

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Audit of
the Patient
Advocacy Program*

March 31, 2017
15-05379-146

ACRONYMS

FY	Fiscal Year
HCS	Health Care System
IT	Information Technology
OIG	Office of Inspector General
OI&T	Office of Information and Technology
OPCC&CT	Office of Patient Centered Care and Cultural Transformation
PATS	Patient Advocate Tracking System
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Highlights: Audit of VHA's Patient Advocacy Program

Why We Did This Audit

The Patient Advocacy Program is intended to identify systemic problems in VA health care with veterans experiencing unsatisfactory service. This audit was conducted to determine whether the Veterans Health Administration (VHA) responded to FY 2015 patient complaints timely and appropriately.

What We Found

VHA did not adequately capture FY 2015 patient complaint information and identify complaint trends. We reviewed responses made as recently as May 2016 to FY 2015 complaints. We projected more than one-third of approximately 135,000 of VHA's serious patient complaints in the Patient Advocate Tracking System (PATS) lacked key information and were closed erroneously. Serious complaints included issues such as delays in accessing care or services, problems with clinical care, and pain management. In addition, we estimated about 11,000 patient complaints at five of the eight sites we visited were not recorded in PATS, and VA medical facilities and Veterans Integrated Service Networks in our fieldwork performed limited or no formal complaint trending.

VHA missed opportunities to achieve its intended program goals because the Patient Advocacy Program had material weaknesses in internal control areas, such as policies, quality control, information technology, and human capital. As a result, lapses in collecting, monitoring, and trending patient complaints reduced the potential effectiveness of the Patient Advocacy Program and affected VA's progress in becoming more veteran-centric, including

identifying systemic issues for improving the quality of veterans' health care.

PATS did not have important security controls in place. Approximately 4,000 of about 7,900 users had inappropriate access to PATS due to VHA's untimely review of user privileges and access rights. PATS also lacked audit logs for significant user actions. These conditions occurred and persisted, in part, because the Office of Information and Technology did not adequately assess PATS security and operational risks. As a result, PATS data were vulnerable to unauthorized access and alteration, and records were not available to monitor modifications to sensitive patient information.

What We Recommended

We recommended the Under Secretary for Health implement operational controls to ensure the effectiveness of the program and reliability of its patient complaint data. We also recommended the Under Secretary and the Assistant Secretary for Information and Technology address PATS security and authorization issues.

Agency Comments

The Under Secretary for Health and Acting Assistant Secretary for Information and Technology concurred with our recommendations. We consider their corrective action plans acceptable and will follow up on their implementation.

A handwritten signature in cursive script that reads "Larry M. Reinkemeyer".

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations	2
Finding 1 VHA Needs To Improve Management of Its Patient Advocacy Program.....	2
Recommendations	10
Finding 2 VA Has Not Effectively Managed PATS Information Security	12
Recommendations	14
Appendix A Background	15
Appendix B Scope and Methodology.....	16
Appendix C Statistical Sampling Methodology	19
Appendix D Under Secretary for Health’s Comments	21
Appendix E Acting Assistant Secretary for Information and Technology’s Comments	25
Appendix F OIG Contact and Staff Acknowledgments.....	27
Appendix G Report Distribution	28

INTRODUCTION

Objective

The audit was performed to determine whether the Veterans Health Administration (VHA) responded to FY 2015 patient complaints timely and appropriately.

**Patient
Advocacy
Program**

VHA's Patient Advocacy Program was created to ensure that veterans and their families have their complaints addressed in a convenient and timely manner. Established in 1990, the Patient Advocacy Program evolved from a primarily administrative function to a problem solving and change agent in VHA's efforts to provide patient satisfaction and customer service.

The program provides an organized approach to identify, resolve, and use patient complaints to improve the services within the VA health care system. Veterans and their families can submit complaints to a VA medical facility by telephone, email, internet, mail, or in person. Complaints are also received through congressional inquiries. The importance of the program increased during VA's recent access-to-care controversy and new initiatives to make VA a more veteran-centric organization.

VHA's Office of Patient Centered Care and Cultural Transformation (OPCC&CT), an element of the Office of the Deputy Under Secretary for Health for Operations and Management, is responsible for managing the Patient Advocacy Program.

**Patient
Complaint
Management
System**

In December 2007, VHA implemented the Patient Advocate Tracking System (PATS), VA's electronic system of record for documenting and tracking patient complaints to support patient advocate responsibilities. Complaints in PATS enable a comprehensive understanding of veteran issues and concerns. PATS provides VA facilities the ability to analyze and trend patient complaints to identify the need for changes within the VA health care system.

Having an effective complaint management system is necessary to ensure a systematic approach to facilitate useful, reliable, and accurate recording of complaint information. In FY 2015, VHA documented close to 289,000 complaint-related contacts involving about 204,000 veterans recorded in PATS, including approximately 135,000 complaints VHA categorized as serious issues, such as delays in accessing care or services, problems with clinical care, and pain management.

RESULTS AND RECOMMENDATIONS

Finding 1 VHA Needs To Improve Management of Its Patient Advocacy Program

VHA did not adequately capture FY 2015 patient complaint information and identify complaint trends. We reviewed responses made as recently as May 2016 to FY 2015 complaints. We projected more than one-third of the approximate 135,000 serious patient complaints in PATS in FY 2015 lacked key information and were closed erroneously. In addition, an estimated 11,000 complaints at five sites we visited were not recorded in PATS, and two VA medical facilities we visited and five Veterans Integrated Service Networks (VISN) performed limited or no formal trending of complaint data. These deficiencies occurred because of material weaknesses in internal control areas, such as policies, quality control, information technology (IT), and human capital.

Incomplete and inaccurate PATS data reduced VHA's ability to ensure timely and appropriate handling of patient concerns and identification of potential systemic issues. As a result, VHA missed opportunities to improve the delivery of health care to veterans and improve their experiences with VA.

***PATS
Contains
Incomplete
and Inaccurate
Complaint
Records***

After reviewing a random statistical sample of 200 patient complaints from a universe of approximately 135,000 unique patient complaints processed in PATS during the period from October 1, 2014 through September 30, 2015, we determined VHA did not timely and appropriately address veterans' serious complaints¹ as intended. Some serious complaint records in PATS contained incomplete information about how complaints were resolved and whether veterans were contacted with a response. Of the serious complaint records identified as incomplete, some also contained inaccurate information on VHA's timeliness in addressing patient complaints.²

¹ We identified the universe of "serious" complaints for our review by selecting complaints in PATS that patient advocates coded as having issues such as delays in accessing care or services, problems with clinical care, and pain management. We did not include complaints coded only with issues such as access to medical records, parking availability, and staff courtesy. The VHA Office of Patient Centered Care and Cultural Transformation agreed with our methodology for selecting complaints with serious issues.

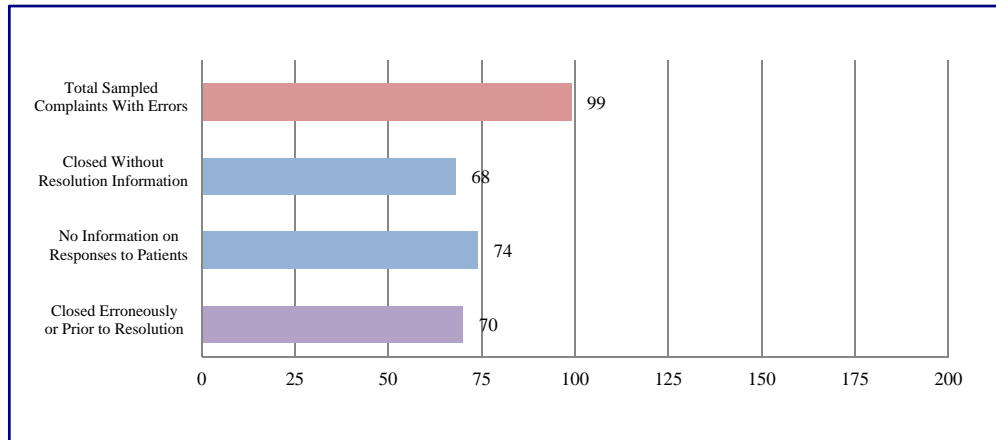
² The sampled complaints in our review may contain both incomplete information and inaccurate timeliness information errors.

PATS supports the recording and tracking of how patient complaints were addressed. In addition, the following requirements apply:

- Patient advocates must ensure each significant patient complaint is brought to the attention of appropriate staff to assess whether there needs to be a systemic analysis of the problem.³
- Staff must respond to complaints within seven days after the complaint is made. Should the complaint require more than seven days, staff are responsible for continuously updating the patient on the status of the complaint and/or resolution.⁴

The figure shows the number of sampled patient complaints in PATS with incomplete information and/or inaccurate timeliness information.

Figure. Sampled Serious Complaints From PATS With Incomplete Information and/or Inaccurate Timeliness Data⁵



Source: VA OIG analysis of identified errors from the sampled complaint review

PATS Has Incomplete Information

Based on our statistical review, just over one-third of VHA's most serious complaints in PATS had incomplete information to indicate whether complaints were resolved and whether veterans were contacted with a response. Of the approximate 135,000 complaints recorded in PATS, we projected just under 45,900 (34 percent) were closed without having information to indicate whether complaints were resolved and approximately 50,000 (37 percent) lacked information to demonstrate whether veterans received a required response to their complaints. For example:

Example 1

According to PATS, a veteran filed a complaint in 2015 with the patient advocate at a VA Medical Center (VAMC) for assistance

³ VHA Handbook 1003.4, paragraph 4e (8), dated September 2, 2005.

⁴ *Ibid*, paragraph 7b (1).

⁵ Sixty-six out of 108 VA medical facilities (61 percent) included in our sample complaint review had errors.

scheduling a colonoscopy procedure after being unable to reach his physician. The patient advocate referred the complaint to the veteran's physician and closed the PATS record four business days later based on the assumption it would be resolved. However, PATS lacked documentation showing whether the veteran was contacted or the complaint was actually resolved.

PATS Has Inaccurate Timeliness Information

More than one-third of the serious patient complaints in PATS did not provide accurate information on the timeliness of the complaint process. We projected just under 47,400 of the approximate 135,000 serious patient complaints (35 percent) were closed erroneously or prior to completion of the actions VA medical facilities took to resolve complaints. The following example demonstrates how PATS provided inaccurate information on the time taken to resolve a complaint.

Example 2

According to PATS, a veteran filed a complaint in 2015 with the patient advocate at a VAMC, alleging that false statements were made about her and that staff handled her in a rough manner while in the Behavioral Health Inpatient Care Unit. The patient advocate closed the complaint in PATS indicating that the complaint was resolved in four business days. However, when we reviewed the complaint approximately seven months after it was closed, the patient advocate acknowledged that no action had been taken to address the veteran's issues, including not forwarding the complaint to VHA staff for review.

Unrecorded Complaints in PATS

We also determined that VHA's Patient Advocacy Program is not accomplishing its goal for all patient complaints to be entered into PATS at some VA facilities. VHA policy states that PATS needs to contain complaints made to patient advocates, management officials, and other VHA staff.⁶ We estimated about 11,000 patient complaints were not recorded in PATS at five of the eight VA medical facilities we visited, based on available records and discussions with patient advocate staff.

The following are instances in which VA medical facilities we visited did not record complaints in PATS.

Example 3

The Indianapolis, IN, VAMC did not enter approximately 2,200 patient complaints into PATS during FY 2015. Starting in October 2014, the VAMC was approved to implement a pilot program allowing patient relations assistants to perform patient-centered tasks including resolving complaints at assigned areas. The patient relations assistants located in clinics recorded and tracked the majority of patient complaints using an internal

⁶ Handbook 1003.4, paragraph 6a.

SharePoint application, instead of PATS. Patient advocate management told us complaints that were resolved at the point of service were not entered in PATS because they did not require assistance from the patient advocates. However, VHA policy requires resolved complaints be reported to patient advocates for tracking and trending purposes.⁷

Example 4

We estimated the Palo Alto, CA, Health Care System (HCS) did not enter about 5,000 patient complaints received in FY 2015 into PATS.⁸ Management and patient advocate staff acknowledged that patient complaints were often not entered into PATS. Instead, patient complaints were tracked using paper records or a locally developed database and were only entered into PATS if they fell into certain categories, such as clinical appeals, according to patient advocate staff.

Inadequate Complaint Trending

VHA did not adequately use its Patient Advocacy Program to monitor veterans' experience at some VA medical facilities in FY 2015 to ensure concerns were appropriately addressed. VHA policy requires VA medical facilities and VISNs to identify trends based on patient complaint data to identify potential changes within the VA health care system.⁹ For example, the Indianapolis, IN, VAMC identified a recurring trend in the number of patient complaints related to decisions and preferences regarding medical care in FY 2015. However, two out of eight VA medical facilities we visited and five VISN patient advocate coordinators performed limited or no formal trending of patient complaint data. For example, the patient advocate at the Albany, NY, VAMC told us that patient complaint data were not trended during FY 2015.

Causes for Missed Opportunities

VHA missed opportunities to achieve its intended program goals, despite ongoing process improvement efforts, because the Patient Advocacy Program had material weaknesses in internal control areas, such as policies, quality control, IT, and human capital. Executive Departments are responsible for establishing and maintaining internal controls to achieve the objectives of effective and efficient operations. Internal controls and decisions must be documented.¹⁰

⁷ Handbook 1003.4, paragraph 4h (2), 6a, and 6b.

⁸ Our estimate was based on the analysis of complaints entered in HCS's database for the seven months it was being used, and a monthly average of complaints that were not entered in the database for the remaining five months.

⁹ Handbook 1003.4, paragraphs 4c (4), 4d (3), 4d (11), and 4e (5).

¹⁰ Office of Management and Budget Circular A-123, *Management's Responsibility for Internal Control*, section 3, and Part 3A, dated December 21, 2004. U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government*, paragraph 3.09 through 3.11, dated September 2014.

*Patient
Advocacy
Policies
Out-of-Date
and No
Standardization
Guidance*

Problems and inconsistencies within the Patient Advocacy Program developed, in part, because VHA's Office of the Deputy Under Secretary for Health for Operations and Management did not routinely update its policies and procedures for the program in response to changing priorities, workload growth, or program challenges. The Patient Advocacy Program handbook provided guidance on establishing Patient Advocacy programs at VA facilities, how to resolve patient complaints and concerns, and minimum data field requirements to be completed in PATS for each complaint. However, the handbook had not been updated in over a decade and lacked standardized guidance on how patient advocates should document complaint details in text fields to ensure the usefulness and reliability of complaint records, including communications with the veteran and resolution actions.

VHA's OPCC&CT, an element of the Office of the Deputy Under Secretary for Health for Operations and Management, was in the process of updating the expired 2005 policy and piloting new models prior to our audit. VHA needs to ensure that its program policies are updated and to develop procedures to ensure pertinent program information is recorded in a standardized format in PATS.

*Inadequate
Program and
Data Controls*

Complaints were inadequately documented, handled, or not consistently trended because VHA had inadequate processes in place to control the quality of the Patient Advocacy Program and PATS data. OPCC&CT, the national program office, is responsible for providing guidance, technical support, education, and tools for the program. In addition, VISN patient advocate coordinators are responsible for developing consistent approaches for entering patient complaints into PATS and assisting patient advocates as needed. However, there was no responsible authority above the facility level responsible for ensuring compliance with program requirements nationally, such as determining whether responses to complaints occurred and were recorded. The Associate Director for OPCC&CT told us that OPCC&CT relied on the VHA facilities to oversee their own patient advocate activities, including monitoring how complaints are recorded and tracked in PATS.

VHA staff at 27 out of 108 medical facilities responsible for processing complaints in our sample review told us there were no reviews performed on PATS data at their facilities to verify responses were sent to veterans or that resolutions were reached and recorded. In addition, patient advocate staff at some VA medical facilities we visited told us there were no systematic reviews of PATS data or that their PATS data reviews were not documented. Supervisors said they might spot check certain records or occasionally review a staff member's work to determine performance issues. VISN patient advocate coordinators for seven of eight VA medical facilities we visited also told us they did not review how complaint details were entered in PATS within their networks for consistency.

Two VA medical facilities and five VISNs in our review performed limited or no formal trending of complaint data because leadership did not monitor whether trending of patient complaints was routinely performed and included in management and quality discussions, as required. VHA should ensure responsible officials and staff perform patient complaint processing activities appropriately to maintain complete and accurate complaint records and improve VHA operations, including how complaint responses and resolutions are documented, how complaints are handled and recorded, and how complaints are trended.

*Limited IT
Functionality*

VHA and the Office of Information and Technology (OI&T) have not updated functionality in PATS sufficiently to ensure it promoted the efficient recording, management, and trending of patient complaints. PATS development occurred between 2002 and 2007. Some patient advocate staff told us that PATS did not fully meet their needs. It did not have a data field requiring entry of the date when veterans receive responses to their complaints. In addition, PATS did not enable staff to upload correspondence or documentation responding to veterans' complaints. In 2012, VHA requested a change to allow documentation to be uploaded into PATS, but OI&T had not fulfilled this request due to other development priorities, according to OPCC&CT management.¹¹ Text fields in PATS were used to document when VA medical facilities communicated with veterans and how complaints were resolved; however, this was not consistently applied in the complaints we reviewed.

Some patient advocate staff said that PATS had more data fields and issue code choices than were necessary that made it inefficient when trying to record incoming complaints directly into PATS. VHA policy allows for up to 30 days between receipt of a complaint and documentation in PATS, which permitted facilities to use a variety of approaches for initially recording and tracking complaints.¹² Three of the VA medical facilities we visited used alternate systems to record and track complaints. Although these alternate systems may have addressed gaps in PATS functionality, they created additional data management issues because their data were not transferred into PATS for reporting and trending. Per VHA's request in 2009, OI&T upgraded PATS to allow certain complaints from another system to be entered automatically into PATS. In addition, during our audit, OPCC&CT identified additional changes to PATS and also explored alternatives to PATS. VHA needs to work with OI&T to ensure PATS meets current program requirements for efficient complaint processing and reporting.

¹¹ The request was still open as of March 14, 2017.

¹² Handbook 1003.4, paragraph 6b.

*Insufficient
Human Capital
Management*

Complaints and their responses were inadequately documented, handled, or not always trended due to inconsistent staffing and training gaps. VHA policy provided facility leadership with minimum standards and a flexible model for implementing the program.¹³ While some VA medical facilities we visited had increased staffing from the minimally required level due to the size of their facilities or the number of patient complaints, other facilities maintained lower staff levels despite these factors. For instance, the Palo Alto, CA, HCS had an average of two patient advocates available to process complaints in FY 2015, compared with the four patient advocates at the Indianapolis, IN, VAMC, even though the both facilities served more than 60,000 unique patients. Most VA medical facilities we visited did not have documentation showing how they determined their Patient Advocate Program staffing requirements, such as whether it was based on workload or other criteria.

VHA staff at 29 out of 108 medical facilities responsible for processing complaints in our sample review reported limited or insufficient staffing resources to complete required processing activities. Some patient advocates told us they frequently omitted required complaint processing steps due to time constraints, such as not following up to ensure patient complaints were resolved and that veterans received responses. In addition, OPCC&CT management told us that several training actions were offered such as monthly calls and periodic face-to-face training. However, patient advocate staff at all eight VA medical facilities we visited, some of whom had limited experience in the program, told us they had not received formal training on how to document complaint details in PATS outside of on-the-job training. VHA needs to ensure staffing levels are maintained to support realistic workload estimates and staff receive periodic formal training.

*Effects of
Inadequate
Capturing and
Analysis of
Program Data*

Lapses in collecting, monitoring, and trending patient complaints in FY 2015 reduced the potential effectiveness of the Patient Advocacy Program and affected VA's progress in becoming more veteran-centric. Incomplete and inaccurate complaint records limited VHA's ability to use these data to identify potential systemic issues for improving the quality, safety, and satisfaction of veterans' health care. Insufficient analysis of complaint data resulted in missed opportunities to assess and improve performance and internal controls of local facility programs.

VHA's inadequate assurance of the quality of PATS data may have undermined the program's transparency and exposed VHA leadership to potentially embarrassing situations. For example, in 2014 a VA medical facility received a prestigious quality award based on a submission that reported, in part, their patient advocate complaint rate had been dropping due

¹³ Handbook 1003.4, paragraphs 5a-b and 7a-b.

to quality initiatives. In fact, the complaint rate at this facility was unusually low because it did not enter the majority of its complaints into PATS.

Operating this program without effective internal controls to ensure that complaints were addressed meant that many veterans seeking help in FY 2015 may have been frustrated regarding the management of their complaints or may not have had their complaints adequately addressed by VHA. Some veterans had to contact VA medical facilities more than once because they were unaware of the status of their complaints. The following example demonstrates the importance of timely responses on serious complaints.

Example 5

In 2014, a veteran complained to a VAMC that he was mistreated during an ultrasound procedure. The VAMC completed its review of the complaint about a week after it was filed, but the patient advocate closed the complaint record without informing the patient of the resolution. The veteran filed another complaint in 2015, requesting a response on the outcome of the 2014 investigation. Despite the follow-up complaint, the patient advocate still had not informed the veteran of the resolution of his initial complaint as of December 2015.

Additionally, veterans with complaints who did not get satisfactory responses within their VA medical facility often sought other avenues of relief, such as contacting the VA Secretary's office. Seeking other sources of assistance delayed service recovery and frequently required more resources than if the problem had been addressed timely and appropriately by the facility patient advocate.

Conclusion

Additional action is needed to ensure the Patient Advocacy Program works as intended to help VHA become a more veteran-centric organization. VHA needs to improve management of its Patient Advocacy Program and to ensure that patient complaint information is captured in PATS and trended. Due to inadequate management and operational controls to monitor the effectiveness of the Patient Advocacy Program and the reliability of its data, we projected more than one-third of VHA's serious patient complaints in PATS during FY 2015 lacked key information and were closed erroneously based on our statistical review of complaints. Moreover, we estimated about 11,000 patient complaints at five of the eight sites we visited were not entered in PATS, and many of the VA medical facilities and VISNs in our review performed limited or no formal trending of complaint data.

Without actions to improve the program, VHA will continue to miss opportunities to improve the delivery of health care to veterans and ensure veterans' concerns and their underlying causes are addressed timely and appropriately.

Recommendations

1. We recommended the Under Secretary for Health update patient advocate policies and procedures to ensure they meet current needs.
2. We recommended the Under Secretary for Health develop procedures to ensure pertinent program information is recorded in a standardized format in the Patient Advocate Tracking System.
3. We recommended the Under Secretary for Health ensure responsible officials and staff perform patient complaint processing activities in accordance with policies and procedures, such as assuring required program information is recorded and trended at the local and national level.
4. We recommended the Under Secretary for Health work with the Assistant Secretary for Information and Technology to ensure its Patient Advocate Tracking System meets current program requirements for efficient complaint processing and reporting.
5. We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.
6. We recommended the Under Secretary for Health provide patient advocates with periodic formal documented training concerning their responsibilities and utilizing the Patient Advocate Tracking System.

VHA Management Comments

The Under Secretary for Health concurred with our recommendations and initiated corrective actions. Specifically, he reported that OPCC&CT is updating its policies and guidance that are in the final stages of review and concurrence.

The Under Secretary reported that current procedures are being revised and strengthened to ensure complaints are captured, tracked, and trended. He also stated that OPCC&CT is working to institute a new customer complaint tracking system in 2019 to replace PATS and allow VA to capture feedback, analyze performance, and take action to improve veteran experiences. The system is currently being piloted and expected to be deployed across VHA facilities by the first quarter of FY 2019.

The Under Secretary reported that guidelines and internal controls are being developed to ensure required program information is recorded and trended at both the local and national level. Specifically, OPCC&CT is working with VISN patient advocate coordinators to ensure patient advocates are entering complaints into PATS timely, to collect complaint data from facilities within

their networks monthly, and to record and trend PATS data at the national level.

He stated that OPCC&CT is working with OI&T to ensure PATS meets current program requirements for efficient complaint processing and reporting. A PATS technical team is working to identify enhancements to PATS to enhance the efficiency of complaint processing.

The Under Secretary reported that OPCC&CT will work with the VA Office of Human Resources Management to determine a process for analysis and guidelines for staffing levels depending on the facility's population, services, and needs. OPCC&CT will update its handbook and communicate these new levels to the VA medical facilities. He also stated that OPCC&CT is updating its patient advocate orientation curriculum to ensure all patient advocates and their supervisors know when, where, and how to complete and document the orientation online. Further, core competency standards will be developed to promote standardization in PATS by patient advocates.

**OIG
Response**

The Under Secretary's planned corrective actions are responsive to our recommendations. We will monitor VHA's implementation of these planned actions and close the recommendations when we receive sufficient evidence demonstrating its completion. Appendix D provides the full text of the Under Secretary's comments.

Finding 2 **VA Has Not Effectively Managed PATS Information Security**

Some information security controls were not present during our review. Approximately 4,000 users had inappropriate access to PATS information, and PATS did not have audit logs to record significant actions by users, such as record deletions. These deficiencies occurred because VHA did not conduct reviews prior to our audit to ensure that PATS user privileges and access rights were appropriate and did not integrate audit logs into PATS during its initial development. These deficiencies persisted for years, in part because OI&T did not apply its mandatory risk assessment and authorization process to PATS.

As a result, PATS data were potentially vulnerable to unauthorized access and alteration by close to 3,300 individuals no longer having a confirmed need to use the system, and records were not available to monitor modifications to patient information in PATS. In addition, VA did not have formal authorization to operate PATS and lacked reasonable assurance that the use of PATS posed an acceptable level of risk.

Risk Assessment and Authority To Operate

VHA and OI&T did not effectively manage PATS information security. VA policy requires information systems used by VA have formal authorization to operate. Authorization is achieved by undergoing risk management processes that ensure information system-related security risks are adequately addressed on an ongoing basis. Through the approval process, the authorizing official, the Assistant Secretary for Information and Technology, affirms understanding and acceptance of the risks based on the implementation of a defined set of security controls and the current security state of the information system.¹⁴ System owners are responsible for ensuring employees have access rights based upon specific job duties and need to know.¹⁵ VA policy also requires the collection and retention of information system audit logs to record significant actions and events.¹⁶

VA Did Not Adequately Control User Access and Changes

VHA's OPCC&CT began a user access and security key clean up in February 2016 in response to our audit inquiries. As of May 2016, according to responding VA facilities, VHA had identified access changes needed for approximately 4,000 out of about 7,900 PATS users (50 percent) including close to 3,300 individuals whose user access privileges to PATS needed to be removed and more than 690 additional employees whose PATS security keys needed to be changed. VHA's corrective actions included reducing access and security keys, such as keys for setting up the original PATS

¹⁴ VA Handbook 6500.3, paragraph 2b (1) (e) through (f), dated February 3, 2014

¹⁵ VA Directive 6500, paragraph 4e (2), dated September 20, 2012

¹⁶ VA Handbook 6500, Appendix F, paragraph 4c (3) (b), dated March 10, 2015

database, that should have been reviewed up to nine years ago when PATS was implemented.

VHA, as the system owner for PATS, inappropriately permitted employees to retain access to read, change, and delete PATS records without determining whether these individuals had a legitimate need to do so. Canceled access to the Veteran Health Information Systems and Technology Architecture system may have mitigated the risk that some individuals could have accessed PATS inappropriately. However, the potential effect of unauthorized changes was greater because PATS did not collect audit logs to facilitate reconstruction of key user actions, such as the date a record was created, who accessed or edited records, when records were accessed or edited, who deleted records, or when deletions were made. PATS collected some audit records, such as the last user to edit a record, but did not maintain a chronological trail of those changes for review.

Inadequate Security Assessment and Oversight of PATS

OI&T, following its creation in 2006, assumed responsibility for operating PATS and for monitoring its compliance with Federal and VA information security requirements. PATS continued to have excessive user access and insufficient audit log records, in part because the Office of the Deputy Assistant Secretary for Information Security did not adequately assess system security and risks, as required. However, in response to our audit, OI&T completed a formal Security Control Assessment of PATS in August 2016 to bring the application into compliance with VA security policy and issued a formal authorization to operate.

According to the OI&T Director of the Certification Program Office, there were no records that established that PATS had undergone a security assessment and authorization process since this requirement was created in 2007.¹⁷ Further, PATS security received less scrutiny prior to our audit because PATS was mistakenly listed as operating as part of a General Support System boundary.¹⁸ OI&T should work with VHA to fully assess PATS security and operational risks and to initiate corrective actions, when appropriate.

PATS Data Were Not Adequately Protected

As a result, the integrity of PATS complaint data was at risk and data were vulnerable to accidental or intentional compromise by employees who should no longer have had access to PATS. Without required audit logs, VHA, security officials, and law enforcement could not analyze activity for unauthorized access or inappropriate changes to data. In addition, the absence of audit logs limited the ability to measure information, such as whether PATS records were created timely after a complaint was received.

¹⁷ VA Handbook 6500.3, Appendix E, paragraph 2d (6)(c), requires authorization documents to be retained based on VA's Record Control Schedule.

¹⁸ A general support system is an interconnected set of information resources under the same direct management control that shares common functionality.

Lastly, failure to complete the required security assessment and authorization process resulted in VA not having sufficient assurance that PATS posed reasonable risk to veterans and VA.

Conclusion

We concluded that PATS data were unsecure and at risk because VHA did not ensure that user access and security keys were reviewed periodically and did not ensure that PATS had appropriate audit logs. Moreover, OI&T did not adequately oversee PATS security. VHA should implement mechanisms to ensure that privileges and access rights to PATS are based upon specific job duties and the need to know. Additionally, OI&T should work with VHA to fully assess PATS security and operational risks and to initiate corrective actions, when appropriate.

Recommendations

7. We recommended the Under Secretary for Health implement mechanisms to ensure that privileges and access rights to the Patient Advocate Tracking System are regularly reviewed and extended based upon specific job duties and the need to know.
8. We recommended the Assistant Secretary for Information and Technology work with the Under Secretary for Health to fully assess the Patient Advocate Tracking System security and operational risks and to initiate appropriate corrective actions, including requesting the authority to operate the Patient Advocate Tracking System, if appropriate.

**VHA
Management
Comments**

The Under Secretary for Health agreed with our recommendation. He reported that network offices and VA medical facilities will work to ensure PATS privileges and access reviews are completed quarterly.

**OI&T
Management
Comments**

The Acting Assistant Secretary for Information and Technology agreed with our recommendation and has started taking corrective action. He reported that the VA Office of Information Security worked with program staff to determine the security requirements for PATS. As a result, PATS was placed into the Federal Information Security Modernization Act inventory of systems to enable VA security compliance and oversight in order to obtain its authorization to operate. The Acting Assistant Secretary reported that PATS has authorization to operate and that another review of PATS will take place on January 30, 2017 to determine its continued information security compliance. OI&T requested closure of this recommendation.

**OIG
Response**

The Under Secretary's and Acting Assistant Secretary's comments and corrective action plans are responsive to the recommendations. We will monitor implementation of these planned actions and close the recommendations when we receive sufficient evidence demonstrating their completion. Appendix D and E provides the full text of the Under Secretary's and Acting Assistant Secretary's comments respectively.

Appendix A Background

Program Office

VHA's OPCC&CT, which is aligned under the Deputy Under Secretary for Health for Operations and Management, received national responsibilities for the Patient Advocacy Program in 2011 and manages PATS. VHA Handbook 1003.4 assigns responsibilities at various levels within VHA, including guidance in resolving and using patient complaints.

VISN and VAMC Responsibilities

VISNs and VA medical facilities have responsibilities under the Patient Advocacy Program. Each VISN has a patient advocate coordinator assigned to assist the medical facilities within its designated region. The responsibilities of VISN patient advocate coordinators include:

- Serving as liaisons between the program office and patient advocates at the VA medical facilities
- Developing consistent approaches for entering patient complaints into PATS
- Communicating VISN complaints trends to VISN leadership

VA medical facility directors are responsible for implementing and overseeing the program within their facility. Their responsibilities include ensuring patient complaint data are collected, trended, analyzed, and communicated at least quarterly among management.

Local Facility Operations

VA medical facilities operate Patient Advocacy Programs. Patient advocate staff help coordinate service recovery, a process intended to help return aggrieved or dissatisfied patients to a state of satisfaction. Patient advocates are assigned to manage the process of filing complaints, ensure complaints are documented, track complaints in order to make improvements, and work to resolve such complaints. Patient advocates assist frontline staff in resolving issues that occur at the point of service and address complaints that were not able to be resolved at the point of service. Patient advocates also work directly with service chiefs to facilitate resolution of issues. As of June 2015, there were about 430 patient advocates assigned to VA health care facilities nationwide.

Appendix B Scope and Methodology

Scope

We conducted our audit work from November 2015 through December 2016. The audit focused on patient complaints recorded in PATS during the period October 1, 2014 through September 30, 2015. This information included the latest complaint records that were available for statistical sampling when we started the project. In addition, we reviewed VHA responses made as recently as May 2016 to FY 2015 complaints.

Methodology

To accomplish the audit objective, we reviewed a random sample of 200 patient complaints from PATS from 108 VA medical facilities that were coded as serious issues, such as delays in accessing care or services, pain management, and problems with clinical care. As part of each sample complaint reviewed, we requested information necessary to evaluate the timeliness and appropriateness of complaint actions. Our complaint review included examinations of testimonial and documentary information from about 150 VHA staff who were personally involved in processing or addressing the sampled complaints. We also reviewed clinical documentation found in VA's Compensation and Pension Record Interchange system. We provided VHA staff at the medical facilities with the results of complaints with issues we identified for feedback and explanations.

To assess program controls, we visited and interviewed about 90 program officials and staff in Washington, DC, and at VA medical facilities in Palo Alto, CA; Gainesville, FL; Indianapolis, IN; Fargo, ND; Albany, NY; Richmond, VA; Milwaukee, WI; and Cheyenne, WY. We also interviewed staff from each of the VISNs assigned to the VA medical facilities we visited and from OI&T. Finally, we reviewed applicable regulations, VA policies and procedures, and industry practices pertaining to complaint management.

Site Selection

We selected eight VA medical facilities to conduct fieldwork based on the number of sample units or the ratio of PATS complaints processed compared to unique patients.

Table 1 lists the VA medical facilities selected for fieldwork and ordered by VISN.

Table 1. VA Medical Facilities Selected for Fieldwork

VA Medical Facility Location	VISN	Sample Units	Unique Patients	Complaints/ Patients
Albany, NY	2	0	36,861	0.30%
Richmond, VA	6	3	57,185	7.76%
Gainesville, FL	8	9	136,641	8.22%
Indianapolis, IN	11	2	64,534	6.77%
Milwaukee, WI	12	5	65,059	7.71%
Cheyenne, WY	19	0	22,790	0.79%
Palo Alto, CA	21	0	68,809	0.60%
Fargo, ND	23	0	33,191	1.18%
Unique Patient Total			485,070	

Source: VA OIG analysis of FY 2015 PATS data and VHA Support Service Center data as of October 18, 2015.

Note: Table 1 shows the assigned VISN before the VISN realignment implemented in October 2015. Additionally, the table includes data from associated facilities and clinics.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during the audit. The audit team exercised due diligence in staying alert to any potential fraud. We did not identify instances of fraud during this audit. However, the absence of audit logs in PATS, as discussed in Finding 2, limited our ability to identify improper edits to PATS records.

Data Reliability

We used computer-processed data from PATS to address our objective of determining whether VHA responded to FY 2015 patient complaints timely and appropriately. To test the reliability of computer-processed data from PATS, we reviewed a statistical sample of patient complaints from PATS and performed checks on whether required data fields in PATS were completed. We also reviewed documents provided by VHA staff with personal involvement in processing or addressing our sampled complaints, as well as in VA's Compensation and Pension Record Interchange system to

assess how complaints were managed. In addition, we interviewed VHA and OI&T staff responsible for PATS, as well as patient advocates responsible for managing the use of PATS.

We concluded that VHA did not record all of its complaints in PATS and provided a recommendation to address this issue. As a result, some VHA complaints were not subject to selection in our statistical sample and this limited our ability to estimate the total number of serious complaints that should have been in PATS. However, this condition did not prevent us from assessing VHA's patient advocate performance regarding recorded PATS complaints.

Our audit also used computer-processed data from other systems, such as VA's Compensation and Pension Record Interchange system. These records were used in conjunction with other sources of evidence to corroborate complaint-related activities. Except for the lack of completeness with PATS records, for which we made recommendations to address this issue, we concluded that the data were sufficiently reliable for the audit objective.

**Government
Standards**

Our assessment of internal controls focused on those controls relating to our audit objective. We conducted this performance audit in accordance with generally accepted government auditing standards. These 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix C Statistical Sampling Methodology

To determine whether VHA responded to patient complaints timely and appropriately, we reviewed a sample of serious patient complaints within the Patient Advocacy Program.

Population

To evaluate the VHA Patient Advocacy Program's effectiveness in responding to patient complaints timely and appropriately, we reviewed a random statistical sample of 200 patient complaints from a universe of approximately 135,000 unique patient complaints processed in PATS during the period from October 1, 2014 through September 30, 2015. Our sample focused on serious issues coded in PATS such as delays in accessing care or services, problems with clinical care, and pain management. We selected these issues after consulting with VHA's OPCC&CT management. Table 2 summarizes the issues selected for statistical sample review.

Table 2. Summary of Complaint Issues Selected for Statistical Sample Review

PATS Issue Category	Universe Count	Universe Percentage	Number of Sample Units
Access and Timeliness	97,016	28%	125
Coordination of Care	43,409	13%	53
Risk Management Complaints	5,451	2%	8
Other Serious Issue Areas	11,287	3%	14
Sample Total			200

Source: VA OIG analysis performed in consultation with the Office of Audits and Evaluations' statistician and the Office of Management and Administration Austin Data Service.

Note: Sample units may contain one or more issue codes from other categories.

Sampling Design

We used a single-stage sampling approach to select the sample. We stratified the sampled universe of approximately 135,000 unique complaints matching serious issues coded in PATS by the 21 VISNs. The sample was proportional to the count of records in each VISN and processed by just under 110 VA medical facilities, to include clinics.

We calculated estimates in this report using weighted sample data. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Table 3 shows the projections for complaint records in PATS with incomplete and inaccurate timeliness information.

Table 3. Summary of Complaint Record Projections

Type of Error	Estimate (Percent)	Margin of Error (Percent)	90% Confidence Interval Lower Limit (Percent)	90% Confidence Interval Upper Limit (Percent)	Number of Errors
Complaints Closed Without Resolution Information in PATS	45,856 (33.9)	7,087 (5.2)	38,769 (28.7)	52,944 (39.2)	68
No Information in PATS of Responses to Patients	50,027 (37)	7,550 (5.6)	42,476 (31.4)	57,577 (42.6)	74
Complaints Closed Erroneously or Prior to Resolution	47,380 (35)	7,031 (5.2)	40,349 (29.8)	54,411 (40.2)	70

Source: VA OIG statistical analysis performed in consultation with the Office of Audits and Evaluations' statistician.

Note: Because sampled complaints may contain multiple errors, columns will not sum. A total 99 of the 200 sampled complaints had errors.

Appendix D Under Secretary for Health's Comments

Department of Veterans Affairs Memorandum

Date: January 13, 2017

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Veterans Health Administration Patient Advocacy Program
(Project Number 2015-05379-D2-0306) (VAIQ 7767674)

To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with recommendations made to the Veterans Health Administration. Attached is the action plan for recommendations 1, 2, 3, 4, 5, 6, and 7. The Office for Information and Technology is responsible for the reply to recommendation 8.
2. The Veterans Health Administration's (VHA) work related to the Office of Inspector General (OIG) report "Veterans Health Administration Audit of the Patient Advocacy Program," addresses the following High Risk Areas: 1 (ambiguous policies and inconsistent processes); 2 (inadequate oversight and accountability); 3 (information technology challenges); 4 (inadequate training for VA staff); and 5 (unclear resource needs and allocation priorities).
3. VHA is actively updating the Patient Advocate and Veterans Experience Handbook. The Office of Patient Centered Care and Cultural Transformation (OPCC&CT) is also working with VA Veterans Experience Program to institute a new customer complaint tracking system to replace the Patient Advocate Tracking System (PATS) in 2019. The product is called Medallia, and is used by private and public sector organizations across the country. In the interim, VHA will continue work to enhance PATS and ensure the System meets current program requirements for efficient complaint processing and reporting.
4. VHA is committed to ensuring that Veterans have an exceptional experience. The organization will continue to ensure that any concerns are resolved as quickly as possible at the point of service. Continued education and training will ensure that staff understands their proactive role in creating the best possible experience for Veterans and their family members, and the new tracking system will support continued refinement of data capture and analysis to ensure continuous quality improvement.
5. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (10E1D) at vha10E1DMRSAction@va.gov.

(Original signed by)

David J. Shulkin, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report, Veterans Health Administration Audit of the Patient Advocacy Program**

Date of Draft Report: December 14, 2016

Recommendations/ Actions	Status	Target Completion Date
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Recommendation 1. We recommended the Under Secretary for Health update patient advocate policies and procedures to ensure they meet current needs.

VHA Comments: Concur. This recommendation is related to High Risk Area 1 (ambiguous policies and inconsistent processes).

The Veterans Health Administration's (VHA) Office of Patient Centered Care and Cultural Transformation (OPCC&CT) is actively updating the Patient Advocate and Veterans Experience Handbook, which provides policy and guidance. The policy is ready for final concurrence, review and signature.

OPCC&CT will continue to facilitate Patient Advocate National calls, which provides a forum for training, networking, national updates, discussions and questions. In addition, the Veterans Integrated Service Network (VISN) Patient Advocate Coordinators (VPACs) monthly call will focus on policy development at the VISN and local facility level and support the role of the VPAC in ensuring compliance with national policy, including the Patient Advocate Tracking System (PATS).

Status:	Target Completion Date:
In process	October 2017

Recommendation 2. We recommended the Under Secretary for Health develop procedures to ensure pertinent program information is recorded in a standardized format in the Patient Advocate Tracking System.

VHA Comments: Concur. This recommendation is related to High Risk Area 1 (ambiguous policies and inconsistent processes).

Current procedures for capturing, tracking and trending complaints will be revised and strengthened.

OIG Draft Report, Veterans Health Administration Audit of the Patient Advocacy Program

OPCC&CT is also working with VA Veterans Experience Program to institute a new customer complaint tracking system in 2019 to replace PATS. The product is called Medallia, and is used by private and public sector organizations across the country. The Medallia software will allow VA to capture feedback (not just in-person with an advocate but also through other platforms), analyze performance and take actions to improve the Veterans' experience. The software is being piloted at five sites this year and is projected to be deployed across VHA facilities by first quarter FY2019.

Status:	Target Completion Date:
In process	Pilot completed October 2017; Full deployment March 2019

Recommendation 3. We recommended the Under Secretary for Health ensure responsible officials and staff perform patient complaint processing activities in accordance with policies and procedures, such as assuring required program information is recorded and trended at the local and national level.

VHA Comments: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability).

OPCC&CT will develop updated guidelines and controls for ensuring required program information is recorded and trended at both the local and national level.

A technical team is working to identify critical enhancements to the PATS system. One of the critical enhancements is for closure codes to be well-defined and entered. In addition, OPCC&CT is working with VPACs to ensure facility-level Patient Advocates are entering complaint data in PATS on a timely basis, collecting complaint data from each facility on a monthly basis, and working with OPCC&CT to record and trend PATS data at the national level. OPCC&CT will continue to report national PATS trends through the Veteran Experience Committee to the National Leadership Council.

Status:	Target Completion Date:
In process	October 2017

OIG Draft Report, Veterans Health Administration Audit of the Patient Advocacy Program

Recommendation 4. We recommended the Under Secretary for Health work with the Assistant Secretary for Information and Technology to ensure its Patient Advocate Tracking System meets current program requirements for efficient complaint processing and reporting.

VHA Comments: Concur. This recommendation is related to High Risk Area 3 (Information technology challenges).

OPCC&CT is working with the Office of Information Technology (OIT) to ensure PATS meets current program requirements for efficient complaint processing and reporting. A PATS technical team is currently working to enhance the efficiency in complaint processing features.

Status:	Target Completion Date:
In process	October 2017

Recommendation 5. We recommended the Under Secretary for Health establish controls to ensure that patient advocate staffing levels are sufficient to support patient advocate workload estimates.

VHA Comments: Concur. This recommendation is related to High Risk Area 5 (unclear resource needs and allocation priorities).

OPCC&CT will work with the Office of Human Resources and Management (OHRM) to determine a process for analysis and guidelines for staffing levels, as each facility's population, services and needs vary. Once OHRM determines staffing guidelines, OPCC&CT will update the handbook and communicate these new levels to the field.

Status:	Target Completion Date:
Ongoing	September 2017

Recommendation 6. We recommended the Under Secretary for Health provide patient advocates with periodic formal documented training concerning their responsibilities and utilizing the Patient Advocate Tracking System.

VHA Comments: Concur. This recommendation is related to High Risk Area 4 (inadequate training for VA staff).

OIG Draft Report, Veterans Health Administration Audit of the Patient Advocacy Program

OPCC&CT is currently updating the Patient Advocate Orientation curriculum and will distribute the updated orientation guidelines to ensure all advocates and their supervisors know when, where and how to complete and document the orientation online. In addition, core competency standards will be developed to promote standardization of the Patient Advocate's role in using PATS. Completion of orientation and core competencies trainings will be verified through a VISN suspense process.

Status:	Target Completion Date:
In process	September 2017

Recommendation 7. We recommended the Under Secretary for Health implement mechanisms to ensure that privileges and access rights to the Patient Advocate Tracking System are regularly reviewed and extended based upon specific job duties and the need to know.

VHA Comments: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability).

On February 12, 2016, the Deputy Under Secretary for Health for Operations and Management issued a memo to the field regarding PATS key management. PATS keys are provided to necessary individuals by local facility OI&T and are managed through local facility controls. Network Offices and Medical Centers will work on a quarterly basis to ensure the PATS privileges and access review process is completed.

Status:	Target Completion Date:
Ongoing	June 2017

Recommendation 8. We recommended the Assistant Secretary for Information and Technology work with the Under Secretary for Health to fully assess the Patient Advocate Tracking System security and operational risks and to initiate appropriate corrective actions, including requesting the authority to operate the Patient Advocate Tracking System, if appropriate.

OIT Comments: OI&T responsible for recommendation 8.

<p><i>For accessibility, the format of the original documents in this appendix has been modified to fit in this document.</i></p>

Appendix E Acting Assistant Secretary for Information and Technology's Comments

Department of Veterans Affairs Memorandum

Date: January 30, 2017

From: Acting Assistant Secretary & Chief Information Officer (005A)

Subj: OIG Draft Report, "Audit of VHA's Patient Advocacy Program" Project No 2015-05379-D2-0306

To: Assistant Inspector General for Audits and Evaluations (52)

Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, "Audit of the Patient Advocacy Program". The Office of Information and Technology concurs with OIG's findings and submits the attached written comments for recommendation 8. If you have any questions, contact me at (202) 461-6910 or have a member of your staff contact Roopangi Kadakia, Deputy Assistant Secretary for Information Security at (202) 632-9650.

(Original signed by)

Rob C. Thomas, II

Attachment

For accessibility, the format of the original documents in this appendix has been modified to fit in this document.

**Office of Information and Technology
Comments on OIG Draft Report,
Audit of VHA's Patient Advocacy Program Project No. 2015-05379-D2-0306**

OIG Recommendation 8: We recommended the Assistant Secretary for Information and Technology work with the Under Secretary for Health to fully assess the Patient Advocate Tracking System security and operational risks and to initiate appropriate corrective actions, including requesting the authority to operate the Patient Advocate Tracking System, if appropriate.

OIT Comments: Concur. The Office of Information Security (OIS) worked with the Patient Advocate Tracking System (PATS) program staff to determine the security requirements of PATS. As a result, PATS was placed into the Federal Information Security Modernization Act (FISMA) inventory of systems to enable compliance and oversight in order to obtain an Authority to Operate (ATO) as required by VA policy.

Currently, PATS has an Authority to Operate. Another review of PATS will take place on January 30, 2017 in order to determine the continued information security compliance of PATS. PATS is now maintained as a FISMA reportable system and OIS provides information security oversight to ensure continued compliance with VA security policy. We request closure of this recommendation based on the evidence provided.

Appendix F **OIG Contact and Staff Acknowledgments**

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Steven Wise, Director Emily Austin Lee Giesbrecht Sharon Richards Tonya Shorts-Smith Michelle Swagler Brandon Thompson
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