal disorder (H35.9)	904	15.5	Combined forms of age-related cataract, left eye (H25.812)	‡	13.9
Unspecified glaucoma (H40.9)	798	13.7	Unspecified glaucoma (H40.9)	797	13.7	Combined forms of age-related cataract, bilateral (H25.813)	‡	8.3
Unspecified cataract (H26.9)	372	6.4	Unspecified cataract (H26.9)	371	6.4	Combined forms of age-related cataract, right eye (H25.811)	‡	8.3
Combined forms of age-related cataract, bilateral (H25.813)	269	4.6	Combined forms of age-related cataract, bilateral (H25.813)	266	4.6	Age-related nuclear cataract, left eye (H25.12)	‡	5.6
Age-related nuclear cataract, bilateral (H25.13)	239	4.1	Age-related nuclear cataract, bilateral (H25.13)	239	4.1	Dry eye syndrome of bilateral lacrimal glands (H04.123)	‡	5.6

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡*Less than 10 patients.*

Table E.5. Top Five Primary Diagnoses for Urology Outpatient Visits

VA Direct and Community Care			VA Direct Care			Community Care		
ICD10 Diagnosis (Code)	Number of Patients (4,852)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (4,839)	Patients (%)	ICD10 Diagnosis (Code)	Number of Patients (23)	Patients (%)
Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	838	17.3	Benign prostatic hyperplasia with lower urinary tract symptoms (N40.1)	837	17.3	Malignant neoplasm of prostate (C61)	10	43.5
Elevated prostate specific antigen [PSA] (R97.20)	403	8.3	Elevated prostate specific antigen [PSA] (R97.20)	403	8.3	Calculus of kidney (N20.0)	‡	13.0
Malignant neoplasm of prostate (C61)	337	6.9	Malignant neoplasm of prostate (C61)	327	6.8	Calculus of ureter (N20.1)	‡	8.7
Other retention of urine (R33.8)	323	6.7	Other retention of urine (R33.8)	322	6.7	Other specified disorders of kidney and ureter (N28.89)	‡	8.7
Male erectile dysfunction, unspecified (N52.9)	297	6.1	Male erectile dysfunction, unspecified (N52.9)	297	6.1	Retention of urine, unspecified (R33.9)	‡	8.7

Source: OIG analysis of VA administrative data for fiscal year 2024.

‡Less than 10 patients.

Appendix F: Excluded Referral Types to Obtain Routine Outpatient Referrals

Table F.1. Excluded Referrals

Referral Type	VA Direct Care		Community Care	
	Number of Referrals	Referrals (%)	Number of Referrals	Referrals (%)
Inpatient	73,960	18.9	837	9.4
Dental	10,064	2.6	211	2.4
E-Consults	18,518	4.7	0	0
Geriatrics and Extended Care	461	0.1	3,131	35.3
Prosthetics	65,437	16.7	0	0
Administrative	58,139	14.9	25	0.3
Future Care*	5,879	1.5	201	2.3
Emergency/Urgent Care	788	0.2	265	3.0
Laboratory	45	<0.1	12	0.1

Source: OIG analysis of VA administrative data for fiscal year 2024.

**Appointment is expected to occur more than 90 days from the date the referral was entered.*

Appendix G: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 22, 2025

From: Director, Department of Veterans Affairs (VA) New England Healthcare System (10N1)

Subj: Office of Inspector General (OIG) report, Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the VA Boston Healthcare System in Massachusetts, Fiscal Year 2024 (VIEWS 13701039)

To: Director, Office of Healthcare Inspections (54HI00)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and comment on the draft report regarding the health care inspection report at the VA Boston Healthcare System. The VA New England Healthcare System is committed to providing exceptional health care to Veterans.

2. I thank the OIG team for their recommendations, which identify areas for improvement. I have reviewed the documentation and concur with recommendations 1 and 3. I also concur in principle with recommendation 2 and will take corrective action.

3. The leadership teams at VA Boston Healthcare System and the Veterans Integrated Network Office are committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve. Should you need further information, please contact the VISN Quality Management Officer.

(Original signed by:)

Ryan Lilly, MPA

[OIG comment: The OIG received the above memorandum from VHA on September 22, 2025.]

Appendix H: VA Boston Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 22, 2025

From: Interim Director, Department of Veterans Affairs (VA) Boston Healthcare System (523/00)

Subj: Office of Inspector General (OIG) Report, Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the VA Boston Healthcare System in Massachusetts, Fiscal Year 2024 (VIEWS 13701039)

To: Network Director, VA New England Healthcare System (10N1)

1. I appreciate the opportunity to review and comment on the OIG draft report—Review of Community Care Utilization, Delivery of Timely Care, and Provider Qualifications at the VA Boston Healthcare System in Massachusetts, Fiscal Year 2024. I concur with recommendations 1 and 3. I also concur in principle with recommendation 2 and will take corrective action.

2. I evaluated the timeliness of appointments for both VA direct and community care referrals. This evaluation ensured that facility staff are establishing appointments within the required time frames, thus improving access to care for Veterans. Additionally, I conducted a thorough review of current consult management practices. This review ensured that consults are being used properly and documented accurately for VA direct care referrals. I will continue to regularly review appointment wait times and address any opportunities for improvement.

3. Should you need further information, please contact the Chief, Quality and Patient Safety.

(*Original signed by:*)

Leslie Pierson, MS, MT

[OIG comment: The OIG received the above memorandum from VHA on September 22, 2025.]

System Director Response

Recommendation 1

The VA Boston Healthcare System Director assesses the timeliness of appointment setting for VA direct and community care referrals and ensures facility staff establish appointments within required time frames.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The Department of Veterans Affairs (VA) Boston Healthcare System (VABHCS) utilizes the Consult Toolbox Management+ system for scheduling appointments and has been a high performer on meeting the seven-day metric. VABHCS has been reviewing a weekly graph of consult timeliness during the Facility Safety Huddle. Additionally, community care scheduling timeframes are reviewed at the facility level weekly in the Group Practice Management (GPM) report and in the weekly community care leadership huddle. To enhance this practice, beginning on September 8, 2025, the information at the Facility Safety Huddle will include specific appointment setting metrics for direct care (by clinic group) and community care.

In addition to reviewing appointment timeliness at the Facility Safety Huddle, the GPM reports weekly to medical center leadership on facility access metrics, including community care scheduling time frames. Beginning in September 2025, the GPM report will include a specific monthly report of all consult timeliness (appointment setting) metrics by stop code, highlighting the top and bottom performers. The GPM presents materials to allow for specific discussions and targeted action plans with the medical center leadership. The Chief of Staff will assess the effectiveness of any action plans. The community care scheduling timeframes are also reviewed at the Veterans Integrated Service Network (VISN) level and shared with facility leadership on a weekly basis; 3- and 7-day. Monthly reviews of timeframes and any relevant action plans are conducted during the facility and VISN level Community Care Oversight Councils to evaluate the efficacy of action plans and identify any opportunities to optimize best practices and refine strategies. The fiscal year (FY) 2025 data demonstrates the positive impact of these plans, evaluations, and strategizing for an improvement of up to 70.2% for our 7-day metric. The 3-day metric for FY 2025 is 71% (clinical and procedure direct care consults).

Recommendation 2

The VA Boston Healthcare System Director reviews consult management practices and ensures the proper use of consults for VA direct care referrals.

_X _Concur in Principle

____Nonconcur

Target date for completion: December 2025

Director Comments

The facility has a strong practice for ensuring proper use of consults through reviews and discussions of consult management practices at the bi-weekly Facility Access Committee. In addition, the Clinic Practice Managers provide coaching, and the Group Practice Manager requires action plans when evaluations reflect a need to reinvigorate adherence to standard procedures.

A comprehensive review of the data demonstrates there are other factors that affect the documentation on a consult that may give an inaccurate impression that consults are not being used as intended. For example, broken consult links are a known issue in the Computerized Patient Record System that cannot be fixed. When a consult link is broken, the appointment cannot be linked to the consult. VABHCS will provide additional training to staff regarding documentation of appointments when a consult needs to be linked to the consult or when a consult link is broken. Education reminding staff to document the appointment on the consult if a link is broken will be conducted in September 2025, and re-education will be completed as of the next Facility Access Committee in September 2025.

Another common situation that can appear to be non-standard use of consults occurs when consults are completed the same day. This frequently happens during subspecialty appointments that require an additional test or procedure. For example, consults in areas like Ophthalmology are entered on the same day by the specialty provider for a test/image to be done in the clinic while the patient is in the clinic for their appointment. These consults are entered by the specialty provider on the day of the appointment and completed on the same day by the technician. Consults must be entered to allow the technician to complete the test. This is standard practice in the current electronic medical record. A separate appointment cannot be created in these scenarios; therefore, we are unable to document it within the consult.

Recommendation 3

The VA Boston Healthcare System Director reviews appointment wait times and acts on identified opportunities for improvement.

_X _Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The Group Practice Manager currently reports weekly on appointment wait times by clinic group for both new and established patients to medical center leadership. This includes the percent scheduled within 20 to 28 days for pending appointments and the average wait for completed and pending appointments.

The VABHCS will add the percent scheduled within 20 to 28 days for completed appointments as well.

The Group Practice Manager reports to medical center leadership weekly regarding facility access metrics. Beginning in September 2025, the VABHCS will include a specific monthly report of all wait-time metrics by stop code, specifically those scheduled within 20 to 28 days. This report will highlight the top and bottom performers, discussing any actions needed for improvement. In addition to this, the Medical Center Director reviews staffing, labor mapping, the Specialty Provider Group Practice Productivity Access Report and Quadrants report, and bookability for all services exceeding 20 to 28 days to ensure maximum access for direct care appointments and works with services on strategies to expand care.

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