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VETERANS HEALTH ADMINISTRATION

Audit of Community Care
Consults during COVID-19

AUDIT

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Executive Summary

The COVID-19 pandemic has had a major impact on the Veterans Health Administration's (VHA) mission of providing health care for veterans. At the onset of the pandemic, VHA postponed nationwide requests for all nonessential services to reduce the spread of the virus. The postponement included care coordinated by VHA and delivered by healthcare providers in the community. VHA's Office of Community Care (OCC) had to take action to ensure veterans continued to have expanded access to health care in the community, required by the VA MISSION Act of 2018.¹ OCC issued policies to VA facilities to protect patients and employees from COVID-19 by postponing nonurgent appointments and offering alternatives to in-person care, such as telehealth.²

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA effectively managed community care consults for routine appointments during the pandemic.³ The OIG acknowledges the ongoing efforts of all VHA community care personnel who have worked to manage the needs of patients and personnel during COVID-19.

What the Audit Found

VHA experienced delays scheduling routine community care consults during the COVID-19 pandemic due largely to related conditions. The OIG found that routine community care consults were unscheduled for an average of 42 days, not meeting VHA's timeliness goal of 30 days. Community care staff faced significant challenges beyond their control that contributed to the scheduling delays, such as the lack of availability of appointments in the community. The OIG also found that some patients were hesitant to schedule appointments during the pandemic, failed to return phone calls, or declined care once it was offered. While these challenges prevented the OIG from evaluating whether timeliness could be improved, they underscore the need for strong adherence to consult scheduling guidance and oversight of the aspects of the community care program that are within VHA's control.

The OIG found scheduling weaknesses that can hinder VHA's ability to manage consults and provide assurance that all efforts were made to schedule care even during a pandemic.

¹ The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, §1703 (2018).

² Both "nonurgent" and "nonemergent" (nonemergency) indicate that a patient should be seen when the VA healthcare provider deems it clinically appropriate.

³ A consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient, seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem. The requesting provider uses an urgency status to communicate how quickly the consult should be addressed. *Routine* indicates the patient should be seen in accordance with the clinically indicated date, while *stat* indicates an immediate need.

Community care providers and staff did not consistently comply with requirements to manage routine consults, and leaders lacked tools to sufficiently monitor program operations that could have identified the problems. Deficiencies were identified in the following areas: documenting when patients were contacted about scheduling appointments, setting consult priority levels, designating when patients could have alternative care options, and ensuring staff training programs addressed those weaknesses.

Communicating with Patients

VHA policy requires staff to make at least two documented attempts to contact patients to schedule non-mental health appointments, and at least four documented attempts to schedule mental health appointments.⁴ However, the audit team found that staff were not consistently documenting their attempts to contact patients. An estimated 65,100 consults (14 percent) lacked evidence that the patient was contacted, and the consults had not been scheduled or completed as of November 9, 2020.⁵ Improved oversight and active monitoring of consult records would help ensure that staff make the minimum number of contact attempts, improving the likelihood that veterans' scheduling needs are being promptly considered.

Setting Priority Levels for Consults

A May 2020 memo from the assistant under secretary for health for operations notified clinicians of changes to the consult toolbox to allow them to indicate scheduling priorities on consults and encouraged facilities to develop criteria for priority designations.⁶ However, the memo did not *require* the use of priority levels. The audit team found that sampled consults from nine facilities assigned priority 1 took an estimated average of 42 days to schedule, compared with 52 days for those assigned priorities 2 through 4.⁷ Beyond the nine facilities examined, the OIG did not assess how other facilities used consult priority levels during the pandemic. VHA mandated the use of priorities 1 and 2 in September 2020.⁸ Because consult prioritization was not initially required and was inconsistently applied at the facilities reviewed, the audit team could not fully evaluate the impact of priority levels on the timeliness of appointment scheduling. As such, the OIG did not make any recommendations related to the use of priority levels for routine community care consult scheduling.

⁴ VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016, rev. June 28, 2019.

⁵ Appendixes A and B contain the audit scope and methodology and the sampling methodology. Figures and percentages in this report have been rounded to the nearest whole number.

⁶ VHA memo, "National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065–COVID-19 Upgrades (VIEWS# 02748457)," May 18, 2020.

⁷ There was no statistically significant difference in average age based on priority 1 versus all other consults with a documented priority level.

⁸ VHA memo, "Changes to Consult/Referral Management during COVID-19," September 15, 2020.

Offering Alternative Forms of Care

Additionally, VHA care providers and clinical staff did not consistently document whether alternative forms of care could be offered to the patient. Referring providers or facility community care clinicians did not always indicate in the consult records whether options such as telehealth were clinically appropriate. Without that information, schedulers would not know whether to offer patients those options. VHA also lacked a method for facility community care departments to monitor whether clinicians were marking alternative care as an option for patients. If VA providers and community care staff fail to document and use all clinically appropriate options for care, including alternatives to in-person appointments, VHA lacks assurance that all efforts were made to schedule a patient for care within prescribed timelines.

Training

OCC highly recommended, but did not require, training in processing community care consults, including how to comply with COVID-19 policy updates.⁹ While all facilities that the OIG reviewed provided the memos and updates to community care staff, the audit team found that there were training inconsistencies within the facilities for staff who process community care consults. Reassessing the frequency of and approach to training within VHA facilities as revisions are made to the various tools may result in more consistent documentation of scheduling contact attempts and alternative care options for patients, while potentially increasing the use of priority designations.

What the OIG Recommended

The identified weaknesses highlight the need to improve governance of community care consults. Only if the weaknesses are addressed will VHA and patients have assurance that medical facilities are doing all they can to provide veterans continued access to care during and after the COVID-19 pandemic.

The OIG made three recommendations to the under secretary for health to improve the monitoring and oversight of routine community care. They include directing facilities' community care leaders to oversee the documentation of communication between staff and patients and to develop a process for facilities to monitor whether community care staff document the suitability of alternatives to face-to-face care and offer these alternatives to patients when clinically appropriate. The final recommendation is to reassess the frequency of and approach to training for scheduling community care consults within VHA facilities as revisions are made to the various tools.

⁹ VHA issued 127 memos between March and October 2020 that included policy updates in response to COVID-19.

Management Comments and OIG Response

The deputy under secretary for health concurred with all three recommendations and provided responsive action plans for each recommendation. Appendix C provides the full text of the deputy under secretary's comments. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.



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Contents

Executive Summary	i
Abbreviations	vi
Introduction.....	1
Results and Recommendations	8
Finding: VHA Faced Delays in Scheduling Community Care Consults Due to COVID-19 Conditions, but Some Internal Processes Also Could Be Improved.....	8
Recommendations 1–3	15
Appendix A: Scope and Methodology.....	17
Appendix B: Statistical Sampling Methodology	20
Appendix C: Management Comments.....	25
OIG Contact and Staff Acknowledgments	27
Report Distribution	28

Abbreviations

OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The COVID-19 pandemic has had a major impact on the Veterans Health Administration's (VHA) mission of providing health care for veterans. At the onset of the pandemic, VHA postponed nationwide requests for all nonessential services to reduce the spread of the virus. The postponement included care coordinated by VHA and delivered by healthcare providers in the community. VHA's Office of Community Care (OCC) had to take action to ensure veterans had expanded access to health care in the community, required by the VA MISSION Act of 2018.¹⁰

In March 2020, VHA issued guidance for the community care program. It directed VA medical facilities to protect patients and employees from COVID-19 by postponing nonemergent procedures and routine eye and dental care. Scheduled nonurgent and nonemergent (nonemergency) face-to-face appointments should also be shifted to VHA e-consults (electronic consultations) or telehealth appointments, such as telephone or video calls, whenever possible.¹¹ When not possible, VHA instructed staff to offer patients a scheduled community care appointment (face-to-face or telehealth) at a later date or refer them for a telehealth appointment.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA medical facilities effectively managed community care consults for routine appointments (referrals) during the pandemic. The audit team assessed whether community care staff documented contact with patients to schedule appointments, prioritized consults, and recorded whether patients could receive an alternative form of care, such as telehealth. The audit focused on routine community care consults that were not scheduled as of October 9, 2020.

The OIG recognizes and appreciates the ongoing efforts of all VHA community care personnel who have been working to manage the needs of patients and personnel during COVID-19. The stresses associated with that work cannot be overstated. The information provided in this report is meant to identify risks, challenges, and responses that are instructive for VHA going forward.

Community Care Roles and Responsibilities

The acting assistant under secretary for health for community care leads OCC and is responsible for managing nationwide programs that allow patients to receive care and services through community providers outside of VHA. According to OCC leaders, their office develops policy, training, technology aids, reports, guidebooks, and other program tools. Additionally, OCC staff

¹⁰ VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (2018).

¹¹ VHA memo, "Guidance on Access Standards in Response to Coronavirus (COVID-19)," March 20, 2020, and updated version on March 30, 2020. Designations of "nonurgent," "nonemergent," and "routine" care indicate that a patient should be seen when the VA provider deems they are clinically appropriate. An e-consult is a clinical consultation involving a chart review which does not entail a face-to-face examination of the patient.

review consult status, timeliness, and workload every week and report areas of concern to the appropriate Veterans Integrated Service Network (VISN) and facility leaders.¹²

OCC stated that, regionally, VISNs provide an important conduit of information from the VA medical facilities to OCC on successes and challenges with community care consults. VISN directors' responsibilities for these consults include ensuring patients receive high-quality health care in a timely manner and monitoring compliance with VHA's directive on scheduling processes and procedures.¹³

Locally, VHA medical facility directors are responsible for appropriately managing community care consults and clinic access, monitoring compliance with the directive, and reporting noncompliance to the VISN director. Each facility has a community care department, whose staff—both clinicians and medical support assistants—are responsible for managing, reviewing, authorizing, and scheduling consults they receive for care in the community. These community care staff members report to the facility director, not to OCC.

Facilities may rely on contractors known as third-party administrators to schedule a community care appointment for patients to reduce the burden on VHA healthcare resources. If third-party administrators do the scheduling, they follow the same protocols VHA staff would.

Community Care Consult Process

Although the community care process has changed somewhat during the pandemic, it generally begins when a VHA provider creates a consult for a patient, and a medical support assistant determines if the patient is eligible for community care under the MISSION Act. A patient is eligible if one of the following is true:

- The patient's average drive time is longer than 30 minutes for primary care or 60 minutes for specialty care.
- VA cannot provide care within 20 days for primary care and 28 days for specialty care.¹⁴

¹² VHA delivers health care through 18 regional VISNs. Each has a director who coordinates and oversees administrative and clinical activities at the medical facilities in the network.

¹³ VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, rev. July 12, 2019.

¹⁴ In a separate review, the OIG assessed allegations related to VHA's disclosure of veteran wait times for VHA appointments, which included evaluating how VHA's calculation methods differed between its public wait time data and its eligibility criteria for the community care program. The OIG report for this separate review will be published subsequent to this report.

- Community care is in the patient’s best medical interest.
- The VHA service does not meet certain quality standards.¹⁵

Medical support assistants use an automated tool to review MISSION Act criteria, determine patient eligibility for community care, and document the decision. Once eligibility is established and the patient chooses to receive care in the community, the consult is sent to the community care department. A clinician reviews the consult, and after it is authorized, it is ready for scheduling.¹⁶

Community care staff are responsible for either contacting the veteran to schedule an appointment within 30 days or checking the consult status to ensure the veteran has scheduled the appointment.¹⁷ Once the appointment is scheduled, medical records are transferred to the community provider and the patient attends the appointment, after which the medical records are returned to the facility’s community care department, and the consult is completed.¹⁸

2020 Guidance Issued in Response to the COVID-19 Pandemic

VHA continued to issue guidance throughout the pandemic to help staff manage community care. VHA issued 127 OCC related updates (memos and attachments) to the field between March and October 9, 2020. The first March 2020 memo was discussed above; it and the other three relevant memos within the scope of this audit are shown in figure 1. The third and fourth memos in the figure pertain to the consult toolbox—software that aids VHA providers and staff in managing community care consults. VHA developed a tab in the consult toolbox to assist with the changes established by the COVID-19-related memos for processing routine community care consults. The COVID-19 tab allows clinicians to document priority levels and the appropriateness of alternative forms of care.

¹⁵ 38 C.F.R. §§ 17.4010 and 17.4040. In addition, a veteran is eligible if no VA facility offers the services the veteran requires, VA does not operate a full-service medical facility in the state in which the veteran resides, or the veteran was eligible under the Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146 (2014) as of June 5, 2018.

¹⁶ Veterans Health Administration, VHA Office of Community Care Field Guidebook, Chapter 2: Eligibility, Referral, and Scheduling (2020). The OCC Field Guidebook is continually updated based on guidance provided by VHA. The guidebook assists staff with obtaining care for patients in the community.

¹⁷ Community care department staff can generate queries and reports from VHA’s Corporate Data Warehouse system to identify patients who have not had the appropriate number of contact attempts and how much time has passed between contacts.

¹⁸ VHA Office of Community Care Field Guidebook, Chapter 3: How to Perform Care Coordination (2020); VHA Office of Community Care Operating Model (Version 1): Activities of the Local OCC Department, May 15, 2017.

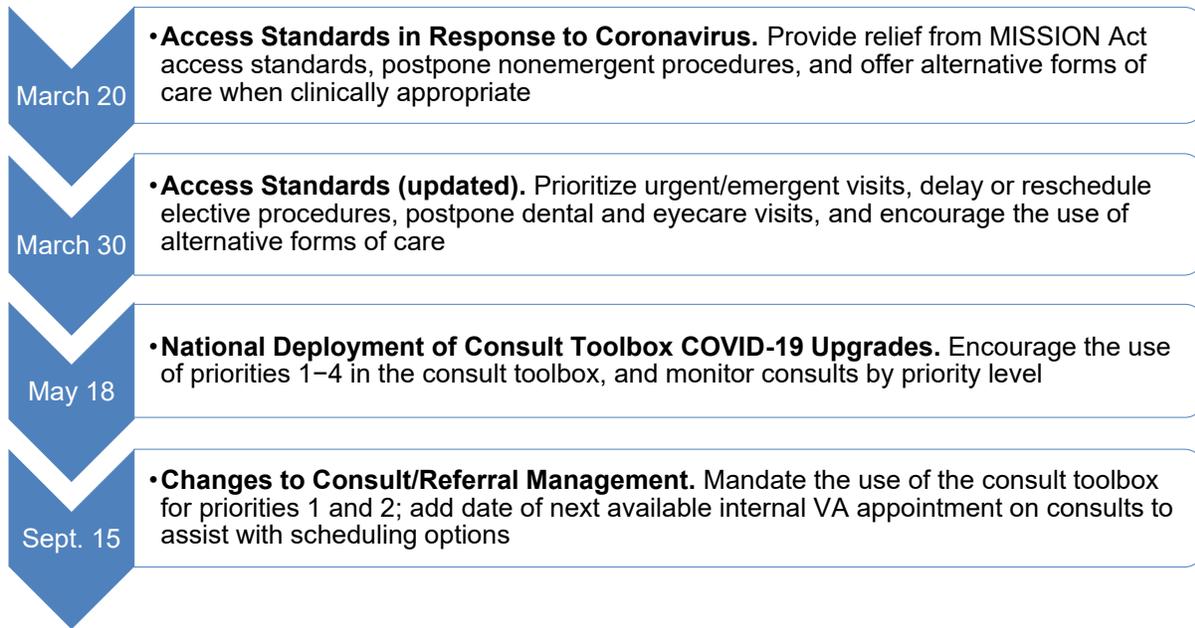


Figure 1. 2020 COVID-19 guidance applied during this audit.

Source: COVID-19 memos released in 2020 (as cited throughout report).

According to OCC officials, the guidance continued to change to ensure clinical reviews were completed and care was delivered in a timely manner. OCC sends new or updated policies and memos to VISN directors, who forward them to their VHA medical center directors. OCC officials also said they use weekly forums, office hours, national calls, blogs, and a monthly newsletter to convey this information. Additionally, guidance is updated regularly in the OCC Field Guidebook. OCC officials said that effective distribution of these updates to the field is one of their main challenges.

Prioritizing the Consults

The May 2020 memo, released by the assistant under secretary for health for operations, notified clinicians of changes to the consult toolbox to allow them to indicate scheduling priorities on the consults. The memo encouraged facility leaders to develop criteria for using priority designations.¹⁹ Assigning a priority for consults assists with identifying the needs of patients and creates a standard way for providers to communicate clinical triage needs for community care. Table 1 summarizes guidance to clinicians on how to use the priority levels.

¹⁹ VHA memo, “National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065–COVID-19 Upgrades (VIEWS# 02748457),” May 18, 2020.

Table 1. Scheduling Priorities and Their Use

Priority level	Scheduling time frame (urgency)	When it should be used
1	Schedule despite COVID-19	The clinician anticipates decline, or a delay of care is likely to lead to harm to the patient.
2	Schedule once authorized by clinical review	New visits for conditions with possible decline should be scheduled based on community availability.
3–4	Locally defined	For routine chronic conditions, a delay is not likely to affect the patient’s health.

Source: VHA memo, “National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065–COVID-19 Upgrades (VIEWS# 02748457),” May 18, 2020.

On September 15, 2020, the assistant under secretary for health for operations updated the guidance to *mandate* that all priority 1 and 2 consults be documented in the consult toolbox.²⁰

Indicating the Appropriateness of Alternative Forms of Care

In keeping with the March 2020 memos on offering veterans alternative forms of care, OCC updated its Field Guidebook to state that all veterans must be offered all appropriate options, including VHA e-consults or telehealth appointments. This guidance allowed community care clinicians, in addition to the referring provider, to indicate in the consult toolbox whether an alternative form of care was appropriate for the patient.

Figure 2 illustrates staff responsibilities when processing a consult and indicates (in blue) responsibilities added during the pandemic.

²⁰ VHA memo, “Changes to Consult/Referral Management during COVID-19,” September 15, 2020.

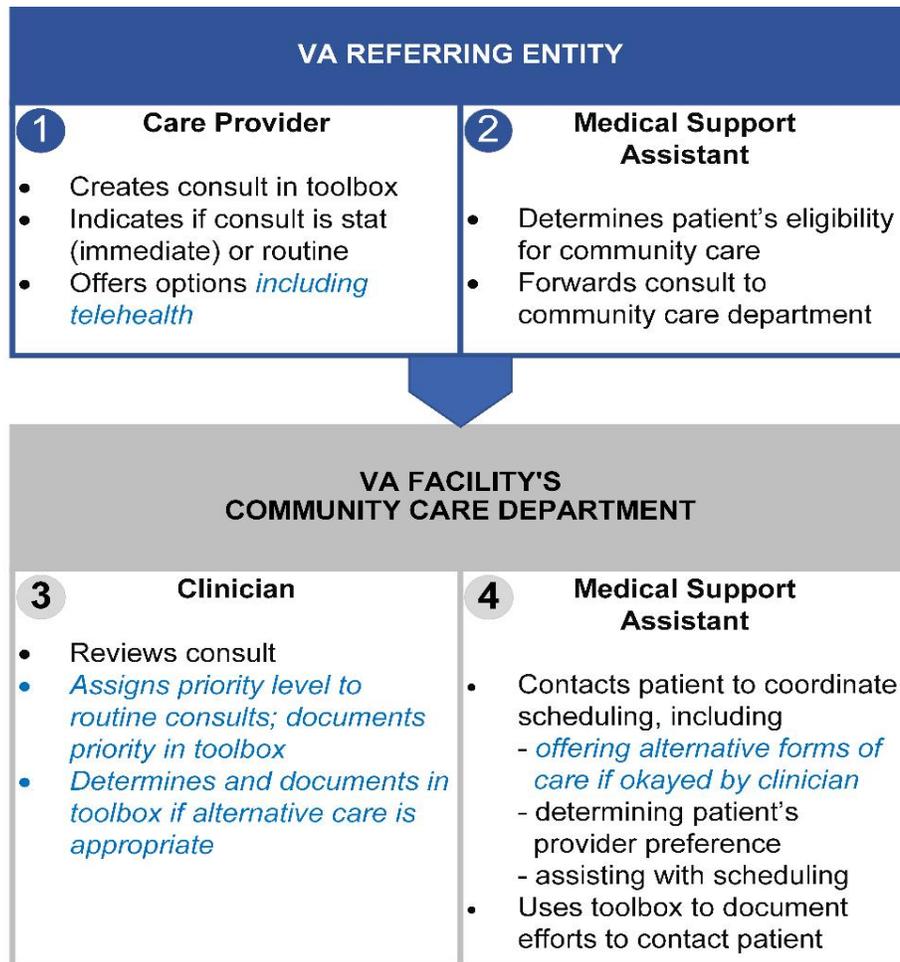


Figure 2. Summary of VA OIG interviews and analysis of laws, guidance, and memos related to VHA community care consults.

Source: The Office of Community Care Field Guidebook and VA OIG interviews.

Note: Italicized steps in blue were added during COVID-19.

Trends in VHA Community Care

VHA’s scheduled and unscheduled community care consults decreased by about 17 percent combined following the onset of COVID-19.²¹ In the seven-month period before the pandemic from August 1, 2019, to February 29, 2020, VA maintained an average of about 1.2 million scheduled and unscheduled community care consults per month. After the declaration of the pandemic, VHA maintained an average of about one million scheduled and unscheduled consults per month between March 1 and October 1, 2020. According to OCC, that decrease occurred as

²¹ For the purposes of this audit, the OIG defined unscheduled consults as those in either pending or active status as of October 9, 2020. A consult in pending status has been sent by the referring care provider but has not yet been acted on by the receiving service or provider. An active consult has been received by the service or provider and is awaiting further action.

both OCC officials and patients tried to determine what kind of care was still offered in the community. Once officials understood what care was available, scheduling resumed and the number of scheduled community care consults began to increase.

Figure 3 shows the scheduled and unscheduled community care consults. The timeline is separated by a vertical line identifying the declaration of the COVID-19 pandemic.

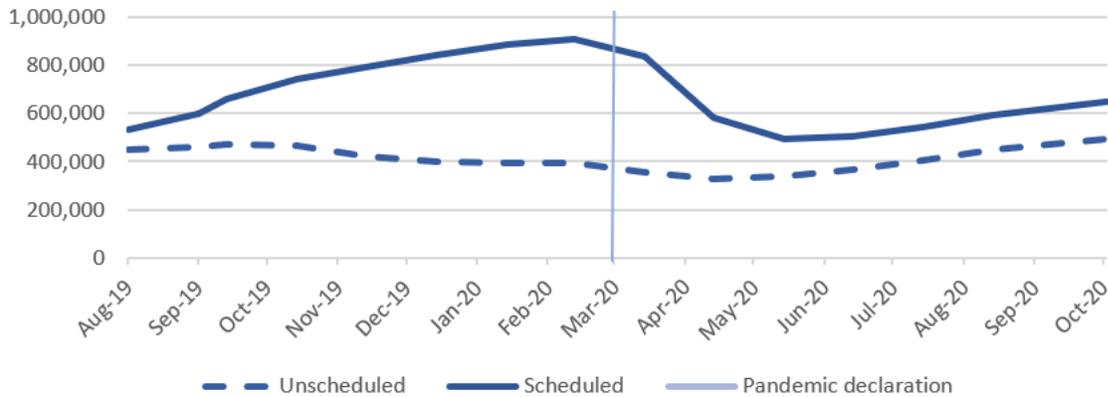


Figure 3. Scheduled and unscheduled community care consults from August 1, 2019, through October 1, 2020.

Source: VHA Support Service Center, Consult Open Trend Report.

The demand for community care remained constant throughout the pandemic and VHA facilities continued to have a steady workload. As of May 1, 2021, VHA had approximately 785,000 community care consults scheduled and approximately 497,000 consults unscheduled.

Results and Recommendations

Finding: VHA Faced Delays in Scheduling Community Care Consults Due to COVID-19 Conditions, but Some Internal Processes Also Could Be Improved

VHA facility community care departments experienced delays scheduling routine community care consults during the COVID-19 pandemic. As one might expect, the OIG found that routine community care consults took longer to schedule than guidance targeted. They were in an active status for an average of 42 days, missing VHA's timeliness goal by 12 days.²² VHA's community care staff faced significant challenges beyond their control that contributed to scheduling delays, such as the lack of availability of appointments in the community and hesitancy by patients to schedule appointments during the pandemic. While these challenges prevented the OIG from evaluating whether timeliness could be improved, they underscore the need for strong governance over the community care program to help minimize the delays as much as circumstances allow.

Although provider availability and patient hesitancy to schedule appointments are not within VHA's control, leaders could take steps to ensure that processes within their scope of authority are being leveraged to the greatest extent possible. The OIG found that VHA facilities could more effectively manage routine community care consults and improve scheduling efforts both during and after the pandemic. For example, staff did not regularly document their attempts to contact patients to schedule appointments, a responsibility that predated the pandemic, or their decisions about whether alternative forms of care could be offered to patients. These conditions occurred in part because VHA did not ensure community care staff followed consult management guidance.

What the OIG Did

On October 9, 2020, VHA had approximately 494,000 unscheduled community care consults. Of those, an estimated 476,000 aligned with the scope of this audit.²³ From those in scope, the audit team reviewed a random sample of 225 consults from nine facilities, including associated documentation, to determine if community care staff effectively managed consults by following guidance provided during the COVID-19 pandemic. From the sample review, the team made projections for the entire population. The team examined medical records to see if there was documentation that facility community care staff (1) communicated with patients, (2) prioritized consults, and (3) indicated whether the patient could receive an alternative form of care, such as

²² Figures and averages in this report have been rounded to the nearest whole number.

²³ OIG estimated that 18,400 of these consults were out of scope as they were for services related to daily living activities or health care in the home. The 18,400 consults also included consults that were misclassified as routine and were subsequently canceled or discontinued. For more on the scope and methodology, see appendixes A and B.

telehealth. Lastly, the audit team interviewed community care leaders at each of the facilities to identify training and communication efforts regarding COVID-related guidance.

Facilities' Community Care Offices Faced Challenges beyond Their Control during the COVID-19 Pandemic

The OCC Field Guidebook sets timeliness goals for processing consults that are in a pending or active (unscheduled) status. As noted earlier, a consult in pending status has been sent by the referring care provider but has not yet been acted on by the receiving service or healthcare provider. An active consult has been received by the service or provider and is awaiting scheduling. During the pandemic, VHA did not relax the requirement that consults should remain in pending status no more than two business days from the consult creation date, and should be active for no more than 30 days.

The audit team found that VHA generally met those timeliness goals for pending routine consults. They averaged two days, which is the goal set by the OCC Field Guidebook. In contrast, the audit team found that routine community care consults were in an active status for an average of 42 days, missing the goal by 12 days.

The audit team found that for an estimated 110,000 of 476,000 consults, staff were able to contact the patient, but no appointment was scheduled for reasons outside of VHA's control. For approximately 68,700 of the 110,000 consults, the audit team found the patient was hesitant to schedule an appointment for routine care during COVID-19, failed to return phone calls, or declined care once it was offered. For the remaining 41,200 consults, the community provider was responsible for hindering scheduling: the community care provider was unavailable to provide care to the patient due to COVID-19 conditions, was no longer in the community care network, or failed to return phone calls.

Opportunities Remain for VHA to Improve Community Care Consult Processes

Despite clear scheduling challenges, routine community care consult processing could be improved to support scheduling efforts. At the onset of the pandemic, VHA stated nonemergent (nonemergency) care should be reviewed on a case-by-case basis. According to a March 23, 2020, guidance document,²⁴

[VHA] is ensuring the best medical interests of Veterans are met by adhering to the law in a manner that takes into account whether referrals for community care are clinically appropriate during the COVID-19 outbreak. Scheduling of non-emergent care with community providers should be reviewed on a case-by-case

²⁴ COVID-19 Frequently Asked Questions (FAQ), "Guidance for VA Community Care Staff," March 23, 2020.

basis, regardless of wait time or drive time eligibility, until such time VHA determines that it will restart routine care.

The following sections describe the audit team's identification of the three areas in which community care leaders and staff could improve the management of routine consults and oversight of program operations: documenting attempts to contact patients, setting priorities for consults, and recording whether the patient could receive alternative forms of care in the community. Additionally, the OIG found that increased training on COVID-19 changes and the consult toolbox could have been useful. If not addressed, these weaknesses may reduce VHA's ability to effectively manage community care consults after the pandemic abates.

Community Care Staff Did Not Consistently Document Contacts with Patients

Documentation of contacts with patients provides a level of assurance that community care staff are doing all they can to schedule an appointment. VHA policy requires schedulers to make at least two documented contact attempts, one by telephone call and one by letter for non-mental health appointments, and at least four attempts for mental health appointments.²⁵

According to OCC leaders, if the facility community care departments were able to contact the patient, the consult comments or changes in the consult status would reflect the actions taken. If contact attempts were not successful, community care leaders would be able to determine that by reviewing notes in the patient records. However, without documentation in the patient's record, the community care leaders would be unable to determine whether the patient was ever contacted.

Based on its sample of 225 consults, the audit team estimated 65,100 of 476,000 consults (14 percent) did not show evidence that the patient was contacted or had a scheduled or completed appointment as of November 9, 2020. Of those without documented contact, the consults went unscheduled for an estimated average of 79 days from the date they were received by the community care department. An estimated 410,000 showed evidence that the patient had been contacted or had a scheduled, completed, canceled, or discontinued appointment. The following examples illustrate that documenting contact attempts with patients could have assisted with scheduling and provided leaders with information needed for monitoring.²⁶

²⁵ VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016, rev. June 28, 2019.

²⁶ The medical centers used in the examples were selected randomly and are only used to show instances of where documenting contact attempts could have assisted with scheduling and monitoring activities.

Example 1

The Baltimore VA Medical Center referred a patient to the community on September 23, 2020. The consult was labeled priority 1, but the audit team did not see evidence in the patient's records, nor could facility leaders provide evidence, of the patient being contacted as of November 9, 2020—47 days after the consult was referred to the community.

Example 2

At the Hampton VA Medical Center, a dermatology consult was designated as priority 2 and submitted on May 1, 2020; however, the first recorded contact attempt was made 159 days later, on October 7, 2020. According to Hampton VA Medical Center community care leaders, they did not provide any follow-up to the patient because they were overwhelmed and only triaging priority 1 consults. The appointment was completed on December 1, 2020.

In both instances, VHA lacked assurance that attempts were made to schedule the appointments because schedulers did not document contact attempts with patients. These problems could have been detected if the VISNs or VA medical facilities were more effectively monitoring these community care program activities. Monitoring includes assessing the quality of performance over time and promptly resolving the findings.²⁷ Active monitoring of patient records using VHA systems would provide facility leaders the necessary information to identify and resolve consults that do not have a record of patients being contacted with the frequency and timeliness set by VHA.

Recommendation 1 addresses the need for facility community care leaders to use VHA's systems to oversee the documentation of communication between staff and the patient and to take appropriate corrective actions.

Routine Community Care Consults Did Not Always Indicate Scheduling Priorities during the COVID-19 Pandemic as OCC Recommended

The assistant under secretary for health for operations issued a memo in May 2020 that notified clinicians of changes to the consult toolbox to allow them to indicate scheduling priorities on consults. It also encouraged local clinic services to develop criteria for using priority designations. The intent of these actions was to standardize the way facilities and providers

²⁷ Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

prioritize consults during the pandemic to ensure patients with the most urgent needs were seen when clinically appropriate.²⁸

The audit team's sample review of 225 consults at nine VHA medical facilities found that consults assigned priority level 1 had an estimated average age of 42 days. Comparatively, consults assigned priority levels 2 through 4 had an estimated average age of 52 days. While this analysis appears to indicate that prioritizing consults had a positive impact on scheduling for patients, the team found that the difference in average age between priority level 1 and all other consults with priority levels was not statistically significant.

Consult prioritization was not required and VHA did not track which facilities did or did not implement scheduling designations. As noted in figure 1, VHA did not mandate that all priority 1 and 2 consults be documented in the toolbox until September 15, 2020.²⁹ Seven of the nine facilities reviewed told the audit team that they used some degree of prioritization before the September policy update.³⁰ Beyond the nine statistically selected sites, however, the OIG did not assess how many facilities used consult priority levels during the pandemic.

According to OCC leaders, standards have been in place to ensure patients are scheduled in a timely manner. Staff use a status of "stat" (immediate) or routine to triage and schedule appointments. Although the additional prioritization guidance came about because of the COVID-19 pandemic, OCC leaders are working on revisions to the consult toolbox to be used in non-pandemic times. Leaders would like to standardize prioritization while allowing flexibility for both the veteran and the provider by establishing an "earliest appropriate date" and a "no later than date." OCC leaders further stated that, in the future, priority levels 1 through 4 will be used only under extenuating circumstances until a new prioritization system is developed.

Because consult prioritization was inconsistently applied at the facilities reviewed and not mandated until September 2020, the audit team could not fully evaluate the impact of priority levels on appointment scheduling. The team also could not determine if prioritization would have provided value if it had been mandated. Therefore, the OIG did not make any recommendations related to the use of priority levels for routine community care consults.

²⁸ VHA memo, "National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065–COVID-19 Upgrades (VIEWS# 02748457)." May 18, 2020.

²⁹ VHA memo, "Changes to Consult/Referral Management during COVID-19," September 15, 2020.

³⁰ The two exceptions followed a process before the pandemic in which staff triaged all community care consults. They elected to not implement additional priority levels outlined in the May 2020 memo. The average age of all community care consults at that medical center was 50 days and the other was 28 days as of October 9, 2020. The audit team did not evaluate the appropriateness of the facilities' decision.

Alternative Care Was Also Not Consistently Documented as an Option

VHA instituted several changes to community care guidance during the COVID-19 pandemic to mitigate the spread of COVID-19. For instance, the March 30, 2020, memo stated the current risk of exposure to COVID-19 often outweighs the benefits associated with in-person delivery of certain routine, elective, and nonemergency appointments. Thus, in-person care was to be shifted to e-consults, telephone, and telehealth care when available and clinically appropriate. According to OCC's Field Guidebook, VHA facilities and community providers can offer alternative forms of care if appropriate when the patient does not require a face-to-face appointment. To that end, COVID-19 tabs were created in the consult toolbox to document whether alternative forms of care could be offered in place of an in-person appointment, either within VA or in the community. Yet the audit team found that referring providers or facility community care clinical staff did not always indicate whether these alternatives were clinically appropriate in the consult records. Without some indication, schedulers would not know whether the patient could be offered an alternative form of care. Further, according to OCC, VHA has not developed a way for facility community care departments to monitor whether alternative care is being marked as an option for patients, which would help ensure the intent of the March 30, 2020, memo was being met.

Facility leaders pointed to instances in which an alternative form of care could have been offered to the patient but was not documented, such as the example that follows.³¹

Example 3

According to leaders at the Baltimore VA Medical Center, a community care consult for behavioral health had a clinically indicated date of June 1, 2020, and was categorized as priority level 1.³² The audit team's review of the patient's record showed the appropriateness of an alternative form of care was never documented. The facility leaders noted that alternative care was available but was not offered to the patient. The patient was scheduled for an appointment on October 30, 2020—151 days after the consult was received.

In these instances, VHA may have missed opportunities to offer alternatives and arrange patient care because there was nothing to alert medical support assistants that other options could be used. If VA providers and community care staff fail to document clinically appropriate options, including alternatives to in-person appointments, VHA lacks assurance that all efforts were made to schedule a patient for care. An oversight mechanism to determine whether alternative forms of

³¹ The medical center used in this example was selected randomly and is only used to show an instance where an alternative form of care could have been offered.

³² A VA provider assigns the date the care is clinically appropriate.

care are clinically appropriate and offered to the patient would assist VHA facilities in providing patients timely access to care using all available options.

Recommendation 2 addresses the need for VHA to develop a process for facilities to monitor whether the appropriateness of alternatives to face-to-face care is being documented and alternatives are then offered to the patient when clinically appropriate.

VHA Did Not Require COVID-19 and Consult Toolbox Training for Staff Who Process Community Care Consults

There may be a range of factors that contributed to the missing documentation regarding communications with patients and whether alternative care options were appropriate. Among them may be inconsistent training. OCC offered training in processing community care consults according to COVID-19 and consult toolbox policies. However, clinicians and medical support assistants who process community care consults are not required to take the training. According to OCC leaders, these trainings were not mandated but were highly recommended.

OCC provided regular guidance to VISN and facility leaders through memos and the OCC Field Guidebook as well as the training noted above. While all sampled facilities provided the memos and updates to community care staff, the audit team found that the training was not consistently provided to staff (clinicians and medical support assistants) who process community care consults. According to facility leaders at four facilities reviewed, clinicians and medical support assistants were not mandated to receive trainings related to COVID-19 and the consult toolbox. According to some facility leaders and staff, they found it hard to keep up with all the changes related to community care consults. For example, from March through October 9, 2020, VHA released approximately 127 OCC-related updates (memos and attachments) to the field. Without COVID-19 and consult toolbox training, staff may continue to have lapses in documenting patient contacts and options for alternative forms of care.

Recommendation 3 addresses the need for VHA to reassess the frequency of and approach to its training within VHA facilities as revisions are made to the various tools.

Conclusion

Community care staff faced tremendous challenges in scheduling healthcare appointments due to patients' hesitancy to attend routine care during the COVID-19 pandemic, unreturned phone calls from patients and providers, and both specific and overall community provider unavailability. Given those conditions, there is even greater need to address processes within VHA's control, as well as its oversight of them, to leverage resources to the greatest extent possible. To do that, additional actions can be taken to help ensure responsible staff document relevant information for routine community care consults in patients' records. This includes consistently recording contact attempts and designating whether alternative forms of care are appropriate for the patient. VHA can also improve the consult process by ensuring that all those

who process community care consults have the information and training needed to schedule consults efficiently and effectively during a pandemic and utilize all available consult scheduling tools.

Recommendations 1–3

The OIG made three recommendations to the under secretary for health:

1. Develop guidelines requiring supervisors to use VHA systems to monitor documentation of efforts to contact patients to schedule an appointment and to take corrective action as appropriate.
2. Establish a tool to monitor whether clinicians are properly indicating the appropriateness of alternative forms of care and whether staff offered them to patients when clinically appropriate.
3. Reassess the frequency of and approach to its training for scheduling community care consults to VHA facilities as revisions are made to the various tools.

Management Comments

The deputy under secretary for health concurred with the three recommendations and provided responsive corrective action plans. For recommendation 1, the deputy under secretary stated that OCC will develop guidelines for local facility community care supervisors to monitor consult toolbox reports showing patient contact attempts to schedule community care appointments. The guidelines will require supervisors to have action plans to address consults that do not display contact attempts timely.

For recommendation 2, the deputy under secretary stated OCC released the consult toolbox 2.0 with guidelines requiring clinical reviewers to document the ways in which the requested care can clinically and appropriately be delivered, such as face-to-face or via telehealth or telephone. Reports from these entries will allow for monitoring of the actions of the clinicians and the schedulers.

For recommendation 3, the deputy under secretary stated OCC will collaborate with other clinical program offices to evaluate how often training is provided regarding the use of new technology for documenting the processes involved in scheduling community care consults. OCC will also evaluate the best way to provide that training. Appendix C provides the full text of the deputy under secretary's comments.

OIG Response

The deputy under secretary for health's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and

will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from December 2020 through October 2021. The scope of the audit focused on assessing whether VHA medical facilities effectively managed community care consults for routine appointments during the COVID-19 pandemic. This included determining whether VHA properly managed and complied with requirements for processing routine community care consults. The audit team analyzed summary community care consult data from August 1, 2019, to May 1, 2021. Additionally, the team sampled 225 routine community care consults that were unscheduled as of October 9, 2020, from the following facilities:

- Atlanta VA Medical Center, Georgia
- Baltimore VA Medical Center, Maryland
- Fresno VA Medical Center, California
- Hampton VA Medical Center, Virginia
- Jesse Brown VA Medical Center, Illinois
- Oklahoma City VA Medical Center, Oklahoma
- Sacramento VA Medical Center, California
- Sheridan VA Medical Center, Wyoming
- Washington DC VA Medical Center, District of Columbia

Methodology

To accomplish its objective, the audit team identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to VHA's community care process and COVID-19 procedures. The team interviewed managers and employees from OCC, VISNs, and the VHA facilities listed above. In addition, the team reviewed prior audits and reviews by the OIG and the Government Accountability Office related to veterans' access to community care and measures taken in response to COVID-19.

VHA's Corporate Data Warehouse provided the data required to assess the management of routine community care by VHA and facility leaders. The team examined procedures used to determine how best to meet patients' care needs in the community by

- identifying and reviewing criteria pertaining to community care consults, including VA policies, procedures, and programs regarding scheduling appointments during COVID-19,

- collaborating with the OIG’s Data Services Division and an OIG statistician to develop an approach and select a statistical sample of unscheduled routine community care consults,
- interviewing OCC staff to gain an understanding of ongoing and future plans, policies, and oversight related to community care consults,
- interviewing facility and VISN community care leaders to gain information on guidance and expectations for coordinating community care at selected locations, and
- examining consult records to determine whether patients were offered an alternative form of care and whether facility employees followed COVID-19 priority-level scheduling guidance while reviewing community care consults.

Internal Controls

The audit team determined that internal controls were significant to the audit objective. The team assessed the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring. The team identified the following components and three related principles as significant to the audit objective. The team identified internal control weaknesses and made recommendations to address deficiencies in the following:³³

- Component 3: Control Activities
 - Principle 12—Implement Control Activities
- Component 5: Monitoring Activities
 - Principle 16—Perform Monitoring Activities (establishment of a baseline, internal control system monitoring, and evaluation of results)
 - Principle 17—Evaluate issues and remediate deficiencies

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, directives, and memorandums, significant in the context of the audit objective, could occur during this audit. The audit team exercised due diligence by staying alert to any fraud indicators. The OIG did not identify any instances of fraud or potential fraud during this audit.

³³ GAO, *Standards for Internal Control in the Federal Government*.

Data Reliability

The audit team used computer-processed data from VHA's Corporate Data Warehouse. To assess the reliability of these data, the audit team performed testing by comparing the consult details from Corporate Data Warehouse data with individual patient records from the Compensation and Pension Record Interchange. Testing of the data did not disclose any concerns with data reliability. Therefore, the audit team concluded that the data obtained from the Corporate Data Warehouse were sufficiently reliable to support the audit objectives, conclusions, and recommendations.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the objective, the audit team reviewed a statistical sample of unscheduled community care consults from January 1 through October 9, 2020. The team used statistical sampling to quantify the number of unscheduled community care consults and determine if facilities effectively managed consults by following VHA guidance during the COVID-19 pandemic. Specifically, the team determined whether patients were offered some form of care, such as VA e-consults (electronic consultations) or telehealth appointments involving telephone or video calls. In addition, the team determined if facility employees followed COVID-19 priority-level scheduling guidance while reviewing community care consults. This included determining if priority levels were assigned in accordance with VHA guidance.

Population

The audit population included 493,964 routine active or pending community care consults that were unscheduled as of October 9, 2020.

Sampling Design

For the 493,964 unscheduled consults, the audit team found that the mean age was 42 days. The audit team used a two-stage sample design to select the VA medical facilities and consults for review. In stage 1, the facilities were stratified into two groups based on the mean age of unscheduled consults. The first group included facilities whose mean age of unscheduled consults was higher than the 42-day national mean. The second group included the facilities whose mean age of unscheduled consults was below the national mean. Nine facilities were selected in proportion to size using the mean age of unscheduled consults, six facilities above the national mean (including one certainty site) and three facilities below the national mean.³⁴ In stage 2, the team randomly selected 25 consults to review from each of the nine facilities identified in stage 1, for a total of 225 consults.

Projections and Margins of Error

The audit team estimated that 18,400 consults were out of scope as these consults were for services related to daily living activities or health care in the home. The estimate also included consults that were misclassified as routine and later canceled or discontinued. An estimated 476,000 consults aligned with the scope of this audit.

³⁴ A certainty site is selected due to certain attributes or factors of interest.

The point estimate (e.g., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error/confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. If the audit team 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.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.

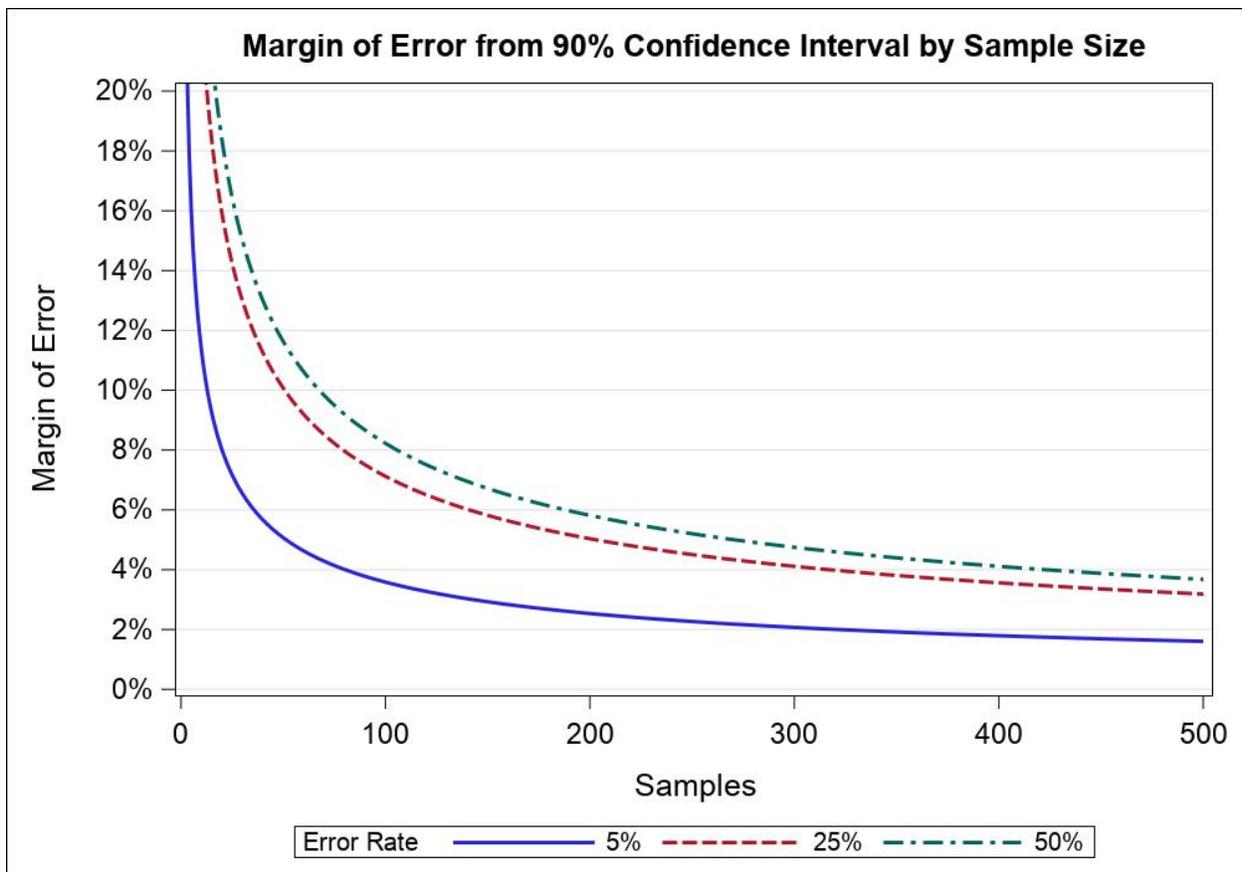


Figure B.1. Effect of sample size on margin of error.

Source: VA OIG statistician’s analysis.

Projections

The following tables present projections from the sample results, including the estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table B.1 summarizes the statistical projections and the confidence intervals for unscheduled consults that align with the audit scope and the unscheduled consults that were determined to be out of scope for this audit.

Table B.1. Statistical Projections Summary for the Audit Scope of Unscheduled Consults

Scope	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
In scope	475,564 (96.3%)	11,478 (2.3%)	464,086 (94.0%)	487,042 (98.6%)	225
Out of scope	18,400 (3.7%)	11,478 (2.3%)	6,922 (1.4%)	29,878 (6.0%)	10

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Table B.2 summarizes the statistical projections and the confidence intervals for consults that were not scheduled by the VHA’s community care department for reasons outside their control.

Table B.2. Statistical Projections Summary for Consults That Showed the Patient Was Contacted but No Appointment Was Scheduled for Reasons outside VHA’s Control

Patient contact but no appointment scheduled	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
Yes	109,831	26,211	83,621	136,042	52

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Note: Figures in this table have been rounded to the nearest whole number.

Table B.3 summarizes the statistical projections and the confidence intervals for consults that were not scheduled for reasons outside VHA’s control.

Table B.3. Statistical Projections Summary for Consults Not Scheduled for Reasons outside VHA’s Control

Reasons consults were not scheduled	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
Community provider did not schedule appointment	41,181	17,611	23,570	58,791	20
Patient did not schedule appointment	68,651	21,586	47,065	90,237	32

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Table B.4 summarizes the statistical projections and the confidence intervals for the estimated number of consults that did not have evidence the patient was contacted and the patient did not have a scheduled or completed appointment as of November 9, 2020.

Table B.4. Statistical Projections Summary for Consults That Did Not Show a Contact Attempt or a Scheduled or Completed Appointment

Contact was not documented and no appointment was scheduled or received	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
Yes	65,142(13.7%)	19,226 (4.0%)	45,916 (9.7%)	84,368 (17.7%)	40

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Table B.5 provides a summary of the statistical projections and the confidence intervals for the estimated number of days a consult remained open when there was no evidence the patient was contacted to schedule the appointment and the patient did not have a scheduled or completed appointment as of November 9, 2020.

Table B.5. Estimated Number of Days Consults Were Open for Those That Did Not Show a Contact Attempt and Were Not Scheduled

Category	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
Days	79	14	66	93	40

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Note: Figures in this table have been rounded to the nearest whole number.

Table B.6 summarizes the statistical projections and the confidence intervals for consults that showed evidence the patient had been contacted or had a scheduled, completed, canceled, or discontinued appointment.

Table B.6. Statistical Projections Summary for Consults That Showed the Patient Had Been Contacted or Was Appropriately Managed

Patient was contacted or had an appropriately documented consult	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
Yes	410,422	21,942	388,480	432,364	185

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Table B.7 summarizes the statistical projections and the confidence intervals for the average number of days to schedule consults as of November 9, 2020.

Table B.7. Average Number of Days to Schedule a Consult

Average number of days to schedule consult	Estimate	Margin of error based on 90 percent confidence interval	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Count from sample
Days for Priority 1	42	9	33	51	41
Days for Priority 2–4	52	8	44	60	99

Source: VA OIG analysis of statistically sampled unscheduled community care consults as of October 9, 2020.

Note: There was no statistically significant difference in average age between priority 1 and all other consults with priority levels.

Appendix C: Management Comments

Department of Veterans Affairs Memorandum

Date: December 6, 2021

From: Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Community Care Consults during COVID-19 (2021-00497-AE-0013) (VIEWS # 6355811)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Audit of Community Care Consults during COVID-19. The Veterans Health Administration (VHA) concurs with the three recommendations and provides an action plan.

2. At the onset of this pandemic and throughout the past 20 months, VHA's foremost priority has been to protect Veterans from this deadly virus, care for them, protect the public health, and support communities as they work tirelessly to save American citizens. VHA's early decision to postpone nationwide requests for all nonessential services ensured Veterans were protected from unnecessary exposure to the virus in compliance with nationwide recommendations from the Center for Disease Control and Prevention. Every day this killer virus ends the lives of our people. We will not falter in our fight to protect Veterans from its devastating effects.

The OIG removed point of contact information prior to publication.

(Original signed by)

Stephen L. Lieberman, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

Audit of Community Care Consults during COVID-19 (2021-00497-AE-0013)

Recommendation 1. The Under Secretary for Health develop guidelines requiring supervisors to use VHA systems to monitor documentation of efforts to contact patients to schedule an appointment and to take corrective action as appropriate.

VHA Comments: Concur

The Office of Community Care will develop guidelines for the Department of Veterans Affairs Medical Center local facility community care supervisors or designated staff to monitor the Consult Toolbox based reports showing patient contact attempts to schedule community care appointments. The guidelines will also require supervisors to have in place action plans to address consults that do not display contact attempts within the required timeframes (e.g., 7 days or 14 days).

Status: In Progress Target Completion Date: March 2022

Recommendation 2. The Under Secretary for Health establish a tool to monitor whether clinicians are properly indicating the appropriateness of alternative forms of care and whether staff offered them to patients when clinically appropriate.

VHA Comments: Concur

The Office of Community Care has released the Consult Toolbox 2.0 with guidelines to the field requiring the clinical reviewers of consults that are destined for community care to document the ways in which the requested care can clinically and appropriately be delivered such as face to face or via telehealth or telephone. This tool allows for clear documentation so whatever methods are deemed clinically appropriate by the reviewing clinician are offered to the veteran when available. Reports from these entries will allow for monitoring of the actions of the clinicians and the schedulers.

Status: In Progress Target Completion Date: March 2022

Recommendation 3. The Under Secretary for Health reassess the frequency of and approach to its training for scheduling community care consults to VHA facilities as revisions are made to the various tools.

VHA Comments: Concur

The Office of Community Care will collaborate with other clinical program offices to evaluate how often training is provided to the field regarding the use of new technology for documenting the processes involved in scheduling community care consults. The group will also evaluate the best way to provide that training.

Status: In Progress Target Completion Date: March 2022

For accessibility, the original format of this appendix has been modified to comply with section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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