DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review to assess the Veterans Health Administration's (VHA) virtual primary care response to the COVID-19 pandemic, as well as the use of virtual care by primary care providers and their perceptions of VA Video Connect (VVC) between February 7 and June 16, 2020.[1]

The COVID-19 pandemic has presented significant challenges to health care delivery worldwide. Because COVID-19 is an infectious disease that spreads from person to person, the Centers for Disease Control and Prevention recommended social distancing as part of an overall public health strategy to prevent transmission.[2] One way to increase social distancing in healthcare settings is to expand the delivery of virtual care, including outpatient and primary care.

Virtual care has had a long-standing presence as a modality of care in VHA. Office of Connected Care leaders told the OIG that, after the hurricanes of 2017, VHA anticipated that virtual care may play a role in emergency disaster and pandemic management.[3] In 2018, VHA initiated a strategic plan, *Anywhere to Anywhere VA Telehealth, Strategic Plan: 2018-2020 Update,* to further implement virtual care across the organization.[4] VHA was in the final year of implementation when the COVID-19 pandemic necessitated an expansion of virtual care that exceeded the strategic plan. On March 11, 2020, the VHA Deputy Under Secretary for Health for Operations and Management issued a memorandum promoting increased use of virtual care

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[1] VA and VHA use several terms in policies and veteran information notices to describe clinical care that is provided in circumstances where distance separates those receiving services from those providing services. These include "telehealth," "telemedicine," "connected care," and "virtual care." For the purpose of this review, the OIG uses the term "virtual care" to refer to care that is provided by telephone; VVC; and third-party video applications such as FaceTime, and Skype (VA transitioned from Skype to Teams in September 2020). VHA Telehealth Services, "VVC VA Video Connect for Providers." https://vaww.telehealth.va.gov/pgm/vvc/providers/index.asp. (The website was accessed on June 24, 2020. This is an internal VA website and not available to the general public.). VVC is "a VA solution that enables Veterans to virtually meet-up with their VA healthcare providers, in something called a virtual medical room, using encrypted video to ensure the session is secure and private."

[2] The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It.* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. (The website was accessed on June 22, 2020.) COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[3] The VHA Office of Connected Care national program office leads VHA-wide virtual care implementation and expansion and oversees infrastructure and policy for virtual care services delivered by facility primary care health programs. VHA Telehealth Services, "About VHA Telehealth Services." https://vaww.telehealth.va.gov/about/index.asp. (The website was accessed on April 24, 2020. This is an internal VA website and not available to the general public.)

[4] VA, *Anywhere to Anywhere VA Telehealth, Strategic Plan:2018-2020 Update.* https://vaww.infoshare.va.gov/sites/telehealth/docs/strat-plan.docx. (The website was accessed on July 23, 2020. This is an internal VA website and not available to the general public.)

across the organization.[5] Approximately a week later, the VA Assistant Secretary for Office Information and Technology issued a memo, *Use of Video Communication Technology Under COVID-19*, that identified VVC as the preferred method to conduct video virtual care.[6] On March 23, 2020, VHA issued an update to the *Veterans Health Administration-Office of Emergency Management COVID-19 Response Plan* emphasizing the expansion of virtual care.[7]

To review VHA's COVID-19 response as it related to the provision of outpatient care, the OIG focused on the use of virtual modalities in primary care, including primary care providers' use and perceptions of VVC.[8] The OIG reviewed primary care encounter data, conducted interviews with VHA leaders, and distributed a questionnaire to primary care providers at selected sites to collect information and perceptions related to the use of virtual care modalities.[9] During the time frame under review, the OIG found the following:[10]

- Face-to-face primary care encounters decreased by 75 percent.

- VA-to-VA virtual primary care encounters, requiring both the patient and the provider to be located at a VA facility, decreased by 49 percent.

- Telephone and VVC/third-party video application primary care encounters increased, with contact by telephone representing 81 percent of all primary care encounters.[11]

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[5] VHA Deputy Under Secretary for Health for Operations and Management, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home,* March 11, 2020. Other clinical services and provider types were identified as priority for virtual care capability; however, the focus of this report was primary care providers, including women's health providers, who were physicians, physician assistants, and nurse practitioners.

[6] VA Assistant Secretary for Office Information and Technology, *Use of Video Communication Technology Under COVID-19*, March 19, 2020.

[7] VHA, *Veterans Health Administration-Office of Emergency Management COVID-19 Response Plan Incident-specific Annex to the VHA High Consequence Infection Base Plan, Version 1.6,* March 23, 2020. https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf. (The website was accessed on May 22, 2020.)

[8] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended on May 26, 2017. "Primary care is the provision of integrated, accessible health care services by health care professionals accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes but is not limited to; diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education."

[9] For the purpose of this review, primary care providers are defined as physicians, physician assistants, and nurse practitioners to align with the Deputy Under Secretary for Health for Operations and Management Memorandum, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home*, March 11, 2020. VHA Directive 1082, *Patient Care Data Capture,* March 24, 2015. VHA defines an encounter as "… a professional contact between a patient and a practitioner assigned with responsibility for diagnosing, evaluating, and treating the patient's condition."

[10] The OIG reviewed primary care encounters for two 45-day periods, from February 7, 2020, through March 22, 2020, and from March 23, 2020, through May 6, 2020.

[11] Third-party video call applications included, but were not limited to Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Microsoft Skype.

The OIG determined that the large increase in telephone encounters, coupled with the decrease in face-to-face visits, reflected VHA's transition to virtual primary care delivery during the review period.

The top factor identified by the OIG as affecting primary care providers' use of VVC was lack of training and support for veterans, to include test visits with patients and staff available to walk patients through the VVC process prior to their appointment. The OIG also identified veteran technology needs, a lack of internet connectivity for veterans, and challenging scheduling processes as issues affecting the use of the VVC. Providers noted that many patients did not have access to the internet or the equipment needed to facilitate VVC video calls such as computers, tablets, or smart phones. Further, VVC scheduling requires the coordination of at least two scheduling systems and is a more complicated scheduling process than the one used for face-to-face care.[12] Providers reported difficulties scheduling and rescheduling VVC appointments and commented on issues with the email links used to connect veterans to VVC appointments. These findings can inform the expansion of VVC and other virtual care modalities across VHA.

The OIG made two recommendations to the Under Secretary for Health related to access, equipment, and VVC application training and support for veteran telehealth users.[13]

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[12] VHA Telehealth Services, "Telehealth Management Platform." https://vaww.telehealth.va.gov/resources/tmp/. (The website was accessed on July 22, 2020. This is an internal VA website and not available to the general public.) Telehealth scheduling systems include the standard scheduling package used by VHA for face-to-face appointments and a second scheduling process that does not interface with the standard scheduling package. VHA notes that "Telehealth scheduling complexities have been addressed through variably effective 'work-arounds,' including commercially available scheduling software, Microsoft Outlook calendars and SharePoint sites, and even some locally developed scheduling solutions." VHA acknowledged that scheduling VVC appointments under the VA's legacy information system presents challenges, because creating an appointment requires the use of separate scheduling systems that are not interoperable.

[13] Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge, who had the authority to perform the Under Secretary's functions and duties. Effective January 20, 2021, he was appointed to Acting Under Secretary for Health with the continued authority to perform the functions and duties of the Under Secretary.

Comments

The Executive in Charge, Office of the Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see appendix E). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

COVID-19	coronavirus disease
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VVC	VA Video Connect

Introduction

The VA Office of Inspector General (OIG) conducted a review to assess the Veterans Health Administration's (VHA) virtual primary care response to the COVID-19 pandemic, as well as the use of virtual care by primary care providers and their perceptions of VA Video Connect (VVC) between February 7 and June 16, 2020.[1]

COVID-19 and Public Health Response

COVID-19 is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2" (SARS-CoV-2).[2] COVID-19 spreads from person to person, and the Centers for Disease Control and Prevention recommends social distancing as a public health strategy to prevent transmission.[3] In response to the recommendation to social distance, and to promote the safety of veterans and staff, VHA quickly expanded virtual care, when possible, in lieu of face-to-face appointments.[4]

History of Virtual Care in VHA

Virtual care is a technology-based mode of health care used "to provide clinical care in circumstances where distance separates those receiving services and those providing services."[5]

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[1] VA and VHA use several terms in policies and veteran information notices to describe clinical care that is provided in circumstances where distance separates those receiving services from those providing services. These include "telehealth," "telemedicine," "connected care," and "virtual care." For the purpose of this review, the OIG uses the term "virtual care" to refer to care that is provided by telephone; VVC; and third-party video applications such as FaceTime, and Skype (VA transitioned from Skype to Teams in September 2020). VHA Telehealth Services, "VVC VA Video Connect for Providers." https://vaww.telehealth.va.gov/pgm/vvc/providers/index.asp. (The website was accessed on June 24, 2020. This is an internal VA website and not available to the general public.). VVC is "a VA solution that enables Veterans to virtually meet-up with their VA healthcare providers, in something called a virtual medical room, using encrypted video to ensure the session is secure and private."

[2] International Committee on Taxonomy of Viruses, *Naming the 2019 Coronavirus.* https://talk.ictvonline.org/. (The website was accessed on September 29, 2020.)

[3] Centers for Disease Control and Prevention, *Symptoms of Coronavirus.* https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html. (The website was accessed on October 6, 2020.) COVID-19 symptoms may appear 2–14 days after exposure and range from mild to severe. Common symptoms include fever, cough, congestion, or diarrhea. Centers for Disease Control and Prevention. *How to Protect Yourself and Others.* https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention-H.pdf. (The website was accessed on July 7, 2020.) "The best way to prevent illness is to avoid being exposed." One strategy is placing six feet between individuals. This is referred to as "social distancing."

[4] Deputy Under Secretary for Health for Operations and Management, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home,* March 11, 2020.

[5] VHA Telehealth Services, "About VHA Telehealth Services." https://vaww.telehealth.va.gov/about/index.asp. (The website was accessed on April 24, 2020. This is an internal VA website and not available to the general public.)

It extends provider reach, expands access to provider expertise and specialty services, and allows for continuity of care in emergency situations.

Virtual care is a long-standing modality within VHA, beginning in 1959 with the delivery of mental health care using a two-way television. Virtual care began to grow between 1994 and 2003 with 30 facilities conducting pilots that were grant funded, facility-specific, and coordinated at the local level.[6]

From 2004 through 2010, VHA began coordinating virtual care at the national level to support the clinical, technological, and business foundations for implementation. It was during this period that the Office of Care Coordination Services was created and made responsible for "developing, disseminating, and sustaining models of telehealth."[7] These efforts resulted in the standardization of technology across VHA, with 44 different clinical areas and specialties delivering virtual care by 2010.

Virtual care continued to grow from 2011 to 2014, as part of efforts to modernize VHA. VHA identified virtual care as a model of care to support this transformation and continued the expansion of virtual care programs. The expansion was facilitated by the establishment of Veterans Integrated Service Network (VISN) telehealth leads, facility telehealth coordinators, telehealth clinical technicians, and the National Telehealth Help Desk.[8] Additional initiatives included VHA's piloting of video virtual care into the home, which allowed veterans to receive real-time video consultation without going to a VHA hospital or clinic.

VHA reported that they continued to invest in virtual care by allocating $323,704,230 in funding across 2017 and 2018. In 2018, VHA set the expectation that 100 percent of all primary care providers would be able to provide virtual care by the end of fiscal year 2020 while noting that all outpatient appointments that do not require a physical exam or face-to-face services could be conducted virtually. That same year, the *Anywhere to Anywhere VA Telehealth, Strategic Plan: 2018-2020 Update* was released, which supported the expansion of virtual care and outlined metrics, milestones, and barriers to implementation of telehealth foundations, including technical infrastructure, and clinical goals.

VHA continues to allocate more resources to virtual care with the fiscal year 2020 allocation exceeding any of the prior three years.

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[6] Adam Darkins, "The Growth of Telehealth Services in the Veterans Health Administration Between 1994 and 2014: A Study in the Diffusion of Innovation" *TELEMEDICINE and e-HEALTH* 20, no. 9 (September 2014): 761–768.

[7] Darkins, 764.

[8] Clinical telehealth technicians provided support to clinicians providing virtual care and the National Telehealth Help Desk was available to troubleshoot problems with virtual care technologies.

Virtual Care and VHA Emergency Management

While VHA has a history of providing virtual care across the country, prior to the emergence of COVID-19, the programmatic goal had been to increase access to care for both rural patients and those needing specialty care that was not locally available. Office of Connected Care leaders told the OIG that VHA had anticipated that virtual care may play a role in emergency disaster and pandemic management and recognized its added value after the hurricanes of 2017.[9] The Office of Connected Care and the Office of Emergency Management held their first emergency drill in May 2018 and have subsequently worked together to ensure continuity of services in an emergency or disaster.[10] In February 2020, prior to the World Health Organization's declaration of a pandemic, VHA issued guidance that facility leaders optimize disaster and emergency plans related to the use of virtual care modalities to avoid outpatient appointment cancellations.

Prior OIG Reports

The OIG conducted two healthcare inspections related to VHA's national COVID-19 response. The first one, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness,* focused on screening processes and pandemic readiness at selected medical facilities, community-based outpatient clinics, and community living centers.[11] No recommendations were made; however, the OIG planned to continue to monitor VHA in its efforts to provide safe quality health care to veterans while also protecting the health of VA employees and preparing for a national crisis response during the pandemic.

On July 16, 2020, the OIG published a second COVID-19-focused report, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*.[12] The OIG outlined VHA's continued response to the pandemic and provided VHA leaders' descriptions of the evolving challenges they faced in caring for veterans and potentially non-veteran patients. The report highlighted a multitude of actions taken by VHA, VISN, and facility leaders to maintain operations, including the use of telehealth. While the OIG made no recommendations, the report presented strategies that various facilities put into place to promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.

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[9] The VHA Office of Connected Care/Telehealth Services national program office leads VHA-wide virtual care implementation and expansion and oversees infrastructure and policy for virtual care services delivered by facility primary care health programs.

[10] The VHA Office of Emergency Management is responsible for coordinating local, regional, and national medical response and support services in an emergency to ensure continuity of health care services.

[11] VA OIG, *OIG Inspection of Veterans Health Administration COVID-19 Screening Processes and Pandemic Readiness,* Report No. 20-02221-120, March 26, 2020.

[12] VA OIG, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020.

The OIG also published a VHA facility-specific report on August 27, 2020, *Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon,* with five recommendations to the Facility Director related to processes for communicating patients' infectious disease status and infection control precautions prior to transfer; processes for identification, exposure risk assessment, monitoring, and provision of guidance for staff with exposure to high-consequence infections; and inclusion of a detailed staff exposure management process in relevant facility policies. The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable plans for improvement. As of September 17, 2020, all five recommendations remained open.[13]

Subsequently, the OIG published a report, *Appointment Management During the COVID-19 Pandemic* with three recommendations related to following up on the cancellation of over two million appointments. The OIG recommended the following to the Under Secretary for Health:

- Develop and communicate a strategic plan to all medical facilities for rescheduling patients,

- Develop a mechanism to monitor facilities' progress with following up on all cancellations, and

- Ensure that facilities take appropriate follow-up action on canceled or discontinued consults.

The Executive in Charge, Office of the Under Secretary for Health, concurred with all three recommendations and provided acceptable action plans responsive to the intent of the recommendations. As of September 17, 2020, all three recommendations remained open.[14]

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[13] VA OIG, *Alleged Deficiencies in the Management of Staff Exposure to a Patient with COVID-19 at the VA Portland Health Care System in Oregon,* Report No. 20-02240-248, August 27, 2020.

[14] VA OIG, *Appointment Management During the COVID-19 Pandemic*, Report No. 20-02794-218, September 1, 2020. The OIG has also monitored VHA's response to other aspects of veterans' care during the COVID-19 crisis including emergency care and community-based outpatient clinic operations. In addition, responses to the COVID-19 crisis will be assessed as part of the OIG's Comprehensive Healthcare Inspection Program, a regularly scheduled review of each VHA facility's key clinical and administrative processes that occurs approximately every three years. "Publications," VA OIG, accessed October 6, 2020, https://www.va.gov/oig/publications/default.asp.

Scope and Methodology

The OIG initiated this review on May 13, 2020, to evaluate virtual primary care with a focus on the use of VVC during the COVID-19 pandemic.[15]

Primary care and video-to-home virtual care encounters are defined by specific primary or secondary stop codes (see appendix A) and include VVC and third-party video application visits.[16] The OIG used VHA Corporate Data Warehouse administrative data to determine the frequency of various types of primary care encounters between two consecutive periods at each VA facility. The time periods were the 45 days before and the 45 days on or after the date of internal release of an update to the *Veterans Health Administration-Office of Emergency Management COVID-19 Response Plan*, (Response Plan), which outlined a four-phased approach for facility leaders to address and emphasized the expansion of virtual care (see discussion below for additional information).[17]

On June 9, 2020, the OIG conducted an interview with VHA leaders. The discussion focused on workload capture of VVC and third-party video application encounters as well as challenges with scheduling virtual care appointments. The OIG conducted an additional interview on August 20, 2020, with the Office of Connected Care's Executive Director, Telehealth Services and the Executive Director, Connected Health. The August interview focused on programmatic timeline and budgeting, the VVC application, and VHA's virtual response to the pandemic.

The OIG ranked facilities by the percentage of primary care providers with at least one video-to-home encounter between March 23 and May 6, 2020. Ten facilities with the highest percentage of primary care providers with at least one video-to-home encounter were selected for inclusion in the review, as were 10 medical centers with the lowest percentage of primary care providers with at least one video-to-home encounter (see appendix B for list of facilities included in the review). The selected facilities did not necessarily have the highest and least number of video-to-home encounters during the period reviewed; rather, they had the greatest and least

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[15] For the purpose of this review, virtual care is defined as VVC; third-party video applications such as FaceTime, Skype, and telephone.

[16] VA, Managerial Cost Accounting Office, "Stop Codes - Instructional Guide." http://vaww.dss.med.va.gov/programdocs/pd_oident.asp. (The website was accessed on March 5, 2021. This is an internal VA website and not available to the general public.) "A stop code is a VHA term used to characterize VHA Outpatient Clinics" by identifying workload for "outpatient encounters, inpatient appointments in outpatient clinics, and inpatient professional services." Stop codes "indicate the work group responsible for providing the specific set of clinical products," in addition to serving as a "stable identification method that can be used to compare costs between facilities." "The primary stop code designates the main clinical group responsible for the care." The secondary stop code "further define[s] the primary workgroup," providing "additional information about the clinic such as the provider type or if the service was delivered via telehealth technology."

[17] VHA, *Veterans Health Administration-Office of Emergency Management COVID-19 Response Plan Incident-specific Annex to the VHA High Consequence Infection Base Plan, Version 1.6*, March 23, 2020. https://www.va.gov/opa/docs/VHA_COVID_19_03232020_vF_1.pdf. (The website was accessed on May 22, 2020.) Specifically, the two periods of the OIG's review were from February 7, 2020, through March 22, 2020, and from March 23, 2020, through May 6, 2020.

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percentage of providers who had conducted at least one video-to-home encounter. This methodology was selected as the OIG sought to survey primary care providers at facilities with the greatest and least exposure to video-to-home encounters across VHA.

The OIG used VHA-provided HR Smart data to identify primary care providers employed at all facilities between February 29 and May 10, 2020.[18]

The OIG distributed a questionnaire to primary care providers at selected sites to collect information and perceptions related to the use of virtual care modalities on and after March 23, 2020.[19] The questions focused on utilization of virtual care, whether providers and patients were equipped with necessary technology, and factors that helped and prevented use of VVC to deliver primary care.[20]

The questionnaire was distributed to 750 primary care providers across the 20 facilities on June 11, 2020, with a due date of June 16, 2020 (see appendix C). Data across the 20 facilities were aggregated for the purpose of the analysis. Two hundred forty-nine providers returned completed questionnaires resulting in a 33 percent response rate.[21] The OIG received at least one response from each selected facility and analyzed all 249 completed questionnaires. Significantly, the OIG did not assess the responses from providers for accuracy.

The OIG analyzed questionnaire responses by calculating the frequency of responses to closed-ended questions to determine providers' perceptions of virtual care modality utilization and availability of equipment needed to provide virtual care using VVC.

The OIG also reviewed free text responses to open-ended questions to establish factors that both helped and hindered delivery of primary care using VVC. Based on provider responses, four common factors emerged: (1) training and support, (2) technology, (3) internet connectivity, and

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[18] HR Smart is VA's human resources information system that supports personnel suitability, payroll, and position management. HR Smart organizes data by position, rather than by employee, and allows for real-time human resources transaction processing for all of VA. Primary care providers who separated from VA or onboarded at any point between these dates were excluded. The OIG selected the date February 29, 2020, to ensure data included the most up-to-date list of providers practicing in VHA during the period of review as VHA maintains monthly historical snapshots as of the last day of each month. The OIG did not assess the accuracy of the VHA-provided HR Smart data.

[19] For the purpose of this review, primary care providers are defined as physicians, physician assistants, and nurse practitioners to align with the Deputy Under Secretary for Health for Operations and Management Memorandum, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home*, March 11, 2020. Third-party video call applications include, but are not limited to, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Microsoft Skype.

[20] Providers and patients must have access to equipment, such as computers, tablets, or smart phones to facilitate VVC video calls. The questionnaire included yes or no, multiple-choice, answer scales, and open-ended questions.

[21] The OIG received eight incomplete surveys, which were excluded from the analysis.

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(4) scheduling. To finalize the review of the free text questions, the OIG manually assigned the individual responses to one or more of the factors.[22]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews information within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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[22] Other factors were analyzed but not included in this review due to infrequency, lack of clarity, and/or redundancy with other factors.

March 2020 VHA Virtual Care Guidance

VHA was in the final year of *Anywhere to Anywhere VA Telehealth, Strategic Plan* implementation when the COVID-19 pandemic necessitated an expansion of virtual care that exceeded the strategic plan.[23]

On March 11, 2020, the World Health Organization declared COVID-19 a global pandemic and the VHA Deputy Under Secretary for Health for Operations and Management issued a memorandum outlining plans for VA "to ensure the safety of its Veterans, staff, and the capacity of its clinical workforce" in light of the pandemic. The memorandum encouraged increased use of virtual care across the organization and allowed for 14 days to establish VVC capability of specific clinics and providers, including primary care and women's health primary care providers.[24]

On March 19, 2020, due to the need for rapid expansion of virtual care in the context of the pandemic, VA suspended compliance with the Health Insurance Portability and Accountability Act, known as HIPAA, in accordance with Department of Health and Human Services guidance. As a result, VHA clinicians were temporarily approved to use third-party video applications for virtual care, such as Skype and FaceTime.[25] The same day, the VA Assistant Secretary for Office Information and Technology memo, *Use of Video Communication Technology Under*

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[23] A pandemic is an outbreak of a disease that occurs over a wide geographic area and affects an exceptionally high proportion of the population. "Definition of pandemic," Merriam Webster, accessed June 19, 2020, https://www.merriamwebster.com/dictionary/pandemic.

[24] VHA Deputy Under Secretary for Health for Operations and Management, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home,* March 11, 2020. https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/Virtual DUSHOM Memo. (The website was accessed on March 30, 2020. This is an internal VA website and not available to the general public.) Other clinical services and provider types were identified as priority for virtual care capability; however, the focus of this report was primary care providers, including women's health providers, who were physicians, physician assistants, and nurse practitioners. VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended on May 26, 2017. VHA defines primary care as "The provision of integrated, accessible health care services by health care professionals accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes but is not limited to; diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education."

[25] U.S. Department of Health and Human Services, "Telehealth: Delivering Care Safely During COVID-19." https://www.hhs.gov/coronavirus/telehealth/index.html#hipaa. (This website was accessed on June 25, 2020). The HIPAA Privacy Rule protects the privacy of patients' protected health information. The Health and Human Services, Office for Civil Rights issued guidance to "empower health care providers to serve patients through telehealth during the national public health emergency. HIPAA-covered health care providers may, in good faith, provide telehealth services to patients using remote communication technologies, such as commonly used apps—including FaceTime, Facebook Messenger, Google Hangouts, Zoom, or Skype—for telehealth services, even if the application does not fully comply with HIPAA rules. However, providers should not use any platforms that are public-facing— for instance, Facebook Live, Twitch, and TikTok." As of the publication of this report, there was no end date identified regarding the relaxation of the HIPAA privacy rules.

COVID-19, identified VVC as the preferred method to conduct video virtual care.[26] However, the Office of Connected Care recognized that there could be issues, such as large numbers of concurrent VVC appointments and the need for additional video conference hardware, and recommended that providers use the telephone when possible to ensure patients received the care they needed.

As noted above, the March 23, 2020, Response Plan provided guidance to facility leaders and staff, which included a four-phased approach (see figure 1).
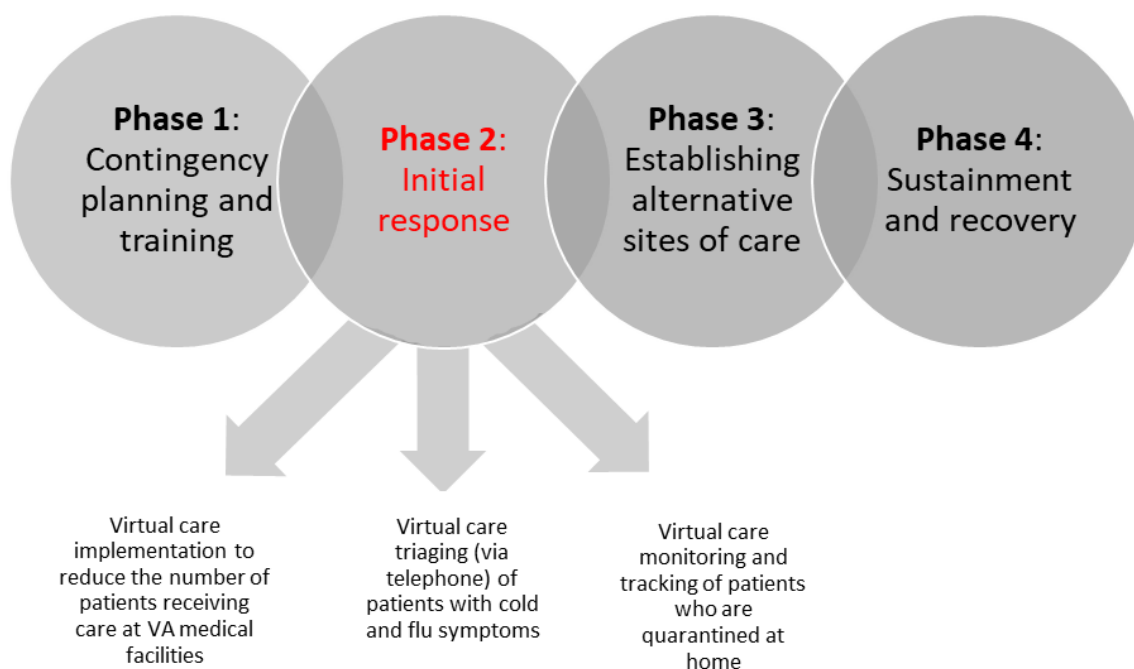
Figure 1: The four phases of the VHA Response Plan (red added for emphasis)
Source: VHA Response Plan[27]

This phased plan included the expansion of virtual care. An overarching principle for phase 1 contingency planning and training was to "leverage technology and communications to minimize exposure" of staff and veterans.[28] The phase 2 initial response plan included a focus on several virtual care strategies:

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[26] VA Assistant Secretary for Office Information and Technology memorandum, *Use of Video Communication Technology Under COVID-19*, March 19, 2020.

[27] VHA, *Response Plan*, March 23, 2020.

[28] VHA, *Response Plan*, March 23, 2020.

- Virtual care implementation to reduce the number of patients receiving care at VHA medical facilities

- Virtual care triaging (via telephone) of patients with cold and flu symptoms

- Virtual care monitoring and tracking of patients who are quarantined at home[29]

- The maintenance of "care for Veterans without COVID-19 through telehealth services, a preferred delivery system, if possible"[30]

Phase 3 focused on establishing alternate physical sites of care and phase 4 extended operations and recovery and included supporting a return to normal operation "or a new standard of normalcy for the provision of healthcare."[31]

As of August 12, 2020, VHA reported that Connected Care Telehealth Services had received $64,644,168 to fund COVID-19-related items, such as technology for patients and providers (for example, tablets, internet services, and webcams), provider training, and help desk expansion.

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[29] VHA, *Response Plan*, March 23, 2020. While this review was conducted during the time that many VA facilities were in phase 2 (initial response), the OIG noted all facilities were expected to implement VA's phase 1 plans to be ready to mount an initial response if and when outbreaks occurred.

[30] VHA, *Response Plan,* March 23, 2020.

[31] VHA, *Response Plan*, March 23, 2020.

Review Results

VHA provides several virtual care modalities that allow patients to receive care at home including (1) VVC, which is real-time, interactive video conferencing with the provider and the patient at different locations, including the home; (2) third-party video applications, which are temporarily authorized to allow for interactive video conferencing; and (3) telephone, which allows for virtual home care without the need for internet or specialized technology.[32] As noted previously, the OIG focused this review on virtual care modalities to the home, with an emphasis on primary care provider utilization of, and experience with, VVC.

1. Review of Virtual Primary Care Encounters

The OIG compared the frequency of certain primary care encounters for the two selected time periods (see figure 2).[33] Face-to-face encounters decreased by 75 percent from 1,842,047 primary care encounters during the first time period to 460,993 primary care encounters during the second time period. Similarly, VA-to-VA virtual encounters, requiring both patient and provider to be located at a VA facility, decreased by 49 percent from 43,913 primary care encounters during the first time period to 22,447 primary care encounters during the second time period.

Telephone and VVC/third-party video application encounters increased between the first and second time periods, with telephone encounters representing 81 percent of all primary care encounters during the second time period and VVC/third-party video application encounters representing three percent of all primary care encounters during that same time period. While VVC saw a significant relative increase in encounters between the two time periods, the vast majority of virtual care was provided over the telephone. The large increase in telephone encounters, coupled with the decrease in face-to-face visits, reflected VHA's transition to virtual primary care delivery during the period under review.

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[32] VHA Telehealth Services, "VVC VA Video Connect for Providers." https://vaww.telehealth.va.gov/pgm/vvc/providers/index.asp. (The website was accessed on June 24, 2020. This is an internal VA website and not available to the general public.). VA Video Connect is "a VA solution that enables Veterans to virtually meet-up with their VA healthcare providers, in something called a virtual medical room, using encrypted video to ensure the session is secure and private."

[33] VHA Directive 1082, *Patient Care Data Capture,* March 24, 2015. VHA defines encounters as "… a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition."
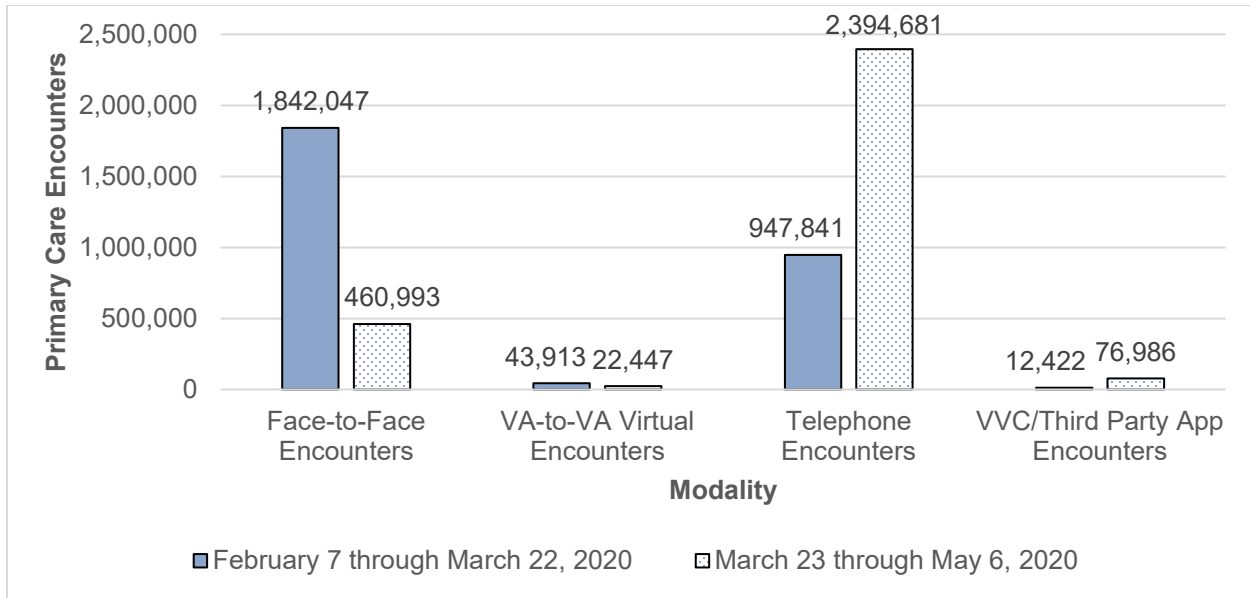
Figure 2. Primary care encounters by modality[34]
Source: VHA Corporate Data Warehouse data

2. Virtual Care Practice

Preferred Modality

VHA uses a commercially available video conferencing application called VVC that can be installed on an internet-enabled device. VHA has noted that VVC is the preferred modality for virtual care as it is integrated within VHA and allows for security and internal controls. Office of Connected Care leaders told the OIG that VHA promotes the use of VVC due to application-specific benefits including e911 as well as limiting the number of applications veterans need to learn in order to receive virtual care.[35]

Veteran Access to VVC Appointments

After scheduling an appointment, VHA staff generate an email to veterans that includes the following information:

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[34] For the purpose of this review, "VA-to-VA Virtual Encounters" are virtual encounters defined as video visits when that occur between a provider and a patient who are located in two different VHA locations and which store and forward encounters (i.e., "where messages, images, or data are collected at one point in time and interpreted or responded to later")"Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic," Centers for Disease Control and Prevention, accessed July 7, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html.

[35] VVC has a function for use by VHA staff in case of emergency known as "e911" that allows staff to call a 911 operator at the patient's location.

- A link to download the application if they have not already done so

- Instructions on how to join the call including link to access the VVC appointment

- A link to conduct a test call prior to the appointment to ensure their device is compatible with VVC

- A link to the VVC website that includes user guides and other resources[36]

Receipt of the email is necessary for each scheduled appointment as it contains the access link. See appendix D for additional details on the multistep-instruction guide provided to veterans for VVC appointments.

Reported Modalities

Ninety-eight percent of questionnaire respondents indicated that they had conducted at least one virtual appointment using VVC, a third-party video application, the telephone, or a combination of modalities, with only four respondents indicating that they had not.

The OIG found that the most frequently used virtual care modality was the telephone, with 98 percent of primary care providers reporting at least one virtual appointment and 89 percent reporting telephone as the virtual care modality most frequently used to communicate with patients.

While 79 percent of providers responded that they had used VVC at least once, only six percent reported that VVC was the modality most frequently used. Third-party video applications were used by 21 percent of respondents, though only two percent reported that this was the virtual modality most frequently used to communicate with patients.

Table 1 shows respondents' most frequently utilized virtual care modalities, comparing the groups of facilities with the highest and lowest percentage of users with at least one VVC encounter. There was little difference between groups with respect to use of the telephone, and even providers from facilities with the highest percentage of VVC and third-party video application users reported low usage of VVC.

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[36] The VVC website can be accessed at https://mobile.va.gov/app/va-video-connect.

Table 1. Most Frequently Reported Virtual Care Modality

Virtual Modality Type	Percent of Reponses (%) from Facilities with Greatest Percentage of Video-to-Home Users (N=152)	Percent of Responses (%) from Facilities with Least Percentage of Video-to-Home Users (N=97)
Telephone	85.5	94.9
VVC	9.9	1
Third-Party Video Application	3.3	0
Not Applicable (N/A)[37]	1.3	4.1

Source: VHA provider responses to the OIG's COVID-19 virtual care questionnaire

Technology Needs

Providers and patients must have access to equipment, such as computers, tablets, or smart phones to facilitate VVC video calls.

Among the providers that completed the questionnaire, 90 percent said they were equipped to conduct virtual primary care via VVC. They did not perceive their patients to be similarly equipped.[38]

Table 2 shows responses from providers as to whether patients were equipped to receive virtual care via VVC.[39] Twenty-four percent of primary care providers reported that patients were "always" or "often" equipped with the needed technology. The OIG has concerns that lack of patient equipment may hinder the ability to conduct primary care using VVC for the other 76 percent of respondents.

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[37] Not applicable (N/A) was included as an option as not all providers may have used one of the listed modalities.

[38] For the purpose of the questionnaire, "equipped" for providers was defined as having equipment including a computer, video camera, headset, and speakers. For veterans, "equipped" was defined as having a smart phone or tablet.

[39] VHA instructs veterans in need of equipment to contact their providers or local VA medical center.

Table 2. Provider-Reported Perception of Patients' VVC Equipment

Patient Had VVC Equipment	Number of Responses (Total N=249)	Percent of Responses (%)
Always	6	2
Often	54	22
Sometimes	118	47
Rarely	26	10
Never	22	9
Not Applicable (N/A)[40]	23	9

Source: VHA provider responses to the OIG's COVID-19 virtual care questionnaire

3. Factors Frequently Cited by Providers that Affected the Use of VVC

The OIG analyzed provider free text responses to two open-ended questions, which informed the factors discussed in this section of the report. Frequently mentioned factors included (1) training and support, (2) technology, (3) internet connectivity, and (4) scheduling (see table 3). [41]

Table 3. Provider-Reported Perception of Factors Affecting Use of VVC

Factor	Number of Responses
Training and Support	172
Technology	100
Internet Connection	72
Scheduling	38

Source: Textual analysis of primary care provider responses to the OIG's COVID-19 virtual care questionnaire

Training and Support was the Most Frequently Identified Factor Affecting VVC Use

The OIG identified training and support as the most frequently identified factor that affected use of VVC to deliver primary care. While some responses noted the need for provider training and support, the need for additional VVC application training and support for veterans was the dominant theme. As noted earlier, patients must follow numerous steps to receive care via VVC (see appendix D). For the purpose of this report, "training and support" included test visits with

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[40] Not applicable (N/A) was included as an option as not all providers may have conducted a virtual appointment.

[41] The OIG did not make a judgment with respect to the accuracy or strength of each provider comment. While they provide additional context, they should not be generalized across all VHA primary care providers.

patients as well as having staff available to walk patients through the VVC process prior to their appointment.

Providers noted technical assistance prior to the provider-veteran interaction was helpful and cited numerous examples of the types of training and support that affected the delivery of care via VVC:

- "Test visits with patient prior to the appointment."

- "It helps if someone has walked them through entire process previously. Otherwise entire VVC appt time is used trying to teach/coach patient to get into VVC conference room."

- "Patients can't find the [VVC] link or figure out how to use it."

Without training and support, veterans may have difficulty navigating the VVC application, which may affect the delivery of care.[42]

Veteran Technology Needs Affected VVC Use

Providers' free text responses to the open-ended questions aligned with the close-ended responses that also identified veteran technology needs as an issue (see table 2 on page 15). Providers noted that some veterans did not have computers, tablets, or smart phones available at home.

Providers cited several examples of a lack of equipment affecting the delivery of care using VVC:[43]

- "Vets do not have access to equipment needed, some have no smart phones, some have never used a computer."

- "Patient does not have proper home equipment needed for VVC appointments."

- "Patients do not have access to equipment necessary for VVC or they have difficulty using technology."

The OIG determined that a lack of technology may prevent the delivery of care via VVC and potentially other virtual care modalities.

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[42] While primary care providers indicated that veterans needed additional training and support, VHA does have a VVC help desk that veterans may access by email or telephone.

[43] The quotes listed are not the full listing of comments by respondents but were selected to provide the reader with examples that were not duplicative and offered unique perspectives. The OIG made edits to statements to correct spelling and write out abbreviations.

Internet Connectivity was Perceived as Lacking

Internet connectivity was another factor that was reported to affect the delivery of primary care.[44] Some providers mentioned veterans in rural areas may have difficulty accessing the internet. Others mentioned issues with internet connectivity more generally, not specific to rurality:

- "[Failure to ensure] scheduling by experienced staff, who would make sure veteran had right device and sufficient bandwidth."

- "A lot of my Veterans live in rural areas and don't have good connectivity."

- "Some Veterans don't want the service. Other Veterans don't have the equipment or internet access. Some don't know how to use computers due to other reasons."

Because VVC software cannot be used without access to the internet, veterans without reliable internet connectivity or a means to connect to the internet cannot receive primary care via VVC.

VVC Virtual Care Scheduling System was Challenging

Providers also noted VVC scheduling challenges. VVC scheduling requires the coordination of at least two scheduling systems and is a more complicated scheduling process than the one used for face-to-face care.[45] Providers reported difficulties scheduling and rescheduling VVC appointments and commented on issues with the email links used to connect veterans to VVC appointments:

- "Complexity of scheduling VVC vs telephone visits"

- "Poor scheduling follow-through (for example, no video link sent to Veteran or provider, lack of knowledge on how to reschedule link myself)"

- "Very difficult to schedule the actual appointment, equipment sometimes malfunctioning, many patients without needed technology" [46]

The OIG determined that scheduling challenges may limit the delivery of care via VVC.

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[44] Internet connectivity is defined as the ability to connect to or communicate with another computer or computer systems. Merriam-Webster, *Definition of Internet Connectivity*. https://www.merriam-webster.com/dictionary/connectivity. (The website was accessed on July 9, 2020.)

[45] VHA Telehealth Services, *Telehealth Management Platform*. https://vaww.telehealth.va.gov/resources/tmp/ (The website was accessed on July 22, 2020. This is an internal VA website and not available to the general public.) Telehealth scheduling systems include the standard scheduling package used by VHA for face-to-face appointments and a second scheduling process that does not interface with the standard scheduling package. VHA notes that, "Telehealth scheduling complexities have been addressed through variably effective "work-arounds," including commercially available scheduling software, Microsoft Outlook calendars and SharePoint sites, and even some locally developed scheduling solutions." VHA acknowledged that scheduling VVC appointments under the VA's legacy information system presents challenges, because creating an appointment requires the use of separate scheduling systems that are not interoperable.

[46] To access a VVC appointment, an email link is automatically sent to the veteran through the scheduling process. Email issues included the veteran not receiving the email link or the link not opening.

Conclusion

The OIG found that VHA increased the use of virtual primary care starting on March 23, 2020, with the majority of encounters being conducted by telephone.

The OIG deployed a questionnaire that focused on provider perceptions of virtual primary care, including the use of VVC. Findings associated with the questionnaire represent the perspectives of 249 providers from 20 facilities. A review of questionnaire responses identified several factors that may affect successful use of VVC. The top factor identified by OIG was training and support for veterans. Other factors included veteran technology needs, a lack of internet connectivity for veterans, and challenging scheduling processes.

Recommendations 1–2[47]

1. The Under Secretary for Health evaluates veteran access to VA Video Connect, including availability of equipment and reliable internet connectivity necessary to use VA Video Connect, and takes appropriate action.

2. The Under Secretary for Health reviews the provision of veteran VA Video Connect training and support, and takes appropriate action.

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[47] The recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who had the authority to perform the functions and duties of the Under Secretary for Health. Effective January 20, 2021, he was appointed to Acting Under Secretary for Health with the continued authority to perform the functions and duties of the Under Secretary.

Appendix A: Stop Codes

Table A.1. Primary Care and Video-to-Home Stop Codes[48]

Note: Primary care stop codes are highlighted in blue and marked with an asterisk.
Note: Video-to-Home stop codes are highlighted in gray and marked with a dagger.

Stop Code	Primary (P), Secondary (S), or Either (E)	Stop Code Name	Definition
179	S	Real-Time Clinical Video Telehealth to Home- Provider Site†	Records workload at the provider site (distant site) using real-time clinical video telehealth as a means to replicate aspects of face-to-face assessment and care provided to Veteran patients in their home (e.g., private residence, vacation home, daughter's home, etc.) or at a non-VA location/home (e.g., homeless shelter, university dormitory room, transitional housing, assisted living center, etc.) when the Veteran patient independently coordinates and conducts the Clinical Video Telehealth (CVT) encounter with their VA provider, without assistance from a non-VA site or 3rd party organization's staff or resources to coordinate, support or assist with the successful completion of the CVT encounter. Assessment and care may include: health/social evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain, etc. These CVT encounters must be electronically documented in CPRS fully meeting criteria for a provider encounter. Use provider work-unit as the primary Stop Code, i.e. 171179 HBPC Nurse, 323179 Home Tele-Primary Care, 502179 Home TeleMental Health.
322	E	Comprehensive Women's Primary Care Clinic*	Records patient visit for primary care services provided to women through a coordinated, interdisciplinary provision of medical, nursing, psychosocial, and allied health services for disease treatment and prevention and health promotion and education, referral for specialty, rehabilitation, and other levels of care, follow-up and overall care management by a Comprehensive Women's Health Primary Care Provider and support team within a separate women's clinic or Center. This includes Comprehensive Women's Center (model 3) and Separate but Shared Space Women's Clinics (model 2). Additional details on models of care are available in Handbook 1330.01 "Health Care Services for Women Veterans". Includes provider and support

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[48] This information is verbatim from VHA's Managerial Cost Accounting Office Fiscal Year 2020 Mid-Year Active Stop Codes.

			services. Women's Subspecialty services may also be provided in the same physical location.
323	E	Primary Care Medicine*	Records patient visit for comprehensive primary care services as outlined in VHA Handbook 1101.10 "Patient Aligned Care Team". Care includes PACT services provided through a coordinated, interdisciplinary provision of medical, nursing, psychosocial, and allied health services for disease treatment and prevention and health promotion and education. Referral for specialty, rehabilitation, and other levels of care, including follow-up and overall care management is provided by the primary care provider and support team for men and women patients. Includes provider and support services.
348	P	Primary Care Shared Appointment*	Records patient visit for a shared group appointment for routine or follow-up primary care. Shared group visits provide a secure but interactive setting that provides for improved access to providers and an opportunity to share experiences. These visits allow for the provision of primary care and are not primarily focused on the provision of education. Includes provider and support services.
350	E	GeriPACT*	Records patient visit for coordinated, interdisciplinary medical (MD, DO, NP or PA), nursing, psychosocial, allied health and support) primary care services offered to aging and elderly patients. Staff assigned to the GeriPACT Team have received specialized training in the patient-centered focus of preventive health and disease management particularly associated with this population (i.e. Geriatric Syndromes, Dementia, Falls, Continence, etc.). Encompasses overall care management to include coordination of disease prevention and management; health promotion and education; referral for specialty, rehabilitation and other levels of care; and follow-up. Includes provider and support services. Use in the primary position unless combined with a telephone Stop Code (e.g., Stop Code 326, 'Telephone Geriatrics'). Stop Code 350 qualifies as GeriPACT only when in PCMM (Primary Care Management Module) and should not be used in combination with Stop Code 323 ('PACT').
648	S	Real-Time Clinical Video Telehealth with Non-VAMC Location-Provider Site†	Records workload at the provider site (distant site) using real-time clinical video telehealth as a means to replicate aspects of face-to-face assessment and care provided to Veteran patients in a non-VA location (e.g., Vet Center, university student health clinic, Indian Health Service clinic, Department of Defense medical treatment facility, State Veterans Home, etc.) when the non-VA patient site staff have actively participated in the coordination and support of the Clinical Video Telehealth

			(CVT) encounter. This non-VA site coordination and support activity may include but is not limited to: providing assistance with scheduling; providing a suitable CVT space; management of VA CVT device and/or related equipment (either owned by the non-VA site or the VA); or accompanying the Veteran patient to or during the CVT encounter. Typically, this coordination and support is documented in a formal written document (e.g., memorandum of understanding (MOU) and/or Telehealth Service Agreement (TSA) between the non-VA site and the VA provider site, however, the 648 CVT encounter could be 'ad hoc' without such written agreement. Telehealth is the use of electronic communications and information technology to provide and support health care when distance separates the participants. Both the patient and provider must be present during the real-time video session.
679	S	National Center Real-Time Clinical Video Telehealth to Home- Provider Site†	Records workload at the provider site (distant site) using real-time Clinical Video Telehealth (CVT) by a provider from a National Telehealth Center as a means to replicate aspects of face-to-face assessment and care provided to Veterans in their home (e.g., private residence, vacation home, daughter's home, etc.) or at a non-VA location/home (e.g., homeless shelter, university dormitory room, transitional housing, assisted living center, etc.) when the Veteran independently coordinates and conducts the CVT encounter with their VA provider, without assistance from a non-VA site or 3rd party organization's staff or resources to coordinate, support or assist with the successful completion of the CVT encounter. Assessment and care may include: health/social evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain, etc. These CVT encounters must be electronically documented in CPRS fully meeting criteria for a provider encounter. Use provider work-unit as the primary Stop Code, i.e., 345679 Home Genomic Care 323679 Home Tele Primary Care, 502679 Home Tele Mental Health.

Source: VHA's Managerial Cost Accounting Office Fiscal Year 2020 mid-year active stop codes

Appendix B: Selected Facilities

Table B.1. List of Selected Facilities by VISN Number

VISN	Facility
1	Togus VA Medical Center in Augusta, Maine
1	Providence VA Medical Center in Rhode Island
1	West Haven VA Medical Center in Connecticut
4	Wilmington VA Medical Center in Delaware
7	Birmingham VA Medical Center in Alabama
7	Carl Vinson VA Medical Center in Dublin, Georgia
7	Tuscaloosa VA Medical Center in Alabama
10	Marion VA Medical Center in Indiana
12	Jesse Brown VA Medical Center in Chicago, Illinois
12	Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois
16	Alexandria VA Medical Center in Pineville, Louisiana
16	G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi
19	Grand Junction VA Medical Center in Colorado
20	Portland VA Medical Center in Oregon
20	Roseburg VA Medical Center in Oregon
20	White City VA Medical Center in Oregon
21	North Las Vegas VA Medical Center in Nevada
22	San Diego VA Medical Center in California
22	Tucson VA Medical Center in Arizona
23	Minneapolis VA Medical Center in Minnesota

Source: OIG analysis of primary care encounter data

Appendix C: Questionnaire

The OIG's questionnaire asked an exclusionary question, followed by seven additional questions if the answer to the exclusionary question was "Yes."

(E) Are you a primary care or women's health primary care provider [Y/N]

(1) Since March 23, 2020, have you conducted at least one virtual primary care appointment with a patient using the following modalities:

　　a) VA Video Connect (VVC) [Y/N]

　　b) Telephone [Y/N]

　　c) Third-party video application(s) (such as FaceTime, Google Hangouts, Facebook Messenger video, Zoom, etc.) [Y/N]

(2) Since March 23, 2020, which of the following modalities of care have you utilized most:

　　a) VA Video Connect (VVC)

　　b) Telephone

　　c) Third-party video application(s)

　　d) N/A

(3) Please share important factors, since March 23, 2020, that prevented you from providing primary care via VA Video Connect (VVC). [1,000-character text box, please enter N/A if this question does not apply to you]

(4) Please share important factors, since March 23, 2020, that helped you provide primary care via VA Video Connect (VVC). [1,000-character text box, please enter N/A if this question does not apply to you]

(5) As of March 23, 2020, were you equipped with the technology needed to provide primary care via VA Video Connect (VVC) (such as computer, video camera, headset, speakers, etc.)? [Y/N]

(6) To your knowledge, since March 23, 2020, were your patients equipped with the technology needed to receive primary care via VA Video Connect (VVC) (such as smart phone, tablet, etc.)? [0=Not Applicable, 1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Always]

(7) Since March 23, 2020, have you used a third-party application to provide virtual primary care due to VA Video Connect (VVC) connectivity issues? [0=Not Applicable, 1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Always]

Appendix D: Steps to Access a VVC Appointment

To receive care using VVC, veterans must be able to access the following:

1. A computer, tablet, or smart phone

2. Internet

3. Email address (on record with VA)

VVC training materials instruct veterans to call the National Technology Help Desk if they have technical questions and note that all other questions or concerns should be addressed to the veteran's VA facility or VA clinical team.
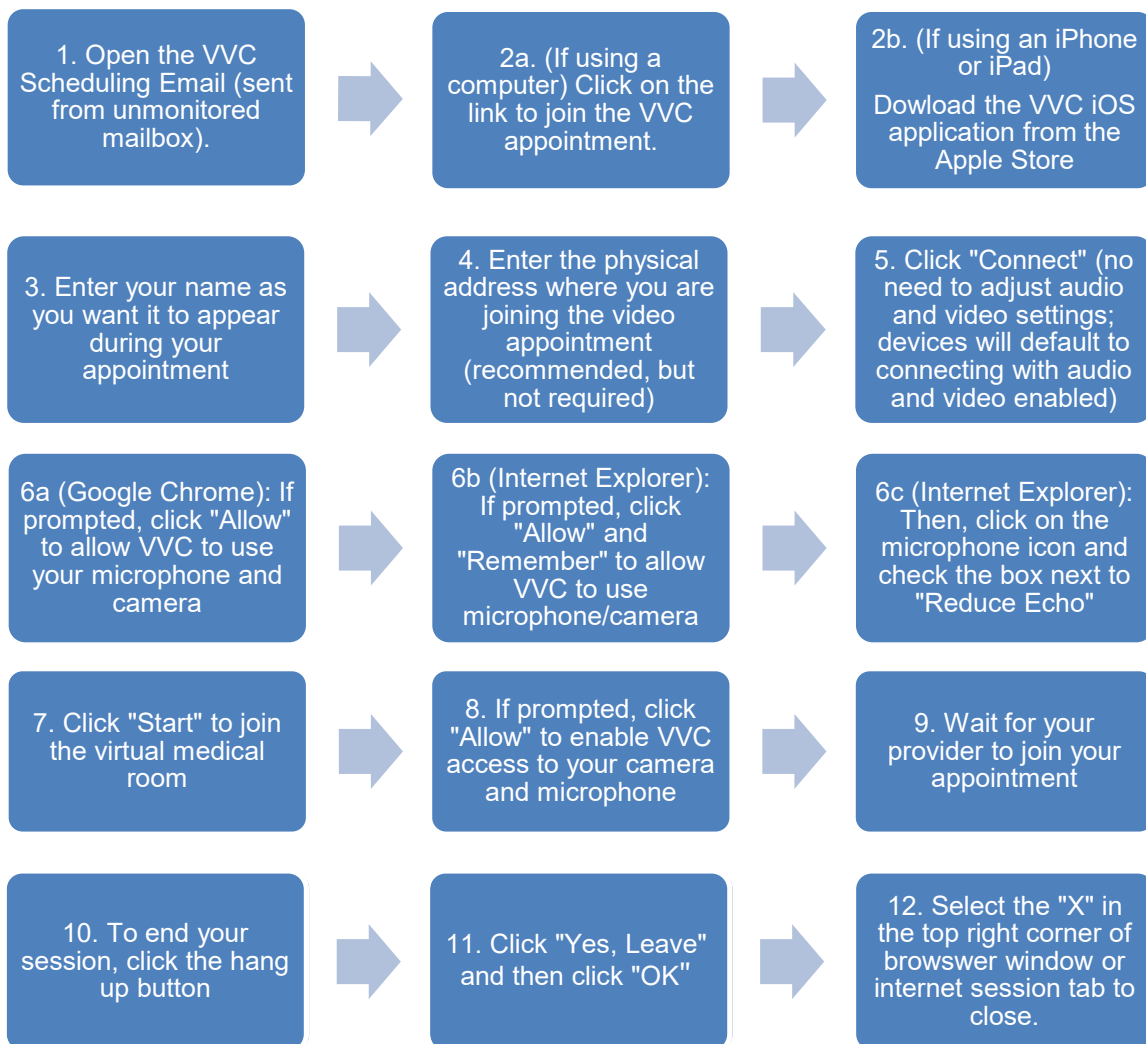
1. Open the VVC Scheduling Email (sent from unmonitored mailbox).	2a. (If using a computer) Click on the link to join the VVC appointment.	2b. (If using an iPhone or iPad) Dowload the VVC iOS application from the Apple Store
3. Enter your name as you want it to appear during your appointment	4. Enter the physical address where you are joining the video appointment (recommended, but not required)	5. Click "Connect" (no need to adjust audio and video settings; devices will default to connecting with audio and video enabled)
6a (Google Chrome): If prompted, click "Allow" to allow VVC to use your microphone and camera	6b (Internet Explorer): If prompted, click "Allow" and "Remember" to allow VVC to use microphone/camera	6c (Internet Explorer): Then, click on the microphone icon and check the box next to "Reduce Echo"
7. Click "Start" to join the virtual medical room	8. If prompted, click "Allow" to enable VVC access to your camera and microphone	9. Wait for your provider to join your appointment
10. To end your session, click the hang up button	11. Click "Yes, Leave" and then click "OK"	12. Select the "X" in the top right corner of browswer window or internet session tab to close.

Figure D.1. Steps to access a VVC appointment
Source: VA Video Connect Web User Guide for Veterans

Appendix E: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: December 15, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

To: Assistant Inspector General for of Healthcare Inspections (54)

Subj: OIG Draft Report, Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic (2020-02717-HI-1041) (VIEWS # 4048686)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*.

2. The Department of Veterans Affairs (VA) recognizes the COVID-19 pandemic has presented significant challenges to health care delivery worldwide. That is why we are proud to be considered a market leader and international exemplar in Connected Care and Telehealth, serving Veterans through what is likely the largest integrated approach to virtual care in the United States. In fiscal year 2020, VA provided greater than 5.6 million episodes of telehealth care to over 1.6 million Veterans. VHA appreciates OIG's comments and recommendations and will continue to expand the delivery of virtual care to all Veterans.

3. Comments related to this memorandum can be directed to Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10BGOALAction@va.gov.

(Original signed by:)

Richard Stone
Executive in Charge
Office of the Under Secretary for Health

Executive in Charge Response

Recommendation 1

The Under Secretary for Health evaluates veteran access to VA Video Connect, including availability of equipment and reliable internet connectivity necessary to use VA Video Connect, and takes appropriate action.

Concur.

Target date for completion: September 2021

Executive in Charge Comments

Concur. VA recognizes the adverse impact of the digital divide on Veterans. Internet access, particularly during the COVID-19 pandemic, is critical for health care access, social engagement, employment, and education. Based on a Federal Communications Commission (FCC) report from 2019, about 2.2 million Veteran households lack either fixed or mobile broadband connections at home. In response, VA has established several mitigation initiatives over the last several years and accelerated key efforts during the pandemic.

Most recently, in September 2020, VA implemented a national digital divide consult integrated within the electronic health record. The consult is used when a Veteran could benefit from telehealth services but lacks the technology or internet connection necessary to participate. The digital divide consult establishes a national, systematic process through which Veterans can get assessed for the digital divide and where multiple mitigation strategies can be aggregated. Eligibility for FCC's Lifeline Program is one mitigation option in the digital divide consult. As part of the consult assessment, the social worker can help determine a Veteran's eligibility for Lifeline and assist them in establishing the Federal internet/technology subsidy.

The VA connected device program is another mitigation strategy available through the digital divide consult. Through this program, Veterans without the technology and internet needed for telehealth, can be loaned a 4G connected tablet or phone. As of the end of November 2020, VA has distributed over 87,884 devices to Veterans though this effort.

Outside the digital divide consult, VA continues work on its Accessing Telehealth Through Local Area Stations (ATLAS) pilot. ATLAS is establishing community locations with internet and telehealth technology, such as at a Walmart store or Veterans Service Organization post, that can be reserved for a Veteran's VA telehealth appointment. The goal of ATLAS is to increase access to VA services, including for Veterans who do not have internet access within their homes.

By September 2021, VA will accomplish the following:

- Expand mitigation options within the digital divide consult: VA will provide Veterans with individualized information about discount internet and technology options in their area.

- Immediate FCC Lifeline Eligibility: VA will establish a timeline for connecting the VA and FCC databases necessary to establish immediate FCC Lifeline eligibility for many Veterans.

- Screening for the digital divide: VA will pilot a digital divide screening tool at one urban and one rural facility. The screening tool will prompt routine screening of Veterans presenting for services to determine whether such a tool provides value above and beyond the digital divide consult process.

- Internet Benefit: VA will assess the feasibility of providing Veterans an internet benefit, as a substitute for their beneficiary travel benefit, for Veterans who are attending a portion of their appointments virtually in place of in-person.

Recommendation 2

The Under Secretary for Health reviews the provision of veteran VA Video Connect training and support, and takes appropriate action.

Concur.

Target date for completion: March 2021

Executive in Charge Comments

Concur. VA surveys both Veterans and health care professionals following their visits to assess their experience with telehealth modalities. In addition, VA has conducted focused surveys to better understand barriers to participant experience; has established a research center of excellence to obtain in depth analysis of telehealth services, including utilization barriers and preferences, or needs, of different demographic cohorts; and is establishing a video to home journey map to ensure it has identified moments that matter in its telehealth processes.

To address an identified challenge faced by Veterans and health care professionals, each VA facility is establishing a VA Video Connect test call service to educate and support Veterans who may not be comfortable with technology or are using telehealth for the first time. As part of the test call service, a VA staff member or volunteer will connect with the Veteran and conduct a test VA Video Connect visit to make sure the Veteran is comfortable using the platform and their technology prior to their first clinical visit.

Similarly, VA is establishing a support contract for its connected device program. When Veterans receive a VA issued video device, a technician will help them set it up, educate them on its functions, and conduct an initial VA Video Connect test call to prepare them for their first clinical telehealth encounter.

Beyond these focused efforts, VA will continue to manage its 24/7 connected care help desk to support both Veterans and health care professionals whenever they need help with telehealth technologies or services. Due to the increase in telehealth utilization, the help desk was expanded by 320% in 2020.

By March 2021, VA will accomplish the following:

- VA Video Connect Test Call Services: Veterans at all VA facilities will have access to a VA Video Connect test call to help them prepare for their VA Video Connect appointments.
- Connected Device Onboarding: Veterans receiving a VA connected device will receive onboarding training and a VA Video Connect test call.

OIG Contact and Staff Acknowledgments

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