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Report to Congressional Requesters

September 2025

VETERANS HEALTH CARE

Better Communication Needed to Integrate Management of Medical Facility and Community-Based Care

GAO-25-107212

GAO Highlights

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Better Communication Needed to Integrate Management of Medical Facility and Community-Based Care

GAO-25-107212 September 2025

Highlights of GAO-25-107212, a report to congressional requesters.

Why This Matters

Since 2014, veterans who face challenges accessing timely health care at Veterans Health Administration (VHA) medical facilities have been increasingly referred to community providers to receive care.

As part of an organizational reform to address its progressively complex processes, VHA created the Office of Integrated Veteran Care (IVC) to improve coordination and provide seamless access to care.

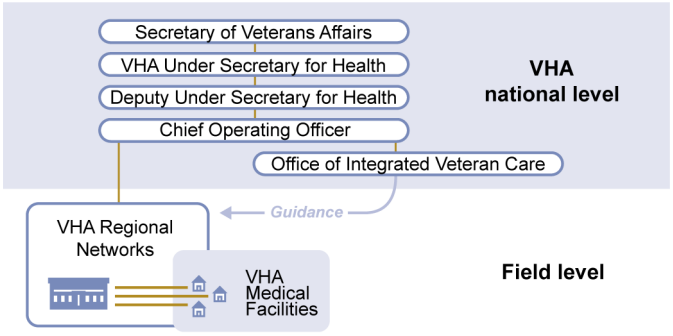
GAO Key Takeaways

IVC combined oversight of the management of VHA medical facility and community care into one office. The office established national priorities and initiatives, such as expanding a new process for specialty care appointments. It is also responsible for developing national policy for VHA's regional networks and medical facilities to guide implementation of initiatives to enhance access to care at medical facilities.

IVC has made several changes to its organizational structure and priorities since it was established. In May 2025, officials said further changes are on hold as the Department of Veterans Affairs undergoes reorganization and workforce reduction that may affect IVC. Congressional stakeholders have raised questions about the potential effects on veteran health care delivery.

The frequent changes have affected officials' ability to carry out the initiatives at some facilities. They reported that IVC did not clearly communicate changes to its organizational structure, and they did not always know where to seek guidance. They also reported that communication was often one-way, and their input was not solicited when making changes. Clear two-way communication will help officials effectively implement initiatives to ensure veterans access timely care.

VHA Organizational Chart as of January 2025



Source: Veterans Health Administration (VHA); GAO (illustration). | GAO-25-107212

How GAO Did This Study

We evaluated VHA's efforts against selected leading agency reform practices identified in prior GAO work. We reviewed documents and interviewed VHA officials from national-level offices, three regional networks, and three medical facilities on IVC's organizational structure and planned changes.

What GAO Recommends

We are recommending that VHA ensure IVC develops a strategy for clear and continuous two-way communication with relevant employees and stakeholders as the office continues to evolve and makes changes to its organizational structure. VHA concurred with our recommendation.

For more information, contact Sharon M. Silas at silass@gao.gov.

Contents

Abbreviations

AUSH	Assistant Under Secretary for Health
FTE	full-time equivalent
IVC	Office of Integrated Veteran Care
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

September 2, 2025

The Honorable Julia Brownley
Ranking Member
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Susie Lee
House of Representatives

The Honorable Chris Pappas
House of Representatives

In the last decade, Congress has taken steps to improve veterans' access to health care by expanding the ability for eligible veterans to receive care from community providers in certain circumstances. Veterans typically receive care from Veterans Health Administration (VHA) medical facilities. However, veterans sometimes face challenges accessing care at VHA facilities and, if eligible, can receive care instead from providers in their surrounding community. Such care is referred to as community care and is paid for by the Department of Veterans Affairs (VA).[1] In particular, VA's implementation of the VA MISSION Act of 2018 made community care a more central part of how the department ensures veterans have access to care. According to VA, the number of veterans who received services through community care increased from about 1.1 million in 2014 to about 3.1 million in 2024.

[1]In August 2014, after several well-publicized events highlighted serious and longstanding issues with veterans' access to care, Congress enacted the Veterans Access, Choice, and Accountability Act of 2014. Among other things, the law established a temporary program—called the Veterans Choice Program—and provided up to $10 billion in funding for veterans to obtain health care services from community providers when they faced long wait times, lengthy travel distances, or other challenges accessing care at VHA facilities. Pub. L. No. 113-146, tit. I, §§ 101, 802(d), 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

In 2019, the Veterans Community Care Program replaced the Veterans Choice Program and consolidated other existing community care programs. The VA MISSION Act of 2018 (VA MISSION Act) broadened veterans' eligibility to receive care outside of the VA health care system under this program. Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395 (2018).

The growth in community care has contributed to VA's increasingly complex processes for managing veterans' access to care at all levels within VHA. For example, VHA has acknowledged complexity in how it schedules veterans' health care appointments that has led to inefficiencies, workarounds, delays in care, and inconsistent veteran experiences. The department currently has several efforts underway to improve its scheduling processes. For example, in 2019, VA began implementing the Referral Coordination Initiative, a significant change to the process for managing specialty care referrals where staff at VHA medical facilities discuss direct care and community care options with veterans.[2]

For nearly 25 years, we have reported on the challenges VA has faced providing veterans with timely access to care. We have issued reports recommending that VHA improve appointment scheduling, ensure the reliability of wait time and other performance data, and improve oversight.[3] Because of concerns with consistent and timely access to health care and other issues, VHA health care continues to be on our High Risk List.[4]

In 2020, VHA performed an assessment to further improve how VHA manages veterans' access to care and to reduce inadvertent overlap and duplication of clinical, administrative, and financial operations in its organizational structure. Based on one of several recommendations from

[2]We reported on the Referral Coordination Initiative in January 2025. See GAO, *Veterans Health Care: Referral Coordination Initiative for Specialty Care Needs Improved Program Direction and Guidance*, GAO-25-106678 (Washington, D.C.: Jan. 21, 2025).

[3]Our February testimony before the House Committee on Veterans' Affairs, Subcommittee on Health summarized many of the recommendations we have made to VHA in the past related to scheduling and access to care, including VHA actions to address our recommendations. See GAO, *Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program,* GAO-25-108101 (Washington, D.C.: Feb. 12, 2025). We also issued reports on IVC's Referral Coordination Initiative and the information technology systems VHA uses for scheduling appointments. See GAO-25-106678 and GAO, *Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization*, GAO-25-106851 (Washington, D.C.: May 22, 2025), respectively.

[4]This list focuses attention on government operations that are most vulnerable to fraud, waste, abuse, or mismanagement, or in need of transformation. To determine which federal government programs and functions should be designated "high risk," we consider factors such as whether the risk involves public health or safety. See GAO, *High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness*, GAO-25-107743 (Washington, D.C.: Feb. 25, 2025). GAO added VA health care to our High-Risk List in 2015. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

this assessment, VHA created the Office of Integrated Veteran Care (IVC) in spring 2022 and began to implement changes to improve coordination of access to both VHA medical facility-based and community care. In March 2025, the Secretary of Veterans Affairs announced a department-wide review to consider future reorganization and workforce reduction efforts, which may affect the future organization and work of IVC.[5]

You asked us to examine issues related to veterans' access to health care and the creation of VHA's IVC. In this report, we examine:

(1) VHA's establishment of IVC and its efforts to coordinate VHA medical facility and community care; and

(2) VHA's efforts to coordinate management of medical facility and community care in the field.

To examine VHA's establishment of IVC and its efforts to coordinate medical facility and community care, we reviewed VHA documents related to the creation of IVC. Specifically, we reviewed documentation of IVC's structure and how staff and roles from the predecessor entities—the Office of Veterans Access to Care and the Office of Community Care—were transitioned to form the IVC. We examined IVC's roles and responsibilities, including its role in providing guidance and information to regional networks known as Veterans Integrated Services Networks (VISN) and VHA medical facilities, through review of directives, training materials, and other relevant documents.[6] We also reviewed relevant findings and recommendations from our prior work.[7]

Additionally, we interviewed relevant VHA officials about IVC's creation, roles, responsibilities, and goals, including officials from IVC and the

[5]This report includes information about IVC prior to any changes that may result from the Secretary of Veterans Affairs' department-wide review.

[6]We focused our work on IVC's activities related to serving veterans; IVC also oversees some programs that serve family members of veterans, but these were not part of our scope.

[7]See, for example, GAO-25-106678; GAO, *Veterans Community Care Program: VA Needs to Strengthen Contract Oversight*, GAO-24-106390 (Washington, D.C.: Aug. 21, 2024); and GAO, *Veterans' Community Care: VA Needs Improved Oversight of Behavioral Health Medical Records and Provider Training*, GAO-25-106910 (Washington, D.C.: May 5, 2025).

Office of Healthcare Transformation.[8] We also conducted interviews with officials from three VISNs and three VHA medical facilities about their experiences working with IVC.[9] We selected these VISNs and facilities to ensure variation in geographic location and in their prior work with IVC.[10] The information we obtained from these interviews is not generalizable to other VISNs or VHA medical facilities.

We assessed IVC's ongoing changes to its organizational structure and its communication with relevant employees—including staff at VISNs and VHA medical facilities—and stakeholders against selected leading practices for agency reform identified in prior GAO work.[11] Specifically, we examined whether IVC has followed selected leading practices that agencies (1) engage relevant employees and stakeholders to develop their proposed reforms, and (2) develop a two-way continuing communications strategy that listens and responds to employee concerns regarding the effects of potential reforms. We selected the leading agency reform practices that were most relevant to our objectives and IVC's priorities in collaborating with relevant employees.

To examine VHA's efforts to coordinate management of medical facility and community care in the field, we reviewed relevant VHA documentation on managing medical facility and community care, such as VA's Functional Organization Manual, and our relevant prior reports as noted previously. We also interviewed VHA officials, including from IVC and selected VISNs, and reviewed VHA documentation on developing a field strategy to better coordinate VHA medical facility and community care in the field. This documentation included assessments of facilities that have implemented a strategy to create a new position at both the VISN and medical facility responsible for coordinating medical facility and community care. Finally, we interviewed officials from our three selected

[8]The Office of Healthcare Transformation is an office within VHA that plans, engineers, and implements enterprise-wide systems and processes of care in support of VA and VHA priorities. This office collaborates with stakeholders to define common goals and implement organizational priorities.

[9]We interviewed officials from VISNs 1, 7, and 19 and officials from VHA medical facilities in Boston, MA; Sheridan, WY; and Columbia, SC.

[10]Site selection was based on variation in interactions IVC documented with VISN and VHA medical facilities. For example, IVC documented several coordination activities with VISN 1, while VISN 7 and 19 were highlighted less frequently.

[11]See GAO, *Government Reorganization: Key Questions to Assess Agency Reform Efforts,* GAO-18-427 (Washington, D.C.: June 13, 2018).

VHA medical facilities to obtain information on how implementation of a field strategy would affect their facility.

We intended to assess VHA's plans to develop and implement a pilot study of approaches for coordinating medical facility and community care in the field against leading practices for pilot design as part of our review. However, as described in this report, in March 2025 VHA postponed development and implementation of the pilot.[12]

We conducted this performance audit from December 2023 to September 2025 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

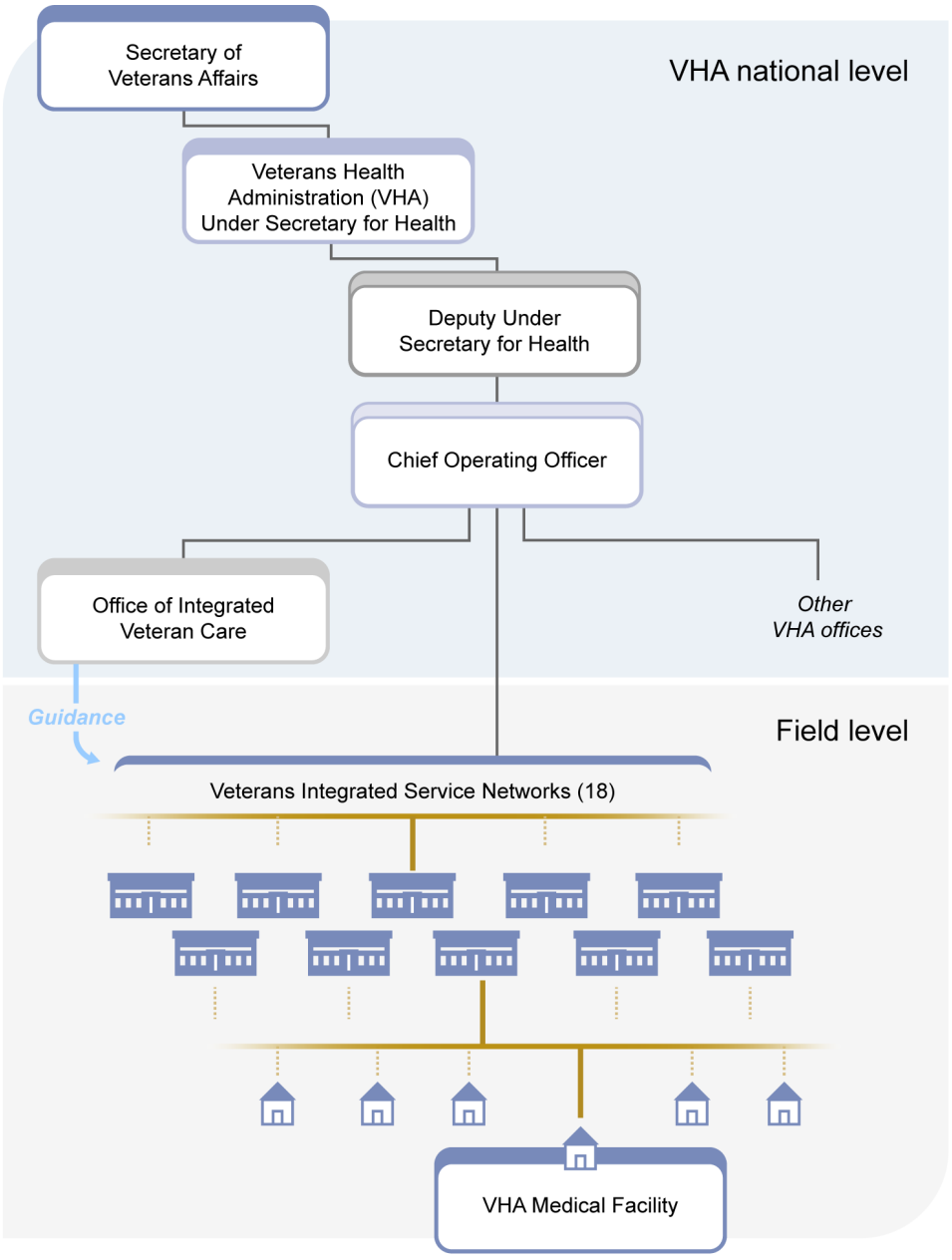
Background

VHA Health Care System

VHA's health care system comprises a central office at the national level, along with the VISNs, and individual medical facilities and outpatient clinics at the field level (see fig. 1).

[12]GAO, *DATA Act: Section 5 Pilot Design Issues Need to Be Addressed to Meet Goal of Reducing Recipient Reporting Burden*, GAO-16-438 (Washington, D.C.: Apr. 19, 2016).

Figure 1: Veterans Health Administration Organizational Chart (as of January 2025)



Source: Department of Veterans Affairs; GAO (illustration). | GAO-25-107212

At VHA's national level central office, the Under Secretary for Health provides leadership over numerous clinical and non-clinical offices with varying spans of responsibilities, including those related to quality of care and patient safety.[13] VHA's central office establishes (1) policy for VHA's health care system based on legal and regulatory requirements and (2) clinical practice guidelines. These policies are to guide the day-to-day functions of VHA medical facilities and are essential for effective oversight, according to VHA. IVC is the principal advisor to the Under Secretary for Health on matters related to veteran access to health care. In particular, IVC is responsible for establishing policy related to scheduling, referrals, and other topics related to veterans' access to both VHA medical facility and community care. For example, IVC manages and oversees the Veterans Community Care Program, including supporting care continuity by providing guidance to and monitoring the efforts of VHA medical facilities.[14]

At the field level, VHA's health care system is organized into 18 VISNs. Together, the VISNs are responsible for overseeing 170 VHA medical facilities and more than 1,000 outpatient clinics within a defined geographic area for each VISN. These facilities, in turn, deliver a wide range of health care services to veterans including traditional hospital-based services (e.g., surgery) and other generally outpatient-based services (e.g., dermatology and podiatry).

[13]Offices in VHA central office are designated as principal offices or program offices. Principal offices have broad spans of control and ensure that program outcomes are organized and aligned with a comprehensive strategy. They are led by a Senior Executive like an Assistant Under Secretary for Health. This executive is responsible for signing policies for subordinate program offices and overseeing, facilitating, and aligning the work of those program offices that fall under their authority. Program offices are the main operating units within VHA central office, responsible for developing policies and strategies and providing tools to the field in support of national goals. See Department of Veterans Affairs, *Veterans Health Administration Directive 1217(1): VHA Operating Units* (Washington D.C.: Aug. 14, 2024, amended Jan. 19, 2025).

[14]VA implemented the Veterans Community Care Program on June 6, 2019, as required under the VA MISSION Act. IVC manages the program through contracts with third-party administrators—with each contract covering services in one region of the country. IVC, along with other offices, oversees the third-party administrators, including the adequacy of their regional networks to provide veterans with sufficient access to care.

IVC also manages several programs that provide health care benefits to veterans' family members based on certain conditions and eligibility requirements. These programs were not the focus of this review.

VHA Functional Assessment of Integrated Veteran Care

The creation of IVC was the direct result of a functional assessment initiated by VHA following implementation of key legislative efforts designed to improve access to VHA health care—including implementing the VA MISSION Act. The objectives of the functional assessment included identifying fragmentation, overlap, and duplication of VHA program office activities related to veterans' access to care. The assessment was also to identify actions that VHA could take to improve how it manages veterans' access to care through changes to clinical, administrative, and financial operations. The team conducting the assessment was comprised of VHA central office and VISN officials.

In December 2020, VHA published the final report of its functional assessment, which included five findings.[15] See table 1.

Table 1: Findings from Veterans Health Administration (VHA) Functional Assessment of Integrated Veteran Care, December 2020

Finding 1	Fragmented finance and access functions within VHA's Office of Finance, Office of Veterans Access to Care, Office of Community Care, and Veterans Integrated Service Networks (VISN)[a]
Finding 2	Disjointed care coordination system between direct and community care[b]
Finding 3	Lack of common tools and resources to effectively manage care delivered to veterans across the enterprise
Finding 4	Opportunities to enhance access by optimizing direct care[b]
Finding 5	Duplicative and overlapping administrative, financial, and operational functions within VHA's Office of Community Care

Source: VHA. | GAO-25-107212

[a]VHA's Office of Finance is responsible for budget development and allocation, including overseeing financial management and accounting operations. VHA's Office of Veterans Access to Care responsibilities included oversight of efforts to manage veterans' care received at VHA medical facilities. VHA's Office of Community Care responsibilities included oversight of efforts to manage veterans' care received from community providers.

[b]Direct care is care received in a VHA medical facility. The functional assessment report noted that due to unique geographic and population needs and challenges, the application of community care standards at that time did not provide flexibility in determining if direct care is a better solution for a veteran, even when that veteran is eligible for community care.

Based on these five findings, the functional assessment included four recommendations to streamline VHA coordination of roles related to VHA medical facility care and community care. The functional assessment report noted that for these recommendations to be successfully executed, sufficient financial and staffing resources would be needed at the VHA facility, VISN, and VHA national levels. VHA officials told us that they have taken actions to address three of the four recommendations, which

[15]Department of Veterans Affairs, Veterans Health Administration, *Integrated Veteran Care Functional Assessment Final Report* (December 17, 2020).

are described below, and have efforts underway to address the remaining recommendation, which are discussed later in this report.

- **Integrate finance functions across VHA.** In September 2021, VHA announced its plans to integrate finance functions across VHA at the national level. Specifically, as of April 2022, officials responsible for community care payment processing and its supporting compliance functions were moved from the Office of Community Care to the Office of Finance. According to a VHA memo, the purpose of this realignment was to clarify oversight and authority, enhance accountability, and improve separation of duties.
- **Establish an Assistant Under Secretary for Health – Integrated Veteran Care.** VHA established the position of Assistant Under Secretary for Health (AUSH) for Integrated Veteran Care to lead VA's efforts to improve coordination of access to VHA facility and community care for veterans and beneficiaries in May 2022. According to the 2023 *VA Functional Organization Manual*, the individual in this role is expected to provide clear and consistent guidance on the use of VHA facility care and community care, and provide a unified veteran-centric access management strategy and performance management framework that is uniformly applied across VHA.
- **Establish VISN directors as operational leaders.** VHA established VISN directors as operational leaders through the August 2024 update to its Directive 1217(1) on VHA operating units.[16] Under the updated directive, VISN directors have newly defined responsibilities in governance, management, expertise, leadership, and oversight not included in the previous version of the directive.[17] More specifically, VISN directors are responsible for communicating with internal and external stakeholders, such

[16]Department of Veterans Affairs, *Veterans Health Administration Directive 1217(1)*. *VHA Directive 1217(1)* sets forth the roles, responsibilities, and decision rights for VHA operating units.

[17]In June 2019, we recommended that VHA should establish a comprehensive policy that clearly defines the roles and responsibilities for managing and overseeing medical care. VHA concurred in principle with our recommendation and subsequently published an updated VHA Directive 1217, including a more defined role for VISNs. As of February 2025, this recommendation was partially implemented because while Directive 1217 defines roles and responsibilities for VISN directors, the directive does not account for all leadership positions in the VISN. See GAO, *Veterans Health Administration: Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities*, GAO-19-462 (Washington, D.C.: June 19, 2019).

as other VHA entities or veterans service organizations, as needed, to help address issues identified by medical facilities within their network, among other things.

- **Design enterprise integrated veteran care model.** The goal of an integrated veteran care model is to improve care coordination and provide seamless access to care for veterans. The functional assessment stated that implementation of this model should include integration of care coordination at every level of the organization, including the national level and the field. VHA has taken some actions to address this recommendation through its efforts to improve coordination of VHA medical facility and community care at the national level within IVC. In addition, in early 2024, VHA began work to develop a field strategy for integrating management of VHA medical facility and community care at the VISN and VHA medical facility level, similar to how these have been integrated at the national level within IVC.

Access to VHA Medical Facility Care and Community Care

VHA medical facility staff are generally responsible for processing referrals and scheduling appointments for enrolled veterans to receive care either from a VHA medical facility provider or a community provider.[18] For a veteran to receive specialty care services, a provider at a VHA medical facility must initiate a request for an appointment by submitting a referral.[19] Clinical staff (e.g., providers and nurses) and administrative staff (e.g., appointment schedulers) at the VHA facility review the referral and consider eligibility for community care. If eligible, veterans may choose to obtain health care services from community providers rather than from providers at a VHA medical facility. There are six criteria that can qualify a veteran to receive community care, including designated access standards related to how far a veteran must drive (drive time) and how long a veteran must wait to be seen by a provider (wait time).[20]

[18]VHA policy uses the terms “consult” and “referral” when describing requests placed by VHA providers. For the purposes of this report, we will use the term referral.

[19]Referrals are not required for primary care appointments. There are also specific specialties, such as audiology, optometry, and podiatry, that participate in self-scheduling, allowing veterans to schedule an appointment at a VHA facility without a referral.

[20]Veterans must either be enrolled in VA health care or be eligible for VA care without needing to enroll, and in most circumstances, veterans must receive approval from VHA prior to obtaining care from a community provider. See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. at 1395-1404. Community care eligibility criteria established under the VA MISSION Act are codified at 38 U.S.C. § 1703(d), (e), with implementing regulations at 38 C.F.R. § 17.4010.

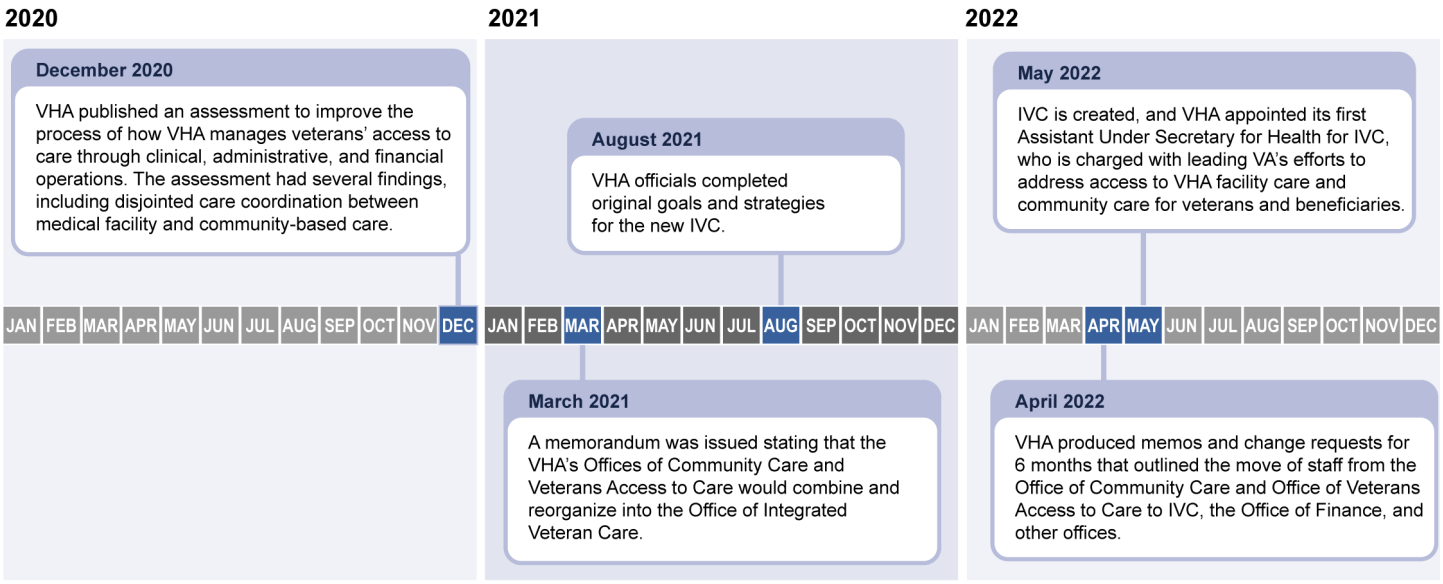
Depending on whether a veteran is eligible for community care and that veteran's scheduling preferences, VHA facility staff will schedule an appointment either with a VHA provider at a VHA facility or with a non-VHA provider in the community. When eligible veterans choose community care, VHA facility community care staff work with them to schedule appointments with community providers. These staff are typically located in separate offices from the staff scheduling VHA medical facility appointments, and they follow different processes. Staff who schedule VHA medical facility appointments have access to providers' appointment schedules and can typically schedule a veteran's appointments via VA's electronic scheduling system. VHA facility staff who schedule community care appointments must contact a community provider listed in a VHA database to determine appointment availability and to schedule an appointment for the veteran.

VHA Established IVC to Improve Care Coordination but Has Not Clearly Communicated Organizational Changes

VHA Established IVC to Improve Care Coordination and Implemented Several Initiatives to Facilitate Veterans' Access

In spring 2022, VHA established the IVC to integrate management of VHA medical facility and community care into one office to improve coordination and provide veterans with seamless access to care. IVC was created by incorporating staff from two predecessor VHA offices: the Office of Veterans Access to Care, which had managed veterans' access to VHA medical facility care, and the Office of Community Care, which had managed care veterans received in the community. See figure 2 for a timeline of IVC's creation.

Figure 2: Creation of the Veterans Health Administration's (VHA) Office of Integrated Veteran Care (IVC)



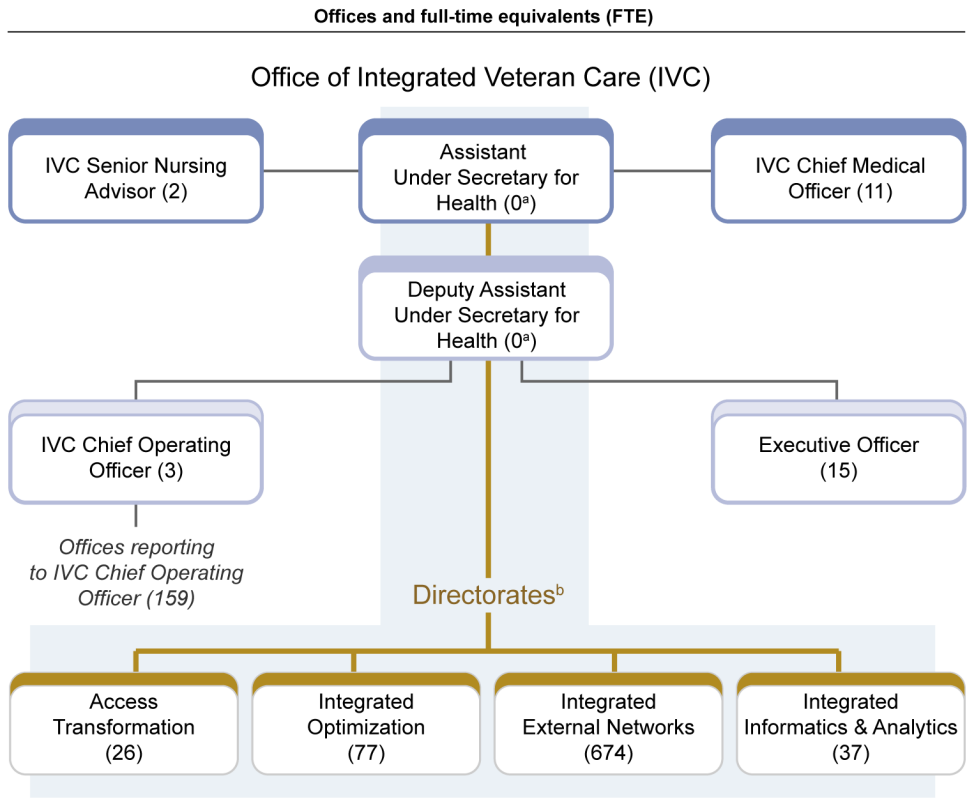
Source: GAO analysis of Department of Veterans Affairs documentation. | GAO-25-107212

IVC's Organizational Structure

The AUSH for Integrated Veteran Care is the head of IVC. The AUSH for IVC is a new position, created in May 2022 when the office was established. According to IVC documentation, the AUSH works to develop priorities for IVC and leads VA's efforts to enhance access to care for veterans and other beneficiaries. IVC's Chief Medical Officer, Senior Nursing Advisor, and Deputy AUSH report directly to the AUSH. The Deputy AUSH oversees IVC's Chief Operating Officer and Executive Officer, as well as four sub-offices, known as directorates.[21] See figure 3.

[21]As we were completing our work on this review, IVC officials told us they intended to designate these four directorates as program offices. Because the change had not yet been finalized, we use the term directorate in this report.

Figure 3: Veterans Health Administration Office of Integrated Veteran Care Organizational Chart, Fiscal Years 2024-2025



Source: Department of Veterans Affairs. | GAO-25-107212

This figure represents the IVC structure following its April 2024 realignment, according to IVC officials.

[a]As of May 2025, the Assistant Under Secretary for Health and Deputy Assistant Under Secretary for Health were serving in an acting capacity, so they were not included in the FTE count for those offices. According to IVC, these acting positions have been in place since February 2024.

[b]As we were completing our work on this review, IVC officials told us they intended to designate these four directorates as program offices. Because the change had not yet been finalized, we use the term directorate in this report.

As of May 2025, IVC included four directorates, with distinct but complementary roles, according to IVC officials.

- **Access Transformation.** This office guides VHA's processes, roles, and practices for providing veterans with access to timely, quality health care. The office is responsible for leading and coordinating technological innovations to support integrated access and care management for VISNs and VHA medical facility

staff. IVC officials said that these modernization efforts involve establishing partnerships with VISN leadership, such as VISN directors, chief medical officers, and chief nursing officers, to implement changes at each VISN.

- **Integrated Optimization.** This office collaborates with VHA medical facilities, VISNs, and leadership from other VHA offices to address challenges and optimize veterans' access to care, including creating tools and identifying opportunities for improvement. Staff within this directorate serve specific functions, and collectively contribute to developing policies, projects, tools, and process improvements to enhance veterans' access to care. For example, this office includes field assistants, who are assigned to certain VISNs and work as liaisons to improve collaboration between IVC and VISNs.[22]
- **Integrated External Networks.** This office leads, develops, and administers contracts and networks for community care for veterans and other beneficiaries. This includes the Veterans Community Care Program and the VA Foreign Medical Program, among others.[23] The office's work focuses on network development and adequacy, contract management and performance, as well as customer support.
- **Integrated Informatics & Analytics.** This office collects, analyzes, and integrates network data for leadership to make data-driven decisions. According to IVC officials, it also provides relevant data to other IVC directorates, offices within VHA, and field staff as needed.

The majority of IVC's 1,000 plus full-time equivalent workforce—about 70 percent—is focused on operations, including central administrative functions such as processing enrollment, claims, and customer service, according to IVC officials. These officials said the remaining 30 percent of its workforce is focused on providing oversight (including oversight of community care processes and IT systems) and developing tools and training to enhance veterans' access.

[22]The role of field assistant is to improve collaboration between IVC and VISNs. Field assistants act as subject matter experts and liaisons between IVC and VISNs, sharing updates on national policies, making recommendations for improvement, and providing additional support as needed, according to IVC officials.

[23]For more information on the VA Foreign Medical Program, specifically, see GAO, *Veterans Health Care: Actions Needed to Improve the Foreign Medical Program,* GAO-25-107149 (Washington, D.C.: Feb. 19, 2025).

IVC's Priorities and Initiatives

IVC's leadership established national priorities to deliver integrated facility and community care. For example, IVC introduced three broad areas of focus for fiscal year 2024, each with several associated initiatives. The fiscal year 2024 areas of focus were (1) enabling access to the soonest and best care, (2) ensuring veterans get the highest value care, and (3) modernizing family member programs.[24] The first two areas of focus are most directly related to veterans' care, while the third relates to technology modernization for programs serving veterans' family members—a small proportion of overall VA beneficiaries.

IVC officials began implementing 11 initiatives to address these three areas of focus; some of the initiatives are ongoing in fiscal year 2025. The initiatives were developed at the national level by IVC sub-offices and directorates and are expected to be carried out in coordination with VISN and medical facility officials in the field. In addition, IVC coordinates with other VHA offices such as Patient Care Services and Clinical Services to determine how to implement these initiatives. According to IVC officials, to successfully enact its initiatives, IVC develops guidance, systems, and processes that support operations in the field—for use by VISNs and VHA medical facilities—to implement the initiatives. These officials told us that IVC typically presents its initiatives and communicates about their progress in regularly scheduled teleconference calls with VISN officials.

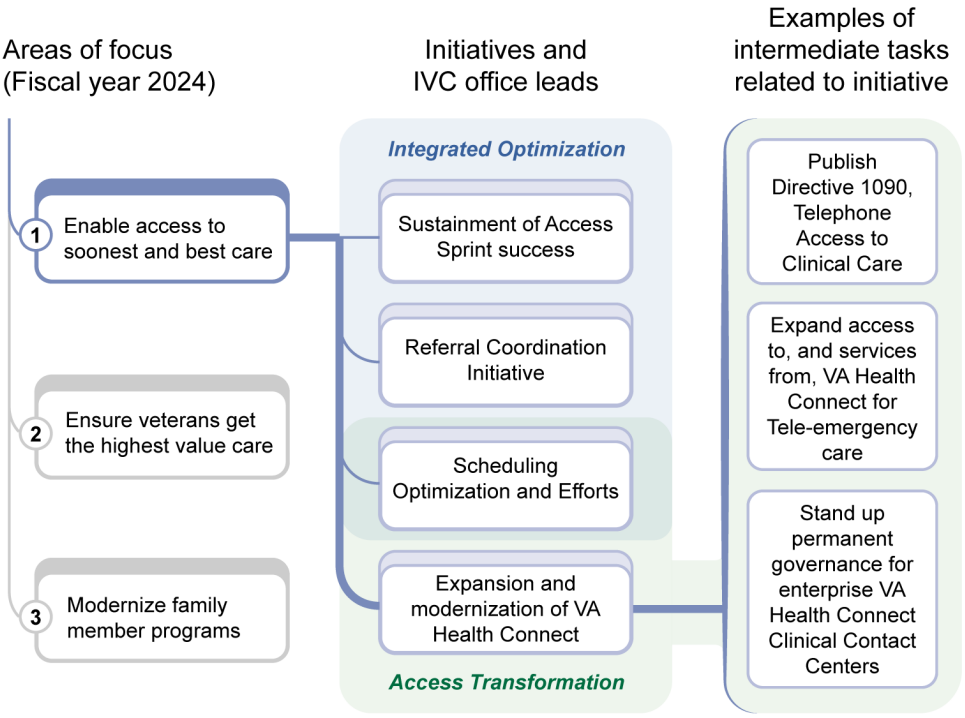
IVC has implemented several large-scale initiatives to transform veterans' experience accessing health care, including expanding and modernizing VA Health Connect and the Referral Coordination Initiative. VA Health Connect is a group of systems—also known as clinical contact centers—used to provide virtual services to veterans, such as customer support, scheduling, and clinical triage. The VA Health Connect expansion and modernization initiative was intended to standardize and improve VA Health Connect across the country, by having these services provided at a VISN-level and increasing the number of virtual services available to veterans in different regions of the country. For example, the modernization initiative expanded access to tele-emergency care by implementing it in additional VISNs. To implement this initiative, officials said IVC scheduled monthly VA Health Connect meetings between IVC and field staff, a weekly debrief, a weekly VA Health Connect roundtable,

[24]IVC developed initial areas of focus for fiscal year 2025, but officials said many efforts to address IVC priorities have been put on hold as VA undergoes a review of department structure and functions.

The programs IVC manages that provide health care benefits to veterans' family members were not the focus of this review.

and a monthly provider meeting. See figure 4 for additional information about the VA Health Connect modernization initiative.

Figure 4: Relationship Between Veterans Health Administration Office of Integrated Veteran Care (IVC) Areas of Focus, Selected Initiatives, and Intermediate Goals in Fiscal Year 2024



Source: Department of Veterans Affairs (VA). | GAO-25-107212

Another initiative, the Referral Coordination Initiative, expanded implementation of a new process developed for managing specialty care appointments for veterans. Through the current process, referral coordination teams at VHA medical facilities review veterans' referrals for specialty care and discuss care options with veterans. The implementation of the initiative marked a significant change to the process previously followed by VHA medical facility staff for management of specialty care referrals. Prior to implementation of the Referral Coordination Initiative process, referrals for specialty care could be sent directly to community care staff for scheduling, and veterans might not be informed of their options to obtain care in a VHA medical facility. To implement this initiative, staff from IVC developed guidance and training materials and shared these with VISN and VHA medical facility officials, who were directed to implement the initiative locally and throughout the

VISN. The Referral Coordination Initiative was the focus of our report issued in January 2025 where we made recommendations to improve implementation of the initiative.[25]

IVC also develops intermediate goals to complete for each initiative and time frames for these goals. For example, for the Referral Coordination Initiative, goals included conducting a current state assessment of implementation across VHA based on results of a pilot study, and refining operating and organizational models, processes, and tools for the initiative based on field feedback and program evaluation data. VISNs also have intermediate goals for these initiatives. For example, for the VA Health Connect modernization initiative, one VISN's goals included implementing an improvement plan for their speed of answering calls and publishing toll-free phone numbers for veterans to reach VA Health Connect.

Changes to IVC's Organizational Structure and Priorities

IVC has undergone changes to its organizational structure since it was established. For example, IVC has changed the names of some of its sub-offices—one directorate was initially called "Integrated Field Operations" in 2022, then was called "Access Optimization" in the *IVC Fiscal Year 2024-2025 Operating Plan*, and was re-named "Integrated Optimization" in an organizational chart in April 2024. Officials said they believe the names of the offices have not always been intuitive to people outside of IVC, and they are striving to improve clarity.

In addition, IVC has changed certain roles within the organization. For example, in October 2024, IVC changed the role of field assistants, who serve as liaisons between IVC and the VISNs. Under the change, field assistants were re-assigned from focusing on either community care or VHA facility care to focusing on one of four work streams: projects and training, operational deployment, site engagement, or VISN operations, IVC officials told us.

In January 2025, IVC officials developed a new proposed design for IVC's organizational structure at the national level, which they refer to as an "integrated veteran care operating model." The documentation of this design included broad descriptions of the responsibilities of each of its sub-component offices, including the directorates. The model lays out

[25]GAO-25-106678.

how IVC's offices align with VHA's established levels of authority, including which IVC sub-components are program offices.[26]

In May 2025, IVC officials told us that this IVC organizational structure effort had been put on hold while VA undergoes a department-wide reorganization and workforce reduction effort. IVC officials said they expected the assessment of VHA's restructure to be complete in June 2025, and they have put efforts to address other IVC priorities on hold until they know the results of the reorganization.

IVC's priorities have also evolved since its establishment. For example, VHA documentation for fiscal year 2022 noted 10 original strategies for IVC, including improving veteran decision-making for care options, making the VHA referral processes easier for providers, and strengthening VHA financial performance. In 2023, IVC developed 11 new initiatives for the office, including deploying predictive analytics to inform decision-making and establishing scheduling solutions across VHA to improve veteran access to care. These 11 new initiatives incorporated some of the same priorities as the original 10 strategies, with some differences. In 2024, IVC re-evaluated the 11 initiatives and consolidated them into the three broad areas of focus for fiscal year 2024. Officials told us these three areas of focus incorporate the work of most of the prior initiatives, but 11 initiatives were too many for IVC to focus on at once.

Officials told us their continuous re-assessment of IVC's priorities since its creation was in part due to resource limitations. For instance, in early 2024, the acting AUSH determined that IVC needed to focus its efforts on fewer strategies, given current IVC staffing levels. Officials said they never had an opportunity to build IVC to its intended staffing level as a new office, and that hiring freezes for national level staff starting in early 2024 prevented them from addressing what they believe is inadequate staffing. In addition, IVC has had significant vacancies—IVC officials stated the overall vacancy rate was 35 percent. As of March 2025, IVC was approved for 1,571 full-time equivalent positions, but 552 of these positions were vacant.

[26]In late 2024, IVC officials told us they had recently determined that IVC is designated as a principal office. Under VHA policy guidance, principal offices and program offices have distinct responsibilities and levels of authority which would affect the scope of IVC's work. As of January 2025, IVC determined that the four existing directorates would be re-designated as program offices, and they would also create a new program office for quality management.

IVC Has Not Clearly Communicated Organizational Changes or Obtained Input from Affected Employees

As IVC has evolved and updated its organizational structure, IVC has not always clearly communicated with relevant parties, including field officials in VISNs and medical facilities, as these changes are being developed and implemented. We have identified some examples that suggest a lack of clear understanding of IVC's organizational structure among employees in the selected VISNs and VHA medical facilities in our review. In addition, we have found that these employees were not always offered the chance to provide input on changes that were relevant to their work, such as changes to roles and responsibilities in IVC.

Lack of clear understanding of organizational changes. Although IVC typically communicated organizational changes to the field through conference calls and presentations, field officials expressed some confusion about IVC's organizational structure and changes made since its creation. Specifically, officials from two of the three VHA medical facilities and two of the three VISNs we interviewed expressed a lack of clarity about changes to IVC roles within the organizational structure since its creation. This has resulted in officials not knowing the division of oversight functions at the IVC level. For this reason, VHA medical facility officials said they did not always know whether it would be more beneficial to reach out to IVC or their VISN, and were not sure if they had been directed to the right person when requesting assistance from IVC. For example, officials from one VISN noted that they were no longer clear about who they can go to for training and assistance with questions. VISN officials said there used to be a service called The Pulse where VISN staff could ask a question and get an official answer from VA's central office. This service no longer exists, officials said, but they believe it is needed. In addition, officials from two of the three VHA medical facilities we spoke with noted that they had not received any communication regarding the planned changes to IVC's organizational structure that were being developed in early 2025. Not knowing the correct person to contact for assistance may cause delays in facilities receiving needed guidance and may affect their ability to effectively carry out initiatives to enhance veterans' access to care.

We also found that IVC sometimes changed the names of its tools without fully informing the field. Specifically, officials from two of the three VISNs we interviewed had not heard of the Field Operations Engagement Support Tool or were only aware of a prior name for the tool. The Field Operations Engagement Support Tool is a tool to track certain metrics in VHA medical facilities. If a certain number of metrics fall below their target, it would trigger additional support from IVC. Officials from one

VISN told us they had used this tool to identify issues about which to proactively seek support from IVC.

Similarly, in August 2024, we found confusion around roles and responsibilities related to contract oversight within IVC. Specifically, we found that IVC does not have centralized documentation of program-wide roles and responsibilities related to community care contracts, and roles are not always clearly defined. We recommended IVC establish a complete set of documentation for oversight of the community care contracts, including documentation of clear and complete procedures and the identification of roles and responsibilities. VA concurred with our recommendation and stated that IVC will review its existing contract oversight documents for gaps in roles and responsibilities and update accordingly.[27]

Lack of VISN and medical facility input before making role changes. Officials from two of the three VISNs we interviewed stated that communication is often one-way, and IVC did not always actively solicit input before changing roles. For example, officials from two of the three VISNs we interviewed expressed concerns about the October 2024 change IVC made to the field assistant's role, a position that IVC officials said was intended to improve coordination between IVC and VISNs. Officials from one of the VISNs said they were told that IVC would be redesigning the role of the field assistant but were not told why. The officials said the change is concerning because the VISN has benefited from the field assistant's communication. Officials we interviewed from our three selected VISNs said they were not asked to provide input or feedback to IVC about the field assistant's role before IVC made this change; instead, they were informed of the change after the decision had been made. Field assistants are particularly key for field staff because they serve as liaisons between the VISNs and IVC to provide updates on new initiatives and guidance from IVC and respond to data requests.

Selected leading practices for agency reforms identified in our prior work call for the inclusion of appropriate employees when developing reforms, such as making organizational changes.[28] Specifically, it is important for agencies to develop a "two-way continuing communications strategy that listens and responds to concerns of employees regarding the effects of

[27]See GAO, *Veterans Community Care Program: VA Needs to Strengthen Contract Oversight*, GAO-24-106390 (Washington, D.C.: Aug. 21, 2024).

[28]GAO-18-427.

potential reforms." Such a strategy could be used to engage employees and ask for their help in developing and implementing reforms.

However, the examples we identified at the selected facilities and VISNs indicate IVC lacks a two-way continuing communications strategy with relevant employees regarding changes. IVC has not consistently involved employees, including officials from VISNs and medical facilities, in planning or implementing these changes, nor has the office clearly and consistently communicated changes to these employees. Instead, officials said there is variation in how IVC communicates changes to the field, and it uses a variety of resources rather than following one standard process or strategy. IVC's current method of communication may be sufficient for some field staff. For example, one VISN official we interviewed who was also involved with IVC through a national-level role said he was informed of upcoming changes. However, other VISN and VHA medical facility officials told us they did not receive sufficient communication about changes that had significant effects on their work. For example, IVC officials said they communicate changes during their calls with VISN directors, but officials from one VISN said these calls are typically the only way that changes are communicated, and as a result the information does not always trickle down past the VISN directors. If their VISN director misses a call, they may not receive the information at all.

Our leading practices for agency reform also call for communicating with relevant stakeholders—including Congress—when agencies plan to make major changes. As VA continues to evolve and make changes to its organizational structure, communication with these stakeholders, along with relevant employees, will be key. In May 2025, the Secretary of Veterans Affairs testified about his plans to "review the department's structure and staffing" with goals to "increase productivity and efficiency, eliminate waste and bureaucracy and improve delivery of health care." These efforts are likely to include changes to the structure and responsibilities of VHA's IVC. Some members of Congress have raised concerns about the lack of communication and visibility regarding the Secretary's plans, including department restructuring that could affect veteran health care delivery.

By developing and implementing a strategy for clearly communicating with relevant employees and stakeholders, such as the Congress, IVC will increase the likelihood of obtaining VISN, facility, and stakeholder understanding and buy-in of the organizational changes. This will help minimize potential confusion or inefficiency between IVC and the field. Better communication and greater efficiency will help IVC to successfully

implement its priorities and initiatives to meet its mission to ensure every veteran can access high-value care where they need it, when they need it. By including stakeholders like Congress in such a communication strategy, IVC would also provide greater transparency into its efforts, which would help to ensure future changes are communicated and understood and congressional oversight is supported.

VHA Has Begun to Develop a Strategy to Better Coordinate Management of Medical Facility and Community Care in the Field

VHA has begun work to develop its field strategy for integrating management of medical facility and community care in the field, as part of its efforts to complete the remaining 2020 Functional Assessment recommendation of designing an enterprise integrated veteran care model. The field strategy is also intended to help address other findings from the 2020 assessment, including disjointed care coordination between VHA medical facility and community care. Although these two types of VHA care have been consolidated at the national office level within IVC, they are still generally managed separately at the VISN and medical facility level. VA stated that the purposes of the field strategy are (1) to develop a clear governance and management framework for integrated veteran care in the field—at VISNs and VHA medical facilities—and (2) to consolidate decision-making and oversight of both medical facility and community care under one organizational umbrella.

To develop this field strategy, VHA officials told us that they plan to take the following steps:

1. Review VISNs and medical facilities that have already integrated the offices that manage and oversee medical facility and community care.
2. Identify best practices for the integration of the offices that manage and oversee medical facility and community care.
3. Implement a pilot study at other VISNs and facilities based on best practices identified for the integration of the offices.
4. Determine how to roll out this integration of offices that manage and oversee medical facility and community care more broadly.

As of March 2025, VHA had begun the first step, with IVC leading a team of officials from VISNs, VHA medical facilities, and other VHA offices to review the efforts of VHA medical facilities and a VISN that have already integrated medical facility and community care functions and governance. For example, IVC officials told us that they reviewed a facility in VISN 6

(VA Mid-Atlantic Health Care Network) that had created a new position—Associate Director of Clinical Business Operations—to oversee veteran access to both VHA facility care and community care. The purpose of IVC's review of the VISN 6 facility was to determine all integration requirements at the facility and the potential benefits of adding this new position. IVC officials said this will help them identify best practices for implementation that could apply to other facilities.

IVC and VISN 6 officials told us in March 2025 that they developed a template that they used to evaluate the facility in VISN 6, which included data metrics to determine if there are access improvements. Based on the data analyzed, officials told us that they had decreased wait times. VISN 6 officials said that from fiscal year 2023 (before the new position was created) to fiscal year 2025 (after the Associate Director was in place), the average number of days to schedule an appointment for VHA facility care decreased by 37 percent.[29] VHA officials also told us that two other VHA facilities have begun integrating management of medical facility and community care, and they will similarly review these facilities' efforts in the future.

In addition, VHA plans to review VISN 19 (VA Rocky Mountain Network) and its new position of Access Director, who oversees VHA facility care and community care for the VISN. IVC officials plan to complete a template, which will include data metrics similar to those reviewed for the facility in VISN 6. In March 2025, VHA officials told us that they did not have a time frame for completing the review, and the new VISN 19 Access Director position would be filled with a detail.[30]

After completing step one to develop the field strategy and continuing to identify best practices as part of step two, IVC officials' next step is to expand their previous efforts into a full pilot study comprising a total of three VISNs and 10 facilities, including the VISNs and facilities discussed previously. They plan to use the results of the pilot study to determine how the field strategy could be implemented in other VISNs and facilities. According to documentation IVC provided in January 2025, the goal is to implement the pilot study by the end of fiscal year 2025. However, as of

[29]Information provided did not include the specific number of days used for this calculation.

[30]A detail is a temporary assignment of an employee to a different position, often to fill a short-term need or a vacant position, with the expectation that the employee will return to their original position after the detail.

March 2025, IVC officials did not know when they expect to determine how to roll out the field strategy more broadly.

As of May 2025, VHA officials told us that efforts to fully implement the pilot study are on pause as VHA has to ensure that this effort aligns with the Secretary of Veterans Affairs' restructuring effort announced in March 2025. They also told us that the continued VA hiring freeze of January 2025 may impact the implementation of this pilot study, as the proposed integration may require the hiring of a new position at both the VISN and the medical facility level.

In addition, IVC officials told us that they have several issues to consider as they continue to develop the field strategy, including how to implement this pilot. For example, officials told us in March 2025 that they need more information—including data from the pilot study—to determine if they will require the field strategy at all VISNs and VHA facilities. Some facilities may already be doing well and VISNs and facilities vary in complexity and the populations that they serve. Officials from all three medical facilities we interviewed also had questions about how integration would work at their facility and raised concerns that it may not be appropriate for every facility. Specifically, one facility told us that they did not think integration was necessary as 70 percent of the care they provide is VHA medical facility based.

As IVC officials continue evaluating best practices for implementation of the field strategy at some VHA medical facilities and VISNs and developing their potential pilot study, they have an opportunity to ensure that the pilot's design incorporates GAO's leading practices for pilot design and evaluation.[31] These practices—such as establishing well defined appropriate and clear measurable outcomes—are intended to help ensure that a pilot is effectively designed to produce good information and to help determine the best course of action following the pilot.

[31]GAO-16-438.

Conclusions

VHA has experienced an increased use of community care in recent years. IVC was created for the express purpose of integrating management of both VHA medical facility-based and community care into one entity within VHA's national level central office. The intent behind this integration is to improve coordination and provide seamless access to care for veterans.

IVC has already undergone several organizational changes since it was established in 2022 and is likely to continue to face changes to its leadership and structure. As of May 2025, VA is conducting a strategic review of facility and community care to consider options for additional restructuring and projected reductions to its workforce. Thus, VHA will likely continue to face changes and uncertainty in its organizational structure and staffing levels in the short term.

As VHA continues to make changes to optimize its organizational structure in the future, it is vital that improving veterans' access to care continues to be a priority. By developing and implementing a strategy for clearly communicating with, and involving, relevant VHA employees and other stakeholders, such as Congress, while making such changes, IVC will increase the likelihood of creating understanding and buy-in regarding changing roles and responsibilities. Clear and two-way communication, especially during times of uncertainty, can help minimize potential confusion or inefficiency across IVC and the field and better enable IVC to meet its mission to ensure every veteran and family member can access high-value care.

Recommendation for Executive Action

The Under Secretary for Health should ensure IVC develops and implements a strategy for conducting clear, direct, and continuous two-way communication with relevant employees—including those at regional networks and medical facilities—and stakeholders as the office continues to evolve and makes changes to its central office organizational structure. (Recommendation 1)

Agency Comments

We provided a draft of this report to VA for review and comment. VA provided written comments, which are reproduced in appendix I. In its written comments, VA concurred with our recommendation. VA also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at SilasS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

//SIGNED//

Sharon M. Silas
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

July 24, 2025

Ms. Sharon M. Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VETERANS HEALTH CARE: Better Communication Needed to Integrate Management of Medical Facility and Community-Based Care*** (GAO-25-107212).

The enclosure contains technical comments and the action plan to address the draft report recommendation. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Christopher D. Syrek
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to the
Government Accountability Office (GAO) Draft Report
VETERANS HEALTH CARE: Better Communication Needed to Integrate Management of Medical Facility and Community-Based Care
(GAO-25-107212)

Recommendation 1: The Under Secretary for Health should ensure IVC develops and implements a strategy for conducting clear, direct, and continuous two-way communication with relevant employees – including those at regional networks and medical facilities – and stakeholders as the office continues to evolve and makes changes to its central office organizational structure.

VA Response: Concur. The Veterans Health Administration (VHA) Integrated Veteran Care (IVC) recognizes the need to continuously improve communication with stakeholders. IVC will review current processes to identify areas for improvement and adopt best practices. This review will guide the development of a strategy to establish clear, direct, and continuous two-way communication with stakeholders at regional networks and medical facilities. This process will keep stakeholders informed and engaged in discussions about organizational changes.

Target Completion Date: March 2026

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Sharon M. Silas, SilasS@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann (Assistant Director), Julie T. Stewart (Analyst-in-Charge), Danielle Bernstein, Caroline Hale, and Ying Hu made key contributions to this report. Also contributing were Jacquelyn Hamilton, Ethiene Salgado-Rodriguez, and Sarah Veale.

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