US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Inspection of Medical Facilities in VISN 17: VA Heart of Texas Healthcare Network

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The Office of Inspector General's (OIG's) Veterans Integrated Service Network (VISN) Care in the Community program evaluated selected performance elements of the Veterans Health Administration (VHA) Veterans Community Care Program.[1] Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, VHA's Veterans Community Care Program simplifies the process for veterans to receive non-VA care (community care) by expanding eligibility criteria.[2] While this report is the final iteration of the OIG's VISN Care in the Community Inspection program, the OIG will continue its comprehensive oversight of VA's Community Care Program through a variety of audits, investigations, cyclical healthcare facility inspections, and national reviews.

As in previous reports, OIG teams reviewed selected care coordination activities required to initiate and process referrals for non-VA care (community care). Along with interview results and analysis of relevant data, these reports highlight opportunities and challenges for VISN and facility staff as they navigate current community care referral processes.

Observations in this report are similar to those in previous OIG Care in the Community Inspection reports. These observations are intended to inform VA leaders as they consider modifications and improvements to the Community Care Network Next Generation contract, and other organizational and operational changes to the Office of Integrated Veteran Care (IVC) in alignment with the MISSION Act.[3] This report does not contain recommendations because previous reports have similar recommendations with VHA that address the observations detailed below. On January 8, 2026, the Veterans Integrated Service Network Director concurred with the report (see appendix C).

---

[1] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, last updated July 28, 2025, https://department.va.gov/integrated-service-networks/.

[2] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101; US Senate Committee on Veterans' Affairs, "The VA MISSION Act of 2018: The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act," accessed July 8, 2021; VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019. The conditions under which VA may furnish veterans health care in the community through eligible entities and providers are set forth in 38 U.S.C. § 1703(d). The VA Secretary's regulations governing eligibility of veterans to receive community care are found at 38 C.F.R. § 17.4010 (2025).

[3] "The VA Community Care Network (CCN) is comprised of five regional networks that serve as the contract vehicle for VA to purchase care for Veterans from community providers…The Office of Integrated Veteran Care (IVC) is a central authority for collaborating with all stakeholders influencing Veterans' access to care. It was established by the VA in June 2020 to integrate all access-related functions, including financial elements, into one office…VA is currently in its market research phase of its acquisition planning schedule for the Community Care Network Next Generation program." "Office of Procurement, Acquisition and Logistics (OPAL)," Department of Veterans Affairs, last updated November 4, 2024, https://www.va.gov/community-care-network.

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiency of VA programs and services, including community care, that improve the health and welfare of veterans and their families.

Inspection Summary

The OIG reviewed community care processes from January 21 through February 7, 2025, at seven medical facilities with a community care program in VISN 17: VA Heart of Texas Healthcare Network, which serves most of Texas and parts of New Mexico and Oklahoma. The OIG evaluated these facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Community Urgent Care Coordination and Management, and Community Emergency Care Coordination and Management.

The OIG described observations across these six domains. The elements evaluated and OIG's observations are summarized below.

Leadership and Administration of Community Care 	The OIG examined how VISN and facility leaders supported community care services. • Not all facilities with community care programs established community care oversight councils, as required by VHA's National Implementation of the Community Care Operating Model memorandum, or had sufficient administrative and clinical staff to adequately manage referrals for community care.[4] • Facility community care staff did not consistently enter patient safety events into the Joint Patient Safety Reporting system, and patient safety managers or designees did not consistently brief patient safety trends at oversight council meetings, as required by the VHA *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.[5] • Facility community care staff did not consistently import community care documents into patients' electronic health records within five business days of receipt, as required by the VHA Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirement.[6]

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

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

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

Community Care Diagnostic Imaging Results 	The OIG assessed how facility staff communicated diagnostic imaging results to the VHA providers who ordered the tests. • Facility staff did not consistently import diagnostic imaging results into the electronic health records or attach any of them to the note required by the VHA Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirement. • Facility staff did not use the significant findings alert in the electronic health record to notify VHA providers of abnormal diagnostic imaging results, as established in the VHA IVC *Community Care Field Guidebook*.[7]
Administratively Closed Community Care Consults 	The OIG inspectors determined whether facility community care staff managed the administrative closure of non-low-risk consults (for example, physical and occupational therapy, acupuncture, and chiropractic care), as detailed in the VHA IVC *Community Care Field Guidebook*.[8] • Staff did not consistently make three attempts to obtain community providers' medical documents within 90 days of the appointment. • Staff did not attach medical documents to the appropriate note in the electronic health record.[9]
Community Care Provider Requests for Additional Services 	The OIG assessed whether facility staff managed requests for additional services according to the VHA IVC *Community Care Field Guidebook*.[10] • Facility community care staff did not consistently process community providers' requests for additional services within three business days of receipt. • Facility community care staff did not always send letters to community providers and patients when they approved or denied requests for additional services.
Community Urgent Care Coordination and Management 	The OIG determined whether facility providers and community care staff coordinated and managed care for patients who received community urgent care services. • Facility community care staff did not create the Community Care–Urgent Care Record note in the electronic health record when they received patients' urgent care documents, as required by the VHA Urgent Care Record Note Setup guide.[11] • The staff did not consistently notify the VHA primary care provider or a designated provider when a patient received community urgent care services.

[7] VHA IVC, chap. 4 in *Community Care Field Guidebook*, August 9, 2024.

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

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

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

[11] VHA Office of Community Care Delivery Operation, "Community Care-Urgent Care Record Note Setup Guide," February 1, 2018.

Community Emergency Care Coordination and Management 	The OIG team assessed how facility providers and community care staff coordinated and managed care for patients who received community emergency care services. The team described several observations, based on requirements in the VHA IVC *Community Care Field Guidebook*.[12] • Facility community care staff did not consistently add all interdisciplinary team members as additional signers to the Community Care–EMER Self-Presenting Care Coordination Plan note in the electronic health record after a patient's emergency care visit. • Facility community care staff did not consistently address follow-up care documented in the patient's discharge plan after the community emergency care visit. • The staff did not consistently obtain medical documents, import them into the electronic health record, and attach them to the required note.

VA Comments and OIG Response

The Veterans Integrated Service Network Director concurred with the report (see appendix C). No further action is required.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[12] VHA IVC, chap. 3 in *Community Care Field Guidebook*, October 17, 2024.

Contents

Abbreviations

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

Introduction

The Office of Inspector General's (OIG's) Veterans Integrated Service Network (VISN) Care in the Community program routinely evaluated selected performance elements of the Veterans Health Administration (VHA) Veterans Community Care Program, as well as VISN facilities' processes for coordinating community care and providing leadership and administrative oversight of the program.[1] While this report is the final iteration of the OIG's VISN Care in the Community Inspection program, the OIG will continue its comprehensive oversight of VA's Community Care Program through a variety of audits, investigations, cyclical healthcare facility inspections, and national reviews.

As in previous reports, OIG inspection teams reviewed selected care coordination activities required to initiate and process referrals for non-VA care (community care). Along with interview results and analysis of relevant data, these reports highlight opportunities and challenges for VISN and facility staff as they navigate current community care referral processes.

Observations in this report are similar to those in previous OIG VISN Care in the Community Inspection reports. These observations are intended to inform VA leaders as they consider modifications and improvements to the Community Care Network Next Generation contract, and other organizational and operational changes to the Office of Integrated Veteran Care (IVC).[2] This report does not contain recommendations because previous reports have open recommendations with VHA that address the observations detailed below. On January 8, 2026, the Veterans Integrated Service Network Director concurred with the report (see appendix C).

Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, VHA's Veterans Community Care Program simplifies the

[1] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, last updated July 28, 2025, https://department.va.gov/integrated-service-networks.

[2] "The VA Community Care Network (CCN) is comprised of five regional networks that serve as the contract vehicle for VA to purchase care for Veterans from community providers…The Office of Integrated Veteran Care (IVC) is a central authority for collaborating with all stakeholders influencing Veterans' access to care. It was established by the VA in June 2020 to integrate all access-related functions, including financial elements, into one office…VA is currently in its market research phase of its acquisition planning schedule for the Community Care Network Next Generation program." "Office of Procurement, Acquisition and Logistics (OPAL)," Department of Veterans Affairs, last updated November 4, 2024, https://www.va.gov/opal/sac/community-care-network.

process for veterans to receive non-VA care (community care) by expanding eligibility criteria.[3] As indicated in the VHA IVC *Community Care Field Guidebook*, IVC aims to provide veterans referred to community care timely access to high quality care through the Veterans Community Care Program in a way "that is easy to understand [and] simple to administer."[4] According to IVC, the field guidebook outlines the program's requirements, "processes and tools related to eligibility, referral and care coordination."[5]

[3] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101; US Senate Committee on Veterans' Affairs, "The VA MISSION Act of 2018: The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act," accessed July 8, 2021; VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019. The conditions under which VA may furnish veterans health care in the community through eligible entities and providers are set forth in 38 U.S.C. § 1703(d). The VA Secretary's regulations governing eligibility of veterans to receive community care are found at 38 C.F.R. § 17.4010 (2025).

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

[5] Department of Veterans Affairs "Office of Integrated Veteran Care (IVC) Field Guidebook," accessed August 26, 2025, https://apps.gov.powerapps.us/play. (This website is not publicly accessible.)

VA Heart of Texas Health Care Network

VISN 17: VA Heart of Texas Healthcare Network includes seven medical centers and over 70 outpatient clinics. It encompasses most of Texas and parts of New Mexico and Oklahoma.[6]

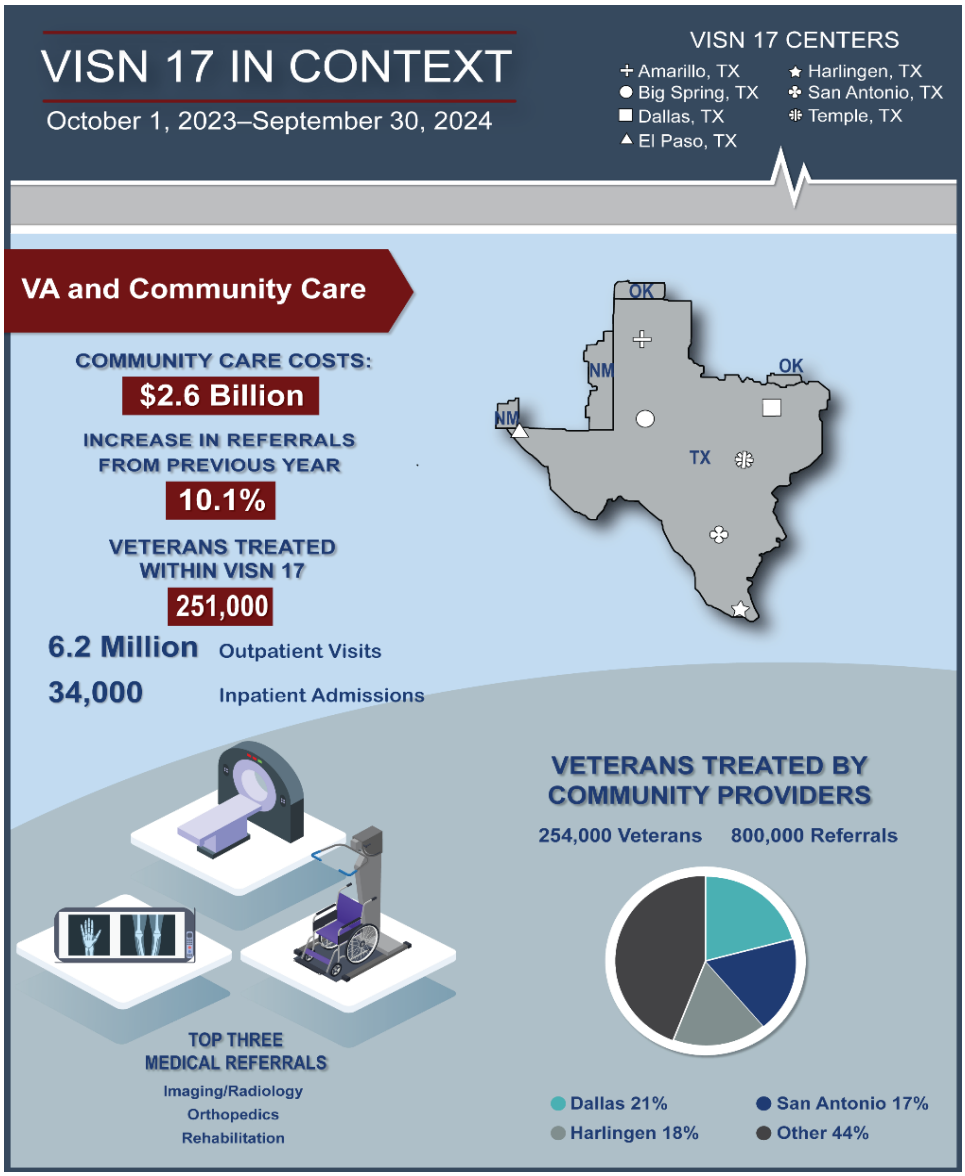

Figure 1. *Community care referral data for VISN 17.*
Source: VHA data. The OIG did not verify the data's accuracy.

[6] "Veterans Health Administration, VISN 17," Department of Veterans Affairs, last updated February 5, 2026, https://department.va.gov/VISN17; Department of Veterans Affairs, *Orientation Guide, VA Heart of Texas Health Care Network*, April 26, 2024.

Community Care Consult Management

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

Inspection Elements

The OIG evaluated VISN 17 facilities' processes for community care referral and care coordination in the following domains: Leadership and Administration of Community Care, Community Care Diagnostic Imaging Results, Administratively Closed Community Care Consults, Community Care Provider Requests for Additional Services, Community Urgent Care Coordination and Management, and Community Emergency Care Coordination and Management. The inspection results describe the OIG's observations related to care coordination activities for patients referred for community care.

Inspection Results

Leadership and Administration of Community Care

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

To determine how VISN 17 and its facility leaders supported community care services, the OIG evaluated requirements established by VHA in the field guidebook.[10] The OIG team discussed required program elements with facility community care and executive leaders, as well as VISN leaders, and elicited reasons when they did not comply with requirements. The team also sought input from the leaders and community care staff about the effectiveness of the community care program based on their experiences.

Community Care Oversight Councils

The OIG examined fiscal year 2024 or 2025 council charters and meeting minutes for the seven facilities inspected and determined that all but two of them had community care oversight councils. VHA's National Implementation of the Community Care Operating Model memorandum requires VISN directors to ensure all medical facilities with community care programs within their network establish a local community care oversight council. These councils consist of clinical and nonclinical staff working together to equitably allocate resources, so all patients receive quality care in the community.[11]

Harlingen community care leaders reported having a consult committee with community care as a topic on the agenda. San Antonio leaders explained they had merged community care oversight responsibilities into the consult management committee in December 2023, but it primarily addressed the processing of community care consults instead of the whole program. Additionally, the OIG found that Temple's oversight council met only 10 of the 12 times

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

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

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

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

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

required by their charter. Facilities without a dedicated, consistently functioning oversight council may be unable to ensure patients receive quality community care.

Resource Utilization

Leaders at all seven facilities reported they evaluated whether to continue purchasing specific types of care in the community or offer the care within the facility. According to the VHA IVC RCI [Referral Coordination Initiative] Resource Analysis Assessment Guidance Document, "VA Medical Center leadership must consider the ability to provide higher quality care, community capabilities, projected demand, current in-house and community access, costs, space constraints, impact on VA's education and research mission, sustainability, and the Veteran experience."[12]

Dallas leaders said they were unable to keep up with increased community care workload due to veterans moving to their area from California, so they increased their capacity in numerous services. For example, they planned to add new magnetic resonance imaging units to the Fort Worth VA Outpatient Clinic and use mobile machines until then.[13]

Amarillo leaders said they tried to treat veterans within their facility where they could better monitor the quality of care, which they could not do when veterans received community care. For example, over the past three years, they increased cardiology clinic capacity so they could treat more veterans at the facility.[14]

However, facility leaders also described barriers when trying to recruit new specialty providers to deliver care at the facilities. Amarillo, Harlingen, and Temple leaders shared they were in locations where people did not like to move, and San Antonio leaders reported they were unable to compete with local salaries for radiologists and dental hygienists.[15]

For all facilities except San Antonio, the OIG determined that most community care referrals were for veterans who met drive time eligibility criteria, and therefore, some facility leaders said

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

[13] Magnetic resonance imaging is a diagnostic technique that produces detailed images of internal organs within the body. *Merriam-Webster*, "Magnetic Resonance Imaging," accessed January 8, 2025, https://www.merriam-webster.com/magneticresonanceimaging.

[14] "Cardiology is the study of the heart and its action and diseases." *Merriam-Webster*, "Cardiology," last updated February 18, 2026, https://www.merriam-webster.com/cardiology.

[15] "Radiologists specialize in diagnosing and treating injuries and diseases using medical imaging and procedures." "What Is a Radiologist," American College of Radiology, accessed March 2, 2025, https://www.acr.org/radiology. "A dental hygienist is an oral healthcare provider who offers teeth cleanings, preventive dental care and oral hygiene instruction." "Dental Hygienist," Cleveland Clinic, last updated September 14, 2023, https://my.clevelandclinic.org/dh.

they expanded, or planned to expand, VHA care options closer to veterans' homes.[16] Dallas leaders shared plans to also open outpatient clinics in six additional counties, while Harlingen leaders discussed using mobile medical units and telemedicine.[17]

Staffing and Operations

VHA has established a community care operating model to standardize organizational structures and business processes across facilities' community care programs.[18] The model includes a staffing tool designed to provide leaders a method to quantify the numbers of administrative and clinical personnel necessary to successfully operate their programs.[19]

The OIG found that leaders at all facilities reassessed staffing at the intervals required by VHA's National Implementation of the Community Care Operating Model Staffing Tool memorandum. The memorandum requires facility leaders to conduct an initial assessment with the tool, then use it to reassess staffing every 90 days.[20] When facility leaders do not reassess staffing at the required intervals, they may not meet workload demands, which could negatively affect community care program operations and patient care.

During interviews, community care leaders at all facilities, except those at El Paso, said the tool did not accurately assess their staffing needs. For example, a Dallas leader explained the tool made them look overstaffed because the preset data options only allowed facilities to increase annual workload by 10 percent, but their workload increased 30 to 40 percent annually.

Further, all facility community care leaders said they needed additional administrative staff, and all but San Antonio said they required additional nursing staff. Leaders shared that these staffing

[16] Veterans are eligible for community care when their "average drive time to a specific VA medical facility" is 30 minutes "for primary care, mental health care, and non-institutional extended care services (including adult day health care)" or 60 minutes for specialty care. 38 C.F.R. § 17.4040 (2025); VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

[17] A mobile medical unit moves from one location to another to provide health care services to patients inside a vehicle or trailer. VHA Directive 1154(1), *Mobile Medical Unit (MMU) Program Management*, July 26, 2017, amended March 11, 2020. Telemedicine is care "provided remotely to a patient in a separate location" than the healthcare provider "using two-way voice and visual communication." *Merriam-Webster*, "Telemedicine," last updated January 24, 2026, https://www.merriam-webster.com/telemedicine.

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

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

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

shortfalls delayed community care staff in scheduling patients' appointments, decreased their job satisfaction, and increased their overtime and burnout.

The OIG reviewed the staffing tool results provided by community care leaders at each facility for the third quarter of fiscal year 2024 and determined that Big Spring, El Paso, and Harlingen did not have sufficient clinical and administrative staff, while San Antonio and Temple lacked adequate clinical staff.[21]

Third-Party Administrator Interactions and Patient Safety Event Reporting

During interviews, facility community care leaders from Big Spring, Dallas, El Paso, San Antonio, and Temple shared concerns about the third-party administrators' lack of responsiveness to submitted potential quality issues. VHA established contracts with third-party administrators to create regional networks of community providers able to provide care to veterans. Third-party administrators are responsible for ensuring safe medical care by network providers and for investigating potential quality issues that may affect patient safety to ensure, if needed, appropriate follow-up actions are taken, per the VHA *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.[22]

Facility patient safety managers and VISN patient safety officers may request updates regarding potential quality issues from third-party administrators. Patient safety managers and officers may then update their facility community care program team. San Antonio leaders emphasized that their third-party administrator said they were not contractually required to describe how they address potential quality issues. The OIG remains concerned that the limited information third-party administrators provide to facility leaders regarding potential quality issues negatively affects their oversight to ensure patients receive quality care.

Facility leaders also expressed specific community care patient safety concerns. For example, El Paso leaders said they investigated a community provider a few years ago who prescribed intravenous ketamine and found the prescriptions were not necessary or appropriate based on the patients' specific conditions.[23] Leaders said the provider stopped prescribing ketamine only after

[21] The OIG calculated the number of administrative and clinical staff needed as the difference between the number of staff authorized to hire by facility leaders and the number recommended by the staffing tool. The staffing tool results indicated El Paso, Harlingen, and Big Spring needed 16, 8, and 3 additional administrative staff, while Temple, Big Spring, and San Antonio needed 24, 16, and 13 additional clinical staff, respectively.

[22] Potential quality issues are patient safety events or "concerns regarding the quality or safety of health care services performed by community care providers." VHA IVC, "VHA Office of Integrated Veteran Care Patient Safety and Quality Frequently Asked Questions," September 2022. VHA, *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022.

[23] Ketamine is a drug that can make patients feel detached from pain. It "distorts the perception of sight and sound and makes the user feel disconnected and not in control." "Ketamine," Drug Enforcement Agency, last updated December 2024, https://www.dea.gov/factsheets/ketamine.

other providers notified the state medical board; eventually, the third-party administrator removed the provider from the network.

Harlingen leaders shared an example of reporting a community provider to the third-party administrator who showed a trend of prescribing opioids in situations where they were contraindicated and could harm patients.[24] These leaders explained the third-party administrator investigated the concerns, validated them, and removed the inpatient behavioral health unit where the community provider worked from their network.

Additionally, the OIG found that staff at five facilities did not enter some patient safety events into VHA's Joint Patient Safety Reporting system, as required by the VHA *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*.[25] Community care staff at all the facilities provided the OIG with lists of potential patient safety issues they reported to the third-party administrator. The OIG compared the lists with events entered into the reporting system and found discrepancies at Amarillo, Big Spring, El Paso, Harlingen, and Temple. For example, Temple community care staff submitted two potential patient safety issues to the third-party administrator but did not enter them into the VHA system.

The OIG also found that only staff at Big Spring and Dallas discussed patient safety event information during community care oversight council meetings. The VHA *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook* requires facility patient safety managers or designees to brief the community care oversight council on patient safety event trends, lessons learned, and corrective actions.[26] When there is no briefing on community care patient safety events, this could jeopardize safe, high quality care.

Medical Documentation Importing Performance

All facility community care leaders said their staff track medical documents to identify backlogs in importing them into the patients' electronic health records, and leaders at Big Spring, Dallas, and Harlingen reported backlogs.[27] The VHA Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirement states that staff must import all community care documents into the patient's electronic health record within five business

[24] Opioids "include both prescription medications used to treat pain and illegal drugs like heroin." "Opioids," National Institute on Drug Abuse, last updated November 2024, https://nida.nih.gov/research-topics/opioids.

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

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

[27] Facility community care staff reported the average time it took to import medical documents into patients' electronic health records was 9 to 12 days for Big Spring, 16 days for Dallas, and 12 days for Harlingen.

days of receipt.[28] A leader from Big Spring reported a backlog of 1,000 documents that staff had not imported. The leader explained their process took longer than five days because clinical staff reviewed the documents, identified the patients' follow-up needs, and alerted the patients' care team before administrative staff imported them. The leader believed their process was a best practice and planned to have clinical staff focus on the backlog.

Facility community care leaders shared challenges they experienced with obtaining medical documents from community providers. Big Spring, Dallas, Harlingen, and Temple leaders reported barriers, such as insufficient network capacity that caused fax systems to stop operating or busy signals when providers attempted to send documents, and lack of incentive for community providers to send medical documents because they receive payment without providing them.[29]

The leaders shared actions they took to address these barriers. For example, San Antonio leaders said they helped community providers enroll in VHA HealthShare Referral Manager, which facilitates two-way electronic sharing of patient health information and eliminates the need for phone calls and faxes.[30] Big Spring leaders explained that staff reduced the number of days they waited after the appointment before they requested the documents. Temple leaders reported they got their staff access to community facilities' electronic health record portals, which allowed them to retrieve the documents themselves. When incoming medical documents are not imported from community providers, care coordination and quality of care could be negatively affected.

Community Care Diagnostic Imaging Results

Patients may receive diagnostic imaging by community providers if the imaging service is not available at a VHA facility or if access to the facility is an obstacle for the patient. VHA staff must ensure the results are entered into the electronic health record correctly, so providers are able to locate the results, especially when they are abnormal.[31]

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

[29] The Provider Profile Management System is a database of community providers and facilities with information such as addresses, phone numbers, and fax numbers. VHA Office of Community Care, "Reference Sheet: Provider Profile Management System (PPMS)," September 14, 2018.

[30] VHA Office of Community Care, "Reference Sheet: HealthShare Referral Manager (HSRM)," August 10, 2018. Community care leaders at Dallas and Temple said the enrollment process for HealthShare Referral Manager is cumbersome and requires community providers' Social Security numbers, which deters enrollment.

[31] VHA Office of Community Care, "Veteran Community Care General Information"; VHA Health Information Management, Office of Health Informatics, "Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirements"; VHA IVC, chap. 4 in *Community Care Field Guidebook*, August 9, 2024.

The OIG selected diagnostic imaging results as an inspection domain because imaging was one of the services most often referred to community providers during fiscal year 2024. The review focused on Amarillo, Big Spring, Dallas, Harlingen, and Temple because staff at these facilities referred the most diagnostic imaging to community providers across VHA.[32]

VHA providers may refer patients to community care if a diagnostic service is not available at a VHA facility or if the patient meets eligibility criteria for community care, such as wait time for an appointment or drive time to the facility.[33] When facility staff receive the imaging results from community providers, the VHA Practice Brief: Community Care–VistA Imaging Capture Best Practice and Minimum Documentation Requirement document indicates they must import the results into the electronic health records and attach them to the Community Care Consult Result, the Community Care–Request for Services, or the Community Care–Care Coordination Plan note.[34] According to the VHA IVC *Community Care Field Guidebook*, VHA expects community care staff to use the significant findings alert in the electronic health records to notify VHA providers of abnormal results.[35]

Diagnostic Imaging Results in Electronic Health Records

The OIG estimated that Temple staff did not import diagnostic imaging results into the electronic health records 34 percent (95% CI: 22 to 48) of the time.[36] Additionally, the OIG estimated that Big Spring community care staff did not attach any imaging results to the required notes.

When staff do not import the results and attach them to the correct notes, VHA providers may be unable to locate results efficiently, which could delay patients' diagnosis and treatment or lead to patients unnecessarily repeating procedures. Big Spring community care leaders explained that staff attached results to the incorrect note title, and Temple leaders said radiology staff received the results and did not forward them for community care staff to attach to the appropriate note.

---

[32] "Diagnostic radiology helps health care providers see structures inside your body." Examples of diagnostic imaging procedures are ultrasound and computed tomography (commonly called CT) scans. National Institutes of Health, National Library of Medicine, MedlinePlus, *A.D.A.M. Medical Encyclopedia*, "Imaging and Radiology," last reviewed July 13, 2025, https://medlineplus.gov/ency/article/007451.

[33] A patient meets community care wait time eligibility when their "appointment wait time at a specific VA medical facility [is] 20 days for primary care, mental health care, and non-institutional extended care services" or "28 days for specialty care from the date of request, unless the Veteran agrees to a later date in consultation with their VA health care provider." VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

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

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

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

Provider Notification of Abnormal Diagnostic Imaging Results

The OIG estimated that none of the community care staff at the facilities reviewed consistently used the significant findings alert in the electronic health records to notify the VHA providers of abnormal diagnostic imaging results.[37]

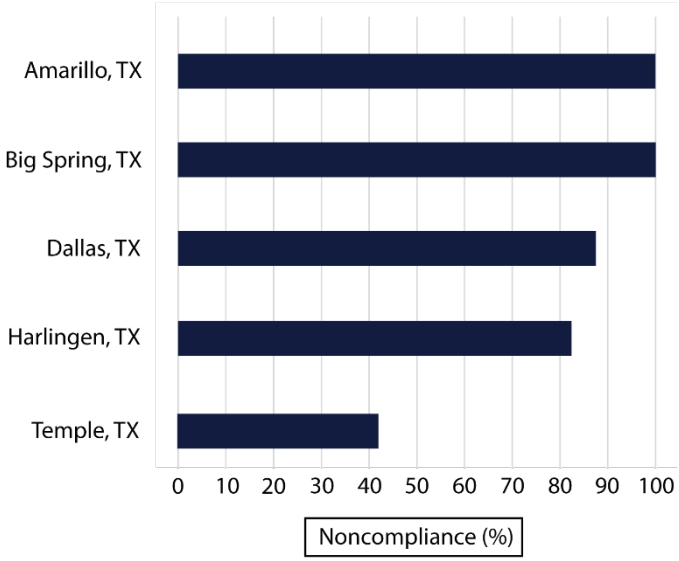

Figure 2. *Provider notification of abnormal community diagnostic imaging results via a significant findings alert.*

Source: OIG analysis of VHA data.

When staff do not use the significant findings alert, VHA providers may be unaware of abnormal diagnostic imaging results, which could delay patients' diagnosis and treatment. The community care leaders reported many reasons why their teams did not use the alert, including

- radiology staff received the results and sent non-significant finding alerts instead;
- staff sent alerts to VHA providers requesting their signature on the note with the results to acknowledge their receipt and review in its place;
- staff needed a better definition of a significant finding, so they would know when to send the alert; and
- staff only used the alert when they did not receive results.

[37] Statistical estimates for facility noncompliance are reported in appendix B.

Administratively Closed Community Care Consults

Health care documents from community providers convey treatment decisions to VHA providers and are important in the patient's care coordination. Delays in the return of medical documents may affect continuity of patient care, and VHA staff must take steps to obtain the medical documents and notify the referring provider if they close the consult without them.

The OIG reviewed six facilities to determine whether community care staff followed VHA processes for administratively closing community care consults.[38] In the VHA IVC *Community Care Field Guidebook*, VHA established a process for staff to administratively close consults if they do not get the medical documents following their first attempt. After the date of the community care appointment, facility community care staff

- contact the patient to confirm appointment attendance,
- make three attempts to obtain the community provider's medical documents within 90 days of the appointment, and
- attach the documents to the Community Care Consult Result, the Community Care–Request for Services, or the Community Care–Care Coordination Plan notes, as appropriate.[39]

Attempts to Obtain Medical Documents

The OIG estimated that Dallas and El Paso community care staff did not make three attempts to obtain community providers' medical documents within 90 days of the appointment for 87 percent (95% CI: 73 to 97) and 97 percent (95% CI: 90 to 100) of non-low-risk consults, respectively, as required in the VHA IVC *Community Care Field Guidebook*.[40] The OIG also estimated that San Antonio and Temple community care staff did not make three attempts to obtain medical documents for any of these consults within 90 days of the appointment.

A community care leader in Dallas explained that staff intended to make all three attempts but did not because they were reducing the backlog of older consults. A Temple community care

[38] The OIG assessed performance in six domains for each facility and selected the three domains where facilities were either underperforming or sent more care to the community than the VHA facility national average. Based on those criteria, the OIG reviewed Big Spring, Dallas, El Paso, Harlingen, San Antonio, and Temple for this domain.

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

[40] "For the purposes of consult processes, VHA has defined low risk clinics nationally to include physical therapy, occupational therapy, kinesiotherapy, acupuncture, smoking clinic, MOVE clinic, massage therapy, chiropractic care and erectile dysfunction clinic." VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. VHA IVC, chap. 4 in *Community Care Field Guidebook*. Statistical analysis for facility noncompliance appears in appendix B.

leader clarified that staff made three attempts, but due to insufficient staffing, they did not make them within 90 days of the scheduled appointment. Staff should make three attempts to obtain the medical documents so they can properly coordinate patients' care.[41]

Attaching Medical Documents to Required Electronic Health Record Notes

The OIG estimated that community care staff at Temple did not attach medical documents to the Community Care Consult Result, the Community Care–Request for Services, or the Community Care–Care Coordination Plan note, as required by the VHA IVC *Community Care Field Guidebook*, 41 percent (95% CI: 27 to 57) of the time.[42] The OIG also estimated that staff at Big Spring did not attach medical documents to any of the notes. Big Spring community care leaders said their staff used the Community Care Consult note instead because the informatics team did not create the correct note titles but planned to in the future. When community care staff do not attach medical documents to the correct note in patients' electronic health records, the VHA provider may not be able to locate them, which could negatively affect ongoing care.

Community Care Provider Requests for Additional Services

Community providers may submit requests for additional services in circumstances when they determine the need for continued care under an expiring VHA authorization, a new specialty referral, or a procedure that was not previously authorized by VHA. VHA staff review and make timely decisions on the requests.[43]

The OIG reviewed facilities' processes to determine how community care staff managed community providers' requests for additional services.[44] The VHA IVC *Community Care Field Guidebook* contains a process for community providers' requests for additional services not already approved under the VHA referral.[45] The process requires community providers to submit the request and supporting medical documents on a VHA-provided form. Then, facility community care staff must

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

[42] Statistical estimates for facility noncompliance appears in appendix B.

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

[44] The OIG assessed performance in six domains for each facility and selected the three domains where facilities were either underperforming or sent more care to the community than the VHA facility national average. Based on these criteria, the OIG reviewed Amarillo, Dallas, San Antonio, and Temple for this domain.

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

- review the request, verify the provider's signature, and ensure the provider included supporting documents;
- obtain approval or denial of the request within three business days of receipt;
- import the request and supporting documents into the patient's electronic health record; and
- send a letter to the community provider and patient to inform them of the decision and explain the reasons for a denied request.[46]

Timely Processing of Requests for Additional Services

The OIG found that community care staff at all four facilities reviewed did not consistently process requests for additional services within three business days of receipt, as required by the VHA IVC *Community Care Field Guidebook*.[47]

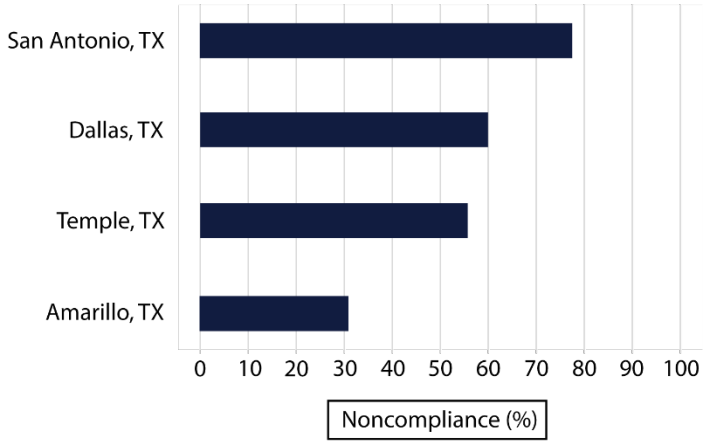

Figure 3. *Requests for additional services processed within three business days of receipt.*
Source: OIG analysis of VHA data.

When staff do not process requests for additional services within three business days, it may delay needed care and negatively affect patient outcomes. Community care staff shared reasons they did not process the requests within three business days, such as

- leaders did not assign staff to cover absences, so they did not continue to process requests for colleagues who were off work;
- staff received a large volume of requests;

[46] VHA IVC, chap. 3 in *Community Care Field Guidebook*.
[47] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Statistical analysis for facility noncompliance appears in appendix B.

- staff were unable to receive and process the requests because the computer software they use to send and receive faxes did not work properly at times;
- VHA providers did not approve the requests timely; and
- staff had to sort requests from other faxes, which took time away from staff processing them.

Community Provider Notification of Requests for Additional Services Decisions

The OIG estimated that community care staff at Temple did not send community providers approval letters for 98 percent (95% CI: 92 to 100) of requests for additional services, as required by the VHA IVC *Community Care Field Guidebook*.[48] Additionally, Dallas staff did not send community providers any approval letters, and Amarillo staff did not send approval or denial letters for the requests.

When not communicated, approvals or denials may delay patient care. Temple community care staff said they were unaware of the requirement. Dallas leaders explained they sent providers a new authorization when they approved requests instead of a letter. Amarillo leaders explained community care staff did not make final decisions for requests for additional services, so they did not send letters.

Patient Notification of Requests for Additional Services Decisions

Additionally, the OIG estimated that Amarillo and Temple community care staff did not send patients approval letters for 94 percent (95% CI: 86 to 100) and 95 percent (95% CI: 88 to 100) of requests for additional services, respectively, as required by the VHA IVC *Community Care Field Guidebook*.[49] Further, the OIG estimated that San Antonio staff did not send patients denial letters for 69 percent (95% CI: 44 to 91) of requests. Finally, the OIG estimated that Dallas staff did not send any approval letters to patients, and Amarillo staff did not send them any denial letters.

When community care staff do not send patients approval or denial letters, they may not receive timely notification of the decision, which may delay their care. Again, Amarillo community care leaders stated they did not send the letters because community care staff did not make the final decisions for additional service requests. Temple community care staff explained they did not have a templated letter to send patients; Dallas leaders clarified that staff sent a new appointment

[48] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Statistical analysis for facility noncompliance appears in appendix B.

[49] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Statistical analysis for facility noncompliance appears in appendix B.

notification letter instead; and San Antonio leaders said when providers denied requests for additional services, staff called patients to schedule the care within the facility.

Community Urgent Care Coordination and Management

Urgent care services include the treatment of injuries and illnesses that need immediate attention but are not life threatening, such as skin infections, minor burns, and influenza.[50] VHA staff must "ensure continuity of care" for patients who receive community urgent care services.[51]

The OIG evaluated urgent care coordination and management at Big Spring and San Antonio.[52] Through the MISSION Act, the urgent care benefit in community care became available in 2019. The primary purpose was for eligible veterans to access services from urgent care providers in VA's community care network without prior VA approval or a community care consult.[53] Within VISN 17 alone, over 51,000 veterans received community urgent care services at a cost of over $12.1 million during fiscal year 2024.[54]

The VHA IVC *Community Care Field Guidebook* requires community urgent care providers to submit medical documents to VHA facilities within 30 calendar days of the patient's urgent care visit; this allows facility staff to arrange follow-up care, if needed.[55] Facility community care staff are required, per the Urgent Care Record Note Setup Guide, to create the Community Care–Urgent Care Record note in the electronic health record and attach the medical documents to the note.[56] Additionally, the guidebook requires community care staff to

- identify the patient's signer for the documents (a provider responsible for receiving an alert and reviewing documents, usually the patient's primary care provider),
- have the Chief of Staff designate a provider to be the signer if the patient does not have an assigned primary care provider, and
- notify the patient's primary care provider or a designated provider of urgent care visits.[57]

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

[51] MISSION Act.

[52] The OIG selected the urgent care domain for Big Spring and San Antonio because they had more patients with repeat visits to community urgent care providers than the VHA facility national average.

[53] MISSION Act, § 105; VHA IVC, chap 8 in *Community Care Field Guidebook*.

[54] The facilities reviewed in this domain combined spent more than $3.5 million for over 16,000 patients to be treated at community urgent care clinics in fiscal year 2024. OIG analysis of VHA data.

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

[56] VHA Office of Community Care Delivery Operation, "Community Care-Urgent Care Record Note Setup Guide," February 1, 2018.

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

Notification of Patients Receiving Community Urgent Care Services

The OIG found that VHA lacks a process to notify facility community care staff when patients receive community urgent care services. VHA provided feedback in response to the OIG report, *Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers*, and said patients and community urgent care centers are not required to notify the local VHA facility of community urgent care visits.[58] Community care leaders at the facilities reviewed reported being unaware when these visits occur. If community care staff are not aware of community urgent care visits, they may not seek documents from urgent care providers. As a result, patients' lack of follow-up care may lead to suboptimal clinical outcomes.

The OIG remains concerned that VHA lacks a process to notify facility staff of community urgent care visits so patients' primary care providers can coordinate any follow-up care. The OIG issued a recommendation for improvement to the IVC in the published report, *Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan*, and will continue to follow up on the prior recommendation to resolve the issue.[59]

Documentation of Patients Receiving Community Urgent Care Services

The OIG estimated that Big Spring community care staff did not create the Community Care–Urgent Care Record note in the electronic health record for any patients reviewed who received community urgent care, as required by the VHA IVC *Community Care Field Guidebook*.[60] Big Spring community care leaders acknowledged this as an area where they need to improve. When the note is not created VHA primary care providers or designated signers may be unaware of a patient's treatment or the need for follow-up care.

VHA Provider Notification of Community Urgent Care Services

The OIG estimated that Big Spring and San Antonio community care staff did not notify the patient's VHA primary care provider or designated provider for 91 percent (95% CI: 83 to 98) and 67 percent (95% CI: 51 to 81) of community urgent care visits, respectively, as required by the VHA IVC *Community Care Field Guidebook*.[61] Community care leaders from Big Spring

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

[59] VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan*, Report No. 24-00824-174, July 29, 2025.

[60] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Statistical analysis for facility noncompliance appears in appendix B.

[61] Statistical estimates for facility noncompliance appears in appendix B.

and San Antonio explained that community urgent care providers sent VHA primary care teams most of the urgent care documents directly instead of sending them to community care staff. The OIG did not find evidence primary care providers were aware of these visits. When community care staff do not notify VHA providers of community urgent care visits, patients may not receive follow-up care.

Community Emergency Care Coordination and Management

Care coordination between VHA and community providers helps improve patients' health outcomes.[62] When care is fragmented following emergency care in the community, patients may experience anxiety, unnecessary repeat testing, lack of communication on pending test results, and missed diagnoses.[63]

The OIG evaluated community emergency care coordination and management at El Paso and Harlingen.[64] Additionally, the OIG determined whether patients returned to the emergency department or were admitted to the hospital within 30 days for the same or similar condition and experienced complications.

Community emergency care expenditures are up 46 percent since 2020 and are now the single largest contributor to VA community care spending.[65] Within VISN 17 alone, 76,644 patients received community emergency care services at a cost of over $633 million during fiscal year 2024.[66] The VHA Veteran Care Emergency Treatment Notification Process Standard Operating Procedures encourages a patient, patient's representative, or community hospital staff to use the Emergency Care Reporting portal to notify VHA staff of a community emergency care visit so they can authorize treatment and determine the reimbursement for the care.[67] They can

[62] VHA Directive 1310(1), *Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers*, October 4, 2021, amended April 13, 2022.

[63] National Quality Forum, *Emergency Department Transitions of Care: A Quality Measurement Framework*, Final Report, August 30, 2017.

[64] The OIG selected the emergency care domain for El Paso and Harlingen because they had more patients with repeat visits to community emergency care providers than the VHA facility national average.

[65] Anita A. Vashi et al., "Community Emergency Care Use by Veterans in an Era of Expanding Choice," *JAMA Network Open* 7, no.3 (March 8, 2024): 1-11, https://doi:10.1001/jamanetworkopen.2024.1626.

[66] For the VISN 17 facilities reviewed in this domain combined, VHA spent over $180,950,079 for almost 20,000 patients for community emergency care in fiscal year 2024. OIG analysis of VHA data.

[67] 38 C.F.R. § 17.4020 (2019); The Emergency Care Reporting tool is a secure VA portal used by community emergency department staff, veterans, and others to enter data related to a veteran's emergency care, which allows VHA staff to begin care coordination activities and authorize care. Department of Veterans Affairs, "VHA Office of Integrated Veteran Care Emergency Treatment Notification Process Standard Operating Procedures," January 6, 2023.

also notify VHA staff through a centralized call center or by contacting the nearest medical facility within 72 hours.[68]

The VHA IVC *Community Care Field Guidebook* requires facility staff to

- review the Emergency Care Reporting portal daily to determine if a patient notified VHA of a community emergency visit,
- add interdisciplinary team members as additional signers to the note to include them in the patient's follow-up care, and
- obtain community emergency care medical documents, import them into the patient's electronic health record, and attach them to the note.[69]

Interdisciplinary Team Involvement with Care Coordination Plan

The OIG estimated that El Paso community care staff did not add all the patient's interdisciplinary team members as additional signers to the Community Care–Care Coordination Plan note or the Community Care–EMER Self-Presenting Care Coordination Plan note in the electronic health record for 97 percent (95% CI: 88 to 100) of community emergency care visits, as required by the VHA IVC *Community Care Field Guidebook*.[70] When facility community care staff do not add all interdisciplinary team members as additional signers, it can lead to them being unaware they need to follow up with the patients. El Paso community care leaders said staff only notify the registered nurse assigned to the patient's primary care team instead of the physician.

Discharge Care Plans

The OIG estimated that Harlingen nursing staff did not address the follow-up care documented in discharge plans for 35 percent (95% CI: 19 to 53) of patients following community emergency care visits, as required by the VHA IVC *Community Care Field Guidebook*.[71] When facility staff do not provide patients with appropriate discharge care after community emergency visits, it can lead to fragmented treatment and less than desirable clinical outcomes.

---

[68] Department of Veterans Affairs, "VHA Office of Integrated Veteran Care Emergency Treatment Notification Process Standard Operating Procedures."

[69] Effective March 11, 2024, community care staff were required to use the Community Care-Emergency (EMER) Self-Presenting Care Coordination Plan note instead of the Community Care Coordination Plan note in the electronic health record to document community emergency care and coordination activities. VHA IVC, chap. 3 in *Community Care Field Guidebook*, October 17, 2024.

[70] Statistical estimates for facility noncompliance appears in appendix B.

[71] Department of Veterans Affairs, "VHA Office of Integrated Veteran Care Emergency Treatment Notification Process Standard Operating Procedures," January 6, 2023. Statistical estimates for facility noncompliance appears in appendix B.

Community Emergency Care Medical Documents Attached to Care Coordination Plan

The OIG estimated that El Paso community care staff did not obtain the patients' medical documents, import them into the electronic health records, and attach them to the Community Care–Care Coordination Plan note or the Community Care–EMER Self-Presenting Care Coordination Plan note for 92 percent (95% CI: 75 to 100) of community emergency care visits, as required by the VHA IVC *Community Care Field Guidebook*.[72] Community care staff not attaching the documents to the appropriate note can lead to fragmented care.

Conclusion

To assist VISN and facility leaders in evaluating the quality and safety of community care at seven facilities within VISN 17, the OIG conducted a detailed inspection across six community care domains from January 21 through February 7, 2025. This resulting report is the final iteration of the OIG's VISN Care in the Community Inspection program. This report does not contain recommendations because previous reports have similar recommendations with VHA that address the observations detailed in the report. The OIG's observations highlight areas of concern and are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Care in the Community Inspection program of VHA medical facilities across the nation, program leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

[72] VHA IVC, chap. 3 in *Community Care Field Guidebook*. Statistical estimates for facility noncompliance appears in appendix B.

Appendix A: Methodology

The OIG reviewed community care processes at seven VISN 17 medical facilities with a community care program from January 21 through February 7, 2025. The facilities were the VA Amarillo Healthcare System (Amarillo), VA West Texas Healthcare System (Big Spring), VA North Texas Health Care System (Dallas), VA El Paso Healthcare System (El Paso), VA Texas Valley Coastal Bend Healthcare System (Harlingen), South Texas Veterans Health Care System (San Antonio), and VA Central Texas Healthcare System (Temple).

The OIG reviewed electronic health records and facilities' policies and standard operating procedures. The OIG also examined the community care oversight council charters and meeting minutes for fiscal year 2024 to determine whether facilities had a council and if it met the minimum number of times per year, as required by their charter. The OIG interviewed leaders and staff to discuss processes, validate observations, and explore reasons for noncompliance. The OIG's analysis relied on inspectors identifying information from interviews, documents, and observational data based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.[1]

The inspection team examined operations and electronic health records from October 1, 2023, through September 30, 2024. The OIG reviewed each selected facility for performance in the Leadership and Administration of Community Care domain. After reviewing facility performance data relevant to each respective domain, the OIG selected three additional domains for Big Spring, Dallas, Harlingen, San Antonio, and Temple, and reviewed a total of four domains for each. For Amarillo and El Paso, the OIG selected two additional domains and reviewed a total of three domains for these facilities. OIG leaders approved all domain selections based on content and professional judgment. The domains selected for each VISN 17 facility are shown in figure 4.

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

	Amarillo TX	Big Spring TX	Dallas TX	El Paso TX	Harlingen TX	San Antonio TX	Temple TX
Leadership and Administration	✓	✓	✓	✓	✓	✓	✓
Diagnostic Imaging Results	✓	✓	✓		✓		✓
Administratively Closed Consults		✓	✓	✓	✓	✓	✓
Requests for Service	✓		✓			✓	✓
Urgent Care		✓				✓	
Emergency Care				✓	✓		

Figure 4. *Domain selections for VISN 17 facilities.*

Source: OIG analysis of VHA data.

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

For each VISN 17 facility reviewed, the OIG used the following criteria to select electronic health records during the review period for each domain:

- Community Care Diagnostic Imaging Results: community care diagnostic imaging referrals for computed tomography, ultrasound, or magnetic resonance imaging.
- Administratively Closed Community Care Consults: community care consults administratively closed without medical documentation, excluding referrals for low risk, emergency care, dental, dialysis, imaging, and geriatrics and extended care services.
- Community Care Provider Requests for Additional Services: patients with requests for additional services submitted by community providers, excluding requests for dental or geriatrics and extended care services. If a patient had more than one request, the OIG evaluated the earliest request during the study period.
- Community Urgent Care Coordination and Management: paid invoices for community urgent care visits of patients with cardiac, respiratory, pain, and mental health needs, excluding patients referred for emergency care the same day as urgent care visits.

- Community Emergency Care Coordination and Management: patients with paid community emergency care claims who are diagnosed with cardiac or respiratory problems, pain, wounds, or infectious diseases, where the medical center received notification within 72 hours of the community emergency care visit. The OIG excluded patients transferred to another emergency care provider, patients admitted to any hospital within three days of the community emergency care visit, patients who died at the community emergency care department, and patients who left the community emergency care department against medical advice.

For all the above domains, the OIG randomly selected 50 electronic health records that met the criteria for the review period. During the review process, the OIG may have excluded some records, which resulted in the analysis of less than 50 records. The OIG statistically analyzed all randomly selected samples. The OIG reported the results of statistical analysis in appendix B.

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

This report is a review of VISN 17 facilities' use of and adherence to VHA community care policies. The OIG included attribution, where appropriate, because information shared during surveys or interviews was not verified for accuracy or completeness. Observations cannot be generalized across VHA.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[2] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Observations do not define a standard of care or establish legal liability. The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

Appendix B: Statistical Analysis

The OIG estimated that Temple staff did not consistently import diagnostic reports into electronic health records, as shown in Table B.1.

Table B.1. Diagnostic Reports Imported Into Electronic Health Records

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	50	0	n/a*
Big Spring	49	0	n/a*
Dallas	49	6	0 to 14
Harlingen	50	8	2 to 16
Temple	50	34	22 to 48

Source: OIG analysis of VHA data.

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

The OIG estimated that Big Spring community care staff did not attach any diagnostic reports to the Community Care Consult Result note, the Community Care–Request for Services note, or the Community Care–Care Coordination Plan note in the electronic health record, as shown in Table B.2.

Table B.2. Diagnostic Reports Attached to the Correct Note

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	50	20	10 to 32
Big Spring	49	100	n/a*
Dallas	46	9	2 to 18
Harlingen	46	0	n/a*
Temple	33	18	6 to 32

Source: OIG analysis of VHA data.

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

The OIG estimated that Amarillo, Big Spring, Dallas, Harlingen, and Temple community care staff did not consistently use the significant findings alert in the electronic health record to notify providers of abnormal test results, as shown in Table B.3.

Table B.3. Significant Findings Alert Used to Notify Providers of Abnormal Diagnostic Imaging Results

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	40	100	n/a*
Big Spring	30	100	n/a*
Dallas	18	89	71 to 100
Harlingen	17	82	62 to 100
Temple	12	42	13 to 71

Source: OIG analysis of VHA data.

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

The OIG estimated that Dallas and El Paso community care staff did not consistently make three attempts to obtain community providers' medical documents within 90 days of the appointment, while San Antonio and Temple did not make three attempts to obtain the documents for any of the consults, as shown in Table B.4.

Table B.4. Attempts to Obtain Medical Documents

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Big Spring	9	n/a*	n/a‡
Dallas	30	87	73 to 97
El Paso	34	97	90 to 100
Harlingen	28	11	0 to 24
San Antonio	32	100	n/a‡
Temple	24	100	n/a‡

Source: OIG analysis of VHA data.

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

The OIG estimated that community care staff at Temple did not consistently attach medical documents to the Community Care Consult Result note, the Community Care–Request for Services note, or the Community Care–Care Coordination Plan note in the electronic health record, while staff at Big Spring did not attach any medical documents to the notes, as shown in Table B.5.

Table B.5. Medical Documents Attached to Electronic Health Record Notes

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Big Spring	45	100	n/a*
Dallas	28	7	0 to 18
El Paso	31	0	n/a*
Harlingen	27	0	n/a*
San Antonio	26	4	0 to 12
Temple	41	41	27 to 57

Source: OIG analysis of VHA data.

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

The OIG estimated that community care staff at Amarillo, Dallas, San Antonio, and Temple did not consistently process requests for additional services within three business days of receipt, as shown in Table B.6.

Table B.6. Requests for Additional Services Processed Within Three Business Days of Receipt

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	48	31	19 to 45
Dallas	45	60	46 to 74
San Antonio	48	77	65 to 88
Temple	47	57	43 to 71

Source: OIG analysis of VHA data.

The OIG found that community care staff at Temple did not consistently send approval letters to community providers, while Amarillo and Dallas did not send any, as shown in Table B.7.

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

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	35	100	n/a*
Dallas	37	100	n/a*
San Antonio	32	3	0 to 10
Temple	40	98	92 to 100

Source: OIG analysis of VHA data.

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

The OIG found that community care staff at Amarillo did not send any community providers denial letters for requests for additional services, as shown in Table B.8.

Table B.8. Denial Letters Sent to Community Providers for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	13	100	n/a*
Dallas	8	n/a‡	n/a
San Antonio	16	0	n/a*
Temple	7	n/a‡	n/a

Source: OIG analysis of VHA data.

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

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

The OIG estimated that Amarillo and Temple community care staff did not consistently send approval letters to patients for requests for additional services while Dallas did not send any, as shown in Table B.9.

Table B.9. Approval Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	35	94	86 to 100
Dallas	37	100	n/a*
San Antonio	32	6	0 to 16
Temple	40	95	88 to 100

Source: OIG analysis of VHA data.

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

The OIG estimated that San Antonio community care staff did not consistently send denial letters to patients for requests for additional services, while Amarillo community care staff did not send any, as shown in Table B.10.

Table B.10. Denial Letters Sent to Patients for Requests for Additional Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Amarillo	13	100	n/a*
Dallas	8	n/a‡	n/a
San Antonio	16	69	44 to 91
Temple	7	n/a‡	n/a

Source: OIG analysis of VHA data.

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

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

The OIG estimated that Big Spring community care staff did not create the Community Care–Urgent Care Record note in the electronic health record for patients who received community urgent care when community urgent care providers sent medical documents, as shown in Table B.11.

Table B.11. Community Care–Urgent Care Record Note Created for Patients Who Received Community Urgent Care

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Big Spring	29	100	n/a*
San Antonio	8	n/a‡	n/a

Source: OIG analysis of VHA data.

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

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

The OIG estimated that Big Spring and San Antonio community care staff did not consistently notify the patient's VHA primary care provider or designated provider of community urgent care visits, as shown in Table B.12.

Table B.12. VHA Providers Notified of Community Urgent Care Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
Big Spring	46	91	83 to 98
San Antonio	39	67	51 to 81

Source: OIG analysis of VHA data.

The OIG estimated that El Paso community care staff did not consistently add interdisciplinary team members as additional signers to the Community Care–Care Coordination Plan note or the Community Care–EMER Self-Presenting Care Coordination Plan note in the electronic health record to include them when the facility healthcare team coordinates the patient's care, as shown in Table B.13.

Table B.13. Interdisciplinary Team Members Added as Additional Signers to Electronic Health Record Notes After Community Emergency Care Services

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
El Paso	29	97	88 to 100
Harlingen	44	2	0 to 7

Source: OIG analysis of VHA data.

The OIG estimated that Harlingen staff did not consistently provide care to address needs documented in the patient's discharge plan after community emergency care visits, as shown in Table B.14.

Table B.14. Community Emergency Care Discharge Plan Care Needs Provided

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
El Paso	5	n/a*	n/a
Harlingen	31	35	19 to 53

Source: OIG analysis of VHA data.

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

The OIG estimated that El Paso community care staff did not consistently obtain, import, and attach community emergency care medical records to the Community Care–Care Coordination Plan note or the Community Care–EMER Self-Presenting Care Coordination Plan note in the electronic health record, as shown in Table B.15.

Table B.15. Community Emergency Care Medical Documents Attached to the Correct Notes

Facility	Number of Patients in Review	Noncompliance Percentage	95% Confidence Interval
El Paso	13	92	75 to 100
Harlingen	42	5	0 to 12

Source: OIG analysis of VHA data.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 8, 2026

From: Director, Veterans Integrated Service Network (VISN) 17: Department of Veterans Affairs (VA) Heart of Texas Healthcare Network (10N17)

Subj: VA OIG Report, Care in the Community Inspection of VISN 17: VA Heart of Texas Healthcare Network

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values.
2. I concur with the report findings of OIG report, Care in the Community Inspection of Medical Facilities in VISN 17: VA Heart of Texas Healthcare Network.
3. Should you need further information, contact the Veterans Integrated Service Network Quality Management Officer.

(*Original signed by:*)

Jamie Park, Ed.D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Shelia Farrington-Sherrod, MSN, RN Carol (Shannon) Foote, MSN, RN Nancy Krzanik, MSN, RN Mahshid Lee, LCSW Renay Montalbano, MSN, RN-BC Mandy Petroski-Moore, LCSW
Other Contributors	Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Courtney Harold, BA LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Ryan McGovern, MS Daphney Morris, MSN, RN Joan Redding, MA April Terenzi, BA, BS Erika Terrazas, MS Thomas Wong, DO Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of Accountability and Whistleblower Protection
Office of Public and Intergovernmental Affairs
Office of General Counsel
Office of Congressional and Legislative Affairs
Director, VISN 17: VA Heart of Texas Healthcare Network

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
New Mexico: Martin Heinrich, Ben Ray Luj?n
Oklahoma: James Lankford, Markwayne Mullin
Texas: John Cornyn, Ted Cruz
US House of Representatives
New Mexico: Teresa Leger Fernandez, Melanie Stansbury, Gabe Vasquez
Oklahoma: Tom Cole, Frank Lucas
Texas: Jodey Arrington, John Carter, Greg Casar, Joaquin Castro, Michael Cloud, Jasmine Crockett, Henry Cuellar, Monica De La Cruz, Lloyd Doggett, Jake Ellzey, Veronica Escobar, Pat Fallon, Brandon Gill, Craig Goldman, Tony Gonzales, Vicente Gonzalez, Lance Gooden, Ronny Jackson, Julie Johnson, Michael McCaul, Nathaniel Moran, August Pfluger, Chip Roy, Keith Self, Pete Sessions, Beth Van Duyne, Marc Veasey, Roger Williams

OIG reports are available at www.vaoig.gov

Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.