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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Digital Divide Consults and Devices for VA Video Connect Appointments

REVIEW | REPORT #21-02668-182 | AUGUST 4, 2022

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Executive Summary

In August 2020, the Veterans Health Administration's (VHA) Office of Connected Care recognized the growing demand for patients' access to video-based virtual care, and that many patients lack a video-capable device, or the internet connection required to access this care.[1] To bridge "the digital divide, which exists between individuals with access to a device and connectivity and those who [lack that] access," VHA introduced the digital divide consult. This process enables patients to receive a video-capable device after obtaining a referral from their care team, licensed independent practitioner, or designee and the approval of a social worker who has conducted a socioeconomic assessment.[2] The digital divide consult improved on the device-lending process by introducing the social worker assessment to help identify and resolve other needs and barriers to care.

The digital divide consult involves staff from multiple VA offices. VHA medical facility staff initiate and complete the consult, conduct an assessment, and order the device from the Denver Logistics Center (DLC) to be sent directly to the patient. Other facility staff must monitor and retrieve unused devices so they can be reissued. Throughout this process, VA staff at the DLC must coordinate with facility staff to ensure devices are issued, retrieved, and refurbished. The VA Office of Inspector General (OIG) initiated this review to evaluate the efficiency and effectiveness of the digital divide consult process, as well as the controls over device issuance, monitoring, and retrieval.

The OIG recognizes the efforts of VHA leaders and staff who have been working in stressful conditions during the COVID-19 pandemic as they manage the needs of patients and personnel. VHA stated that the implementation and subsequent decisions regarding the digital divide consult, standard operating procedures (SOPs), device retrieval efforts, and other program modifications were completed amid the pandemic, which required an urgency of decision-making to address critical veteran access needs and affected the prioritization of efforts in the program office and at the medical facilities.

What the Review Found

The review team found that VHA's digital divide program was successful in distributing devices to patients but identified several gaps in oversight and guidance preventing the program from fully meeting its intended purpose for patients to receive virtual care via VA Video Connect

[1] Assistant under secretary for health for operations (10N) memo, "Expanding Access to Telehealth for Veterans through the Digital Divide Consult," August 12, 2020.

[2] A digital divide consult can also be used to help veterans benefit from additional federal subsidies, in addition to the video-capable device. The consult helps identify a need, and grant government subsidies, for reduced-cost internet service for patients. This review focused on the loaned devices and did not assess the reduced-cost internet service aspect.

(VVC). VHA's SOP includes eligibility criteria purposely left broad in light of the pandemic and does not require scheduling the patient for a VVC appointment.[3] After introducing the digital divide consult, VHA issued devices to about 41,000 patients during the first three quarters of fiscal year 2021.[4] The review team determined that VHA staff took, on average, about 14 days from the date the digital divide consult was submitted to the date the device was ordered. These devices were not always used to connect to video telehealth, as only an estimated 20,300 of the patients (49 percent) with issued devices completed a VVC appointment.

The remaining patients had not used the devices for VVC appointments. An estimated 10,700 patients never had a VVC appointment scheduled, as there was no requirement to schedule, and neither the patient nor the staff initiated scheduling a VVC appointment. The review team estimated that more than 10,000 patients had a VVC appointment scheduled but did not complete the VVC visit for various reasons, such as technical issues or a cancelation, and a subsequent VVC appointment was not completed.

The review team concluded the low VVC appointment completion rates occurred for multiple reasons. VHA Connected Care did not establish clear oversight roles and responsibilities for Veterans Integrated Service Network (VISN) and medical facility employees. Additionally, the SOP does not include requirements or mechanisms for staff to schedule a VVC appointment for patients with a loaned device, though it does require staff to initiate retrieval efforts of unused devices if no VVC appointment has occurred within 90 days of receipt.[5] Further, digital divide consult and video device order processing lacked clear timeliness standards, presenting a risk of delay in sending a video-enabled device and scheduling and completing VVC appointments. Also, staff did not follow or were not aware of SOP updates as VHA did not effectively communicate them to facility staff.[6] Overall, VHA loaned devices to an estimated 20,800 patients (51 percent) during the period who did not use the devices for a VVC appointment.

The OIG review team also found lapses in device issuance and management through the review of VHA's tablet dashboard data.[7] Specifically, despite guidance limiting devices to one per patient, VHA issued multiple devices to 3,119 patients. Additionally, the review team initially determined that VHA staff did not retrieve about 11,000 unused devices as required by the SOP. When usage was assessed by the review team in November 2021, VHA's tablet dashboard

[3] VHA's Office of Connected Care, "Digital Divide Consult Process SOP [Standard Operating Procedure]," November 2020, retitled "Digital Divide Standard Operating Procedure" and revised May, July, and December 2021 and February 2022.

[4] Devices include mini and full-size Verizon Wireless and T-Mobile iPads.

[5] The SOP requires facility staff to contact veterans to understand any barriers they may be experiencing with their tablets and determine if the devices are no longer needed or used for VVC appointments. If not, telehealth coordinators are to initiate retrieval efforts.

[6] As of February 2022, Connected Care had issued five versions of the SOP.

[7] Appendixes A and B detail the review methodology and statistical sampling methodology.

showed nearly 8,300 of the 11,000 unused devices still did not have VVC activity and were not retrieved to make them available to other patients. The value of the 8,300 devices was about $6.3 million and cost VHA about $78,000 in additional cellular data fees during the period under review.[8] These lapses occurred because Connected Care did not clearly define device-monitoring roles, responsibilities, or metrics. Further, VHA medical facility staff said they were unaware of their monitoring responsibility, were using outdated versions of guidance, or said they did not have time to monitor device use while balancing collateral duties. When VHA does not retrieve and update its loaned, unused devices, it cannot make them available to other patients.

The review team also determined that, as of January 2022, there was a backlog of about 14,800 returned devices pending refurbishment. The returned devices that were not refurbished accumulated primarily because of technical issues with the refurbishment system at the DLC. As a result, these devices were not yet logged into shippable inventory and were not available to be distributed to other patients. Despite being aware of the backlog of devices awaiting refurbishment through the DLC's weekly reporting, VHA did not suspend purchases of new devices from its contractor. Instead, in August 2021, VHA placed a purchase order for additional new devices. As of December 2, 2021, VHA bought 9,720 devices under this purchase order, totaling about $8.1 million.

In total, the review team determined that VHA could have made better use of approximately $14.5 million in program funds with better device monitoring and retrieval controls and oversight.[9]

What the OIG Recommended

The OIG made 10 recommendations to the under secretary for health for continued program development.[10] Besides assigning process oversight roles and responsibilities, the first four involve developing a mechanism to alert the requesting clinic that a patient can be scheduled for a VVC appointment, and revising the SOP both to clarify the number of days from consult initiation to device order and to ensure staff are trained on program changes. The OIG also recommended VHA add procedures to prevent issuance of and retrieve duplicate devices,

[8] The review team calculated this value using the actual purchase cost of the device type, including full size and mini Verizon Wireless and T-Mobile iPads. Because these devices were issued but not used to provide VVC care and not retrieved, and VHA can retrieve and then lend these devices to other patients, the OIG identified the value of these devices as a potential better use of funds. The review team prorated the annual cost of unlimited cellular plans associated with the devices by the months beyond the first year of service included in the initial purchase price.

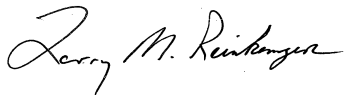
[9] This total consists of the value of about 8,300 devices issued but not used to provide VVC care and not retrieved as of November 10, 2021 ($6.3 million); data plan costs for nearly 11,000 devices issued but not used to provide VVC care as of June 30, 2021 ($78,000); and $8.1 million for 9,720 new devices purchased by VHA despite having devices pending refurbishment. Appendix C presents estimates of monetary benefits from implementing this report's recommendations.

[10] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

designate responsible facility staff to monitor for VVC appointment activity and connected device use, clearly define VISN lead oversight responsibilities, establish an automated report of devices that are not being used for VVC and are therefore eligible for retrieval, and initiate retrieval efforts. Lastly, the recommendations call on VHA to enhance tracking of device packages, implement more detailed device refurbishment reporting, and use such data when considering new device purchases.

VA Comments and OIG Response

The deputy under secretary for health, performing the delegable duties of the under secretary for health, concurred or concurred in principle with all the report's recommendations and submitted action plans for recommendations 1 through 10. Appendix D provides the full text of the deputy under secretary's comments. The OIG will assess the satisfactory completion of the actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in VHA's action plans are responsive to the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress addressing the issues identified.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

DLC	Denver Logistics Center
FY	fiscal year
OIG	Office of Inspector General
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VVC	VA Video Connect

Introduction

The Veterans Health Administration's (VHA) Office of Connected Care has determined that many patients are turning to virtual options to obtain their VA health care. An internal briefing by Connected Care in August 2020 referenced this increasing demand as a factor driving the department's focus on increasing access to telehealth—in particular, video-based virtual care by way of VA Video Connect (VVC).[11] The importance of such care has been further emphasized by the COVID-19 pandemic. Recognizing that not all patients have a video-capable device with broadband internet to utilize video-based care, Connected Care introduced a new process to help bridge "the gap that exists between individuals with access to a device and connectivity and those who do not have [lack] access to similar resources."[12] According to VHA's executive director of telehealth, Connected Care designed the digital divide consult to help VHA expand services to veterans who may be at higher risk for health issues due to periods of isolation during the pandemic.

The digital divide consult is a multistep process enabling patients to receive a VA-loaned, video-capable tablet after a referral by their care team and a comprehensive qualifying assessment by a VA social worker.[13] An earlier VHA program called the clinical video telehealth tablet consult provided some patients a video-capable device following a request from their care team but did not include the social worker assessment.[14] Connected Care states this assessment gives social workers an opportunity to assist patients, their families, and caregivers in resolving socioeconomic barriers to care.[15]

The digital divide program represents a substantial monetary investment. VHA's most recent purchase order covering August 13, 2021, through August 12, 2022, shows device costs of $595 for each T-Mobile device and $835 for each Verizon device. From this purchase order,

[11] VHA's Office of Connected Care, "Connecting Veterans: VA's New Digital Divide Consult," PowerPoint presentation, August 2020; VHA's Office of Connected Care, "VA Video Connect Supplement," September 2018. VVC enables patients to virtually meet with their VA healthcare providers in a virtual meeting room, using encrypted video to ensure the session is secure and private.

[12] Assistant under secretary for health for operations (10N) memo, "Expanding Access to Telehealth for Veterans through the Digital Divide Consult," August 12, 2020.

[13] 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 social worker assessment includes reviewing the patient's housing, economic barriers, access to care, psychological and functional status, and social support. A digital divide consult can also be used to help veterans benefit from additional federal subsidies, in addition to the video-capable device. The consult helps identify a need, and grant government subsidies, for reduced-cost internet service for patients. This review did not assess the reduced-cost internet service aspect.

[14] Devices issued to patients included mini and full-size Verizon Wireless and T-Mobile iPads.

[15] VHA's Office of Connected Care, "VA's New Digital Divide Consult."

VHA acquired 5,250 T-Mobile devices and 9,750 Verizon devices, scheduled to be delivered throughout the contract period, for a total of nearly $11.3 million.

The VA Office of Inspector General (OIG) conducted this review to determine whether eligible patients promptly received devices and accessed VVC care using the consult. Specifically, the OIG evaluated

- the effectiveness and efficiency of the consult process (finding 1); and
- the controls in place to issue, monitor, and appropriately retrieve VA-loaned devices (finding 2).

The OIG recognizes the efforts of VHA leaders and staff who have been working in stressful conditions during the COVID-19 pandemic as they manage the needs of patients and personnel. VHA stated that the implementation and subsequent decisions regarding the digital divide consult, standard operating procedures (SOPs), device retrieval efforts, and other program modifications were completed amid the pandemic, which required an urgency of decision-making to address critical veteran access needs and affected the prioritization of efforts in the program office and at the medical facilities.

Digital Divide Consult Process and Responsibilities

Connected Care is responsible for issuing consult policy and procedures, and facility staff from multiple offices are responsible for executing it, as described in figure 1. Since the consult was introduced, Connected Care provided staff device order processing instructions through its October 2020 "VA Loaned Devices Standard Operating Procedure" for processing device orders. Connected Care then published the "Digital Divide Consult Process SOP" in November 2020 and continues to publish updates to program guidance.[16] With the updates, the process steps and workflow have remained relatively consistent. It is VHA policy to ensure timely and clinically appropriate care to all patients by standardizing and managing consultation processes.[17]

[16] VHA's Office of Connected Care, "Digital Divide Consult Process SOP [Standard Operating Procedure]," November 2020, retitled "Digital Divide Standard Operating Procedure," rev. May, July, and December 2021 and February 2022. The SOP has been the primary guidance document used to disseminate policy and procedure standards to VA medical facility staff involved in the digital divide process.

[17] VHA Directive 1232(3), *Consult Processes and Procedures*, August 14, 2016, amended April 5, 2021.

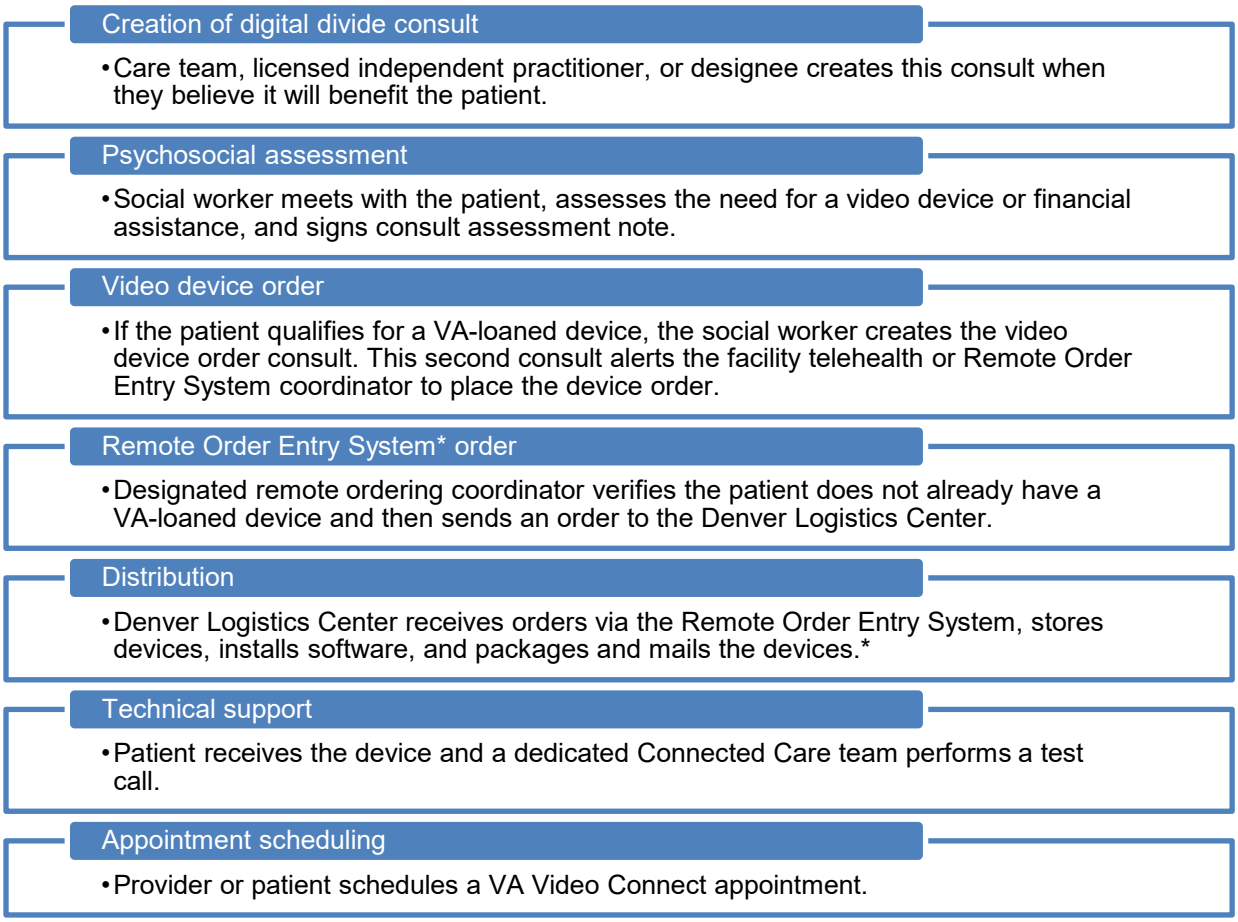


Figure 1. *Clinical consult and administrative video device ordering process.*
Source: VA OIG's analysis of Connected Care's consult and Denver Logistics Center guidance.

** VA's Remote Order Entry System is an online ordering application used by clinical and administrative VA staff to facilitate ordering and reordering items warehoused and distributed by the Denver Logistics Center.*

The consult process begins when a member of the patient's care team determines that the patient would benefit from access to virtual care but lacks a video-capable device to facilitate this care. When this need is identified, the care team places a digital divide consult that is sent to locally designated social work staff for further processing. Although care team staff may schedule virtual care based on the need leading to the digital divide consult, scheduling is not a requirement in the digital divide process, and further input from the care team is not required.

VHA social workers have an important role in the consult process. During consult review, the social worker conducts a comprehensive assessment of the patient's housing, economic situation, access to care, psychological and functional status, and social support. The social worker checks whether the patient qualifies for a VA-loaned device: the patient cannot already have a video-capable device and must meet one or more of the clinical criteria on the consult. If a patient does qualify, the social worker confirms the patient's interest, verifies the shipping

address, and places a video device order consult (referred to as a device order). If the patient does not qualify, the social worker annotates the consult with the reason and closes the consult.

Facility telehealth coordinators are responsible for receiving the device order and submitting it through the Remote Order Entry System to the Denver Logistics Center (DLC).[18] The DLC maintains weekly inventory reports that include the number of device orders made by medical facilities per week. DLC staff ship the device directly to the patient. Each patient who obtains a VA-loaned device should be contacted by a member of the white-glove team to assist them with setting up and using the VA-loaned device.[19] The final step in the process is scheduling and then conducting a VVC appointment.

Device Management and Retrieval

Once the device is issued, device management steps begin. Although it does not specify which staff are to perform the task, the SOP requires facility staff to review the list of devices issued to patients, contact the veterans to understand any barriers they may be experiencing with their tablets, and determine if the device is no longer needed or used for VVC appointments. If not, telehealth coordinators are to initiate retrieval efforts by sending a retrieval kit to the patient (a box with a return shipping label). SOP versions have varied regarding when to initiate retrieval. The November 2020 SOP required a monthly review of loaned devices to determine if a patient had a VVC appointment 30 days before or after the date of review and initiate retrieval when warranted. This guidance was updated in the May 2021 SOP, which indicated retrieval priorities for patients with devices for more than 90 days with no past or future scheduled VVC appointments. The July 2021 version of the SOP stated that staff should send the retrieval kit if a VVC appointment had not occurred or was not scheduled within 90 days at the time of review.

The DLC staff that distribute the devices are also responsible for receiving, refurbishing, and redistributing them. A DLC official explained that refurbishing refers to physically cleaning the device and connecting the device to a refurbishment cart that removes personal information and reinstalls the correct software with VA-established settings. In the final step, DLC staff package the device and update the inventory, making the device available in the ordering system for redistribution.

[18] Facility telehealth coordinators and Remote Order Entry System coordinators are both referred to in this report as telehealth coordinators.

[19] The Connected Device Support Program provides a white-glove setup experience (special care or attention) for veterans receiving VA loaned devices through the digital divide consult.

Results and Recommendations

Finding 1: VHA Sent Loaned Devices to Eligible Patients, but Only about Half of Them Completed a Video Telehealth Appointment

VHA's digital divide consult is designed for patients who would benefit from VVC but lack an affordable or quality internet connection or a video-capable device. According to Connected Care officials, leaving eligibility criteria broad allowed VHA to increase its distribution of loaned video-capable devices so that patients could connect virtually with providers during the pandemic. Initially, VHA did not require scheduling the patient for a VVC appointment after the device order was placed. During the first three quarters of fiscal year (FY) 2021, VHA facility staff created digital divide consults for 56,350 patients that they thought met the criteria. Following a favorable eligibility assessment by social work staff, VHA sent devices to an estimated 41,000 of these patients. The review team determined that VHA staff ordered a device for those patients an average of 14 days after the initial consult, and that an estimated 20,300 of those patients (49 percent) went on to complete a VVC appointment.

The review team concluded the low VVC appointment completion rate occurred for multiple reasons, including gaps in VHA's SOP and its dissemination to staff. The SOP does not, for example, assign oversight roles and responsibilities. Furthermore, the SOP lacks procedures to prompt VVC scheduling efforts for patients with a loaned device, even though it requires retrieval efforts when devices are not used for VVC. Finally, the responsible Connected Care and Veterans Integrated Service Network (VISN) staff did not effectively communicate and ensure all facility staff were using the digital divide consult and trained on subsequent SOP updates.[20] As a result, VHA loaned devices to an estimated 20,800 patients who had not used the device for a VVC appointment.

What the OIG Did

The review team examined the consult workflow at VA medical facilities during FY 2021. Of 61,348 consults that VHA staff submitted for 56,350 patients from October 1, 2020, through June 30, 2021, the review team analyzed a sample of 134 consults for 120 patients from eight VA medical facilities, stratified according to the volume of consults per facility.[21] The review

[20] VHA is organized into 18 regional networks called VISNs, each led by a director who is responsible for the coordination and oversight of administrative and clinical activities at the medical facilities within the specified geographic area. A VISN telehealth lead is responsible for the digital divide program at the medical facilities within that VISN.

[21] Patients may have more than one consult if the patient care team submitted duplicate digital divide consult requests around the same period, or a new consult was initiated after a patient failed to respond to staff contact attempts and the first consult was discontinued or canceled. See appendix A for additional information on the review scope and methodology, and appendix B for information on the statistical sampling methodology.

team determined the percentage of patients who completed a VVC appointment, and the time from the creation of the consult to the device order.

The review team interviewed key officials from Connected Care who were primarily responsible for the digital divide program. The team conducted virtual site visits with leads from five VISNs and staff from the eight facilities in the sample to ascertain their digital divide processes and procedures, determine the national program office's effectiveness at disseminating guidance, and identify potential internal control gaps in the consult guidance and device management. The review team also discussed sample review findings with VA medical facility staff to confirm the identified issues and establish their causes.

The following determinations support finding 1:

- Staff generally assessed patients' eligibility and ordered devices according to guidance.
- About 49 percent of the patients who were sent a device went on to complete a VVC appointment.
- VHA did not implement sufficiently detailed guidance or effectively communicate updates to staff.

Staff Generally Assessed Patients' Eligibility and Ordered Devices according to Guidance

From the 56,350 patients who had a digital divide consult, VHA facility staff completed those consults for an estimated 48,400 patients, while the remaining were canceled or discontinued. Social workers then submitted a device order consult for an estimated 42,400 patients following a social worker assessment.[22]

Social workers did not submit device order consults for about 6,000 patients they assessed. For an estimated 4,400 of the 6,000, the patients already owned a device, did not respond to social worker contact attempts, or had no interest in a VA-loaned device. The review team determined the social workers' actions in these cases were appropriate and in compliance with guidance. For the rest, the review team found the consults were not completed as required by the SOP. In these lesser occurrences, a social worker certified the patients as eligible for a device and completed the digital divide consult but did not submit a device order.[23]

[22] Medical facility care teams (provider, licensed independent practitioner, or designee) can create a digital divide consult and release it to a social worker for an assessment. Patients may have one or more digital divide consults.

[23] Due to the small number of instances in this category, this estimate was not suitable for reporting.

About 49 Percent of the Patients Who Were Sent a Device Went on to Complete a VVC Appointment

VHA facility staff sent devices to an estimated 41,000 patients, on average, about 14 days from when the initial digital divide consult was submitted for processing by the care team.[24] VHA cannot determine how long it took patients to receive the device because it does not track the date the device was delivered to the patient.

The review determined that an estimated 20,300 of the patients (49 percent) that were sent devices ultimately completed a VVC appointment. Figure 2 illustrates the number of patients with consults created during the period of review and the number of patients with completed VVC appointments.

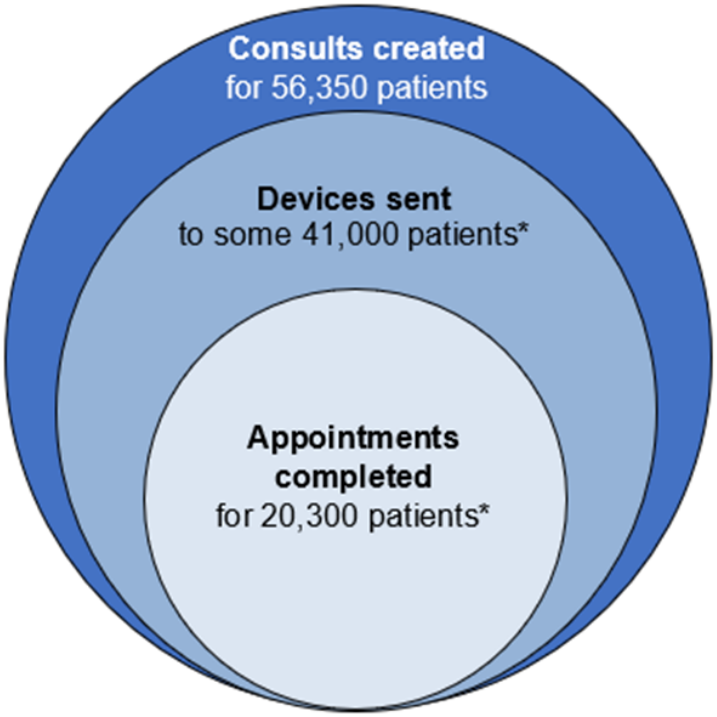


Figure 2. *Digital divide consults processed through VVC appointment completion.*

Source: VA OIG analysis of a sample of digital divide consults projected to the population.

** Estimated.*

Of the estimated 20,800 patients (51 percent) who received devices but did not complete VVC appointments, 10,700 patients never had a VVC visit scheduled. The SOP does not mention the

[24] VHA staff discontinued a small number of the estimated 42,400 video device order consults.

need or assign responsibility for scheduling a VVC appointment prior to or after loaning a device, and in these instances neither the patient nor facility staff initiated scheduling a VVC appointment. When the review team asked why, the facility staff could not provide a specific reason. Example 1 illustrates one patient's case.

Example 1

A physician submitted a digital divide consult on April 13, 2021. The social worker assessed and approved the request by documenting that the patient did not have internet or a video-capable device and submitted a video device order. A telehealth coordinator ordered an iPad for this patient on April 16, 2021. A successful test call was completed by a nurse practitioner while the patient was at the VA medical facility telehealth clinic on April 27, 2021. The patient has since completed many in-person appointments but has not completed a VVC appointment.

Of the remaining patients, the review team estimated that more than 10,000 patients had a VVC appointment scheduled but did not complete the visit. In these instances, facility staff cited myriad reasons, including that patients reported technical issues when connecting to VVC, the provider changed the appointment modality from video to telephone, or the patient did not show up for the scheduled VVC appointment and a subsequent VVC appointment was not successfully scheduled. Other explanations included that facility staff were unable to contact the patient, the requesting clinic canceled and did not reschedule, and, in one instance, a patient returned the device after receipt but before an appointment was scheduled. Example 2 illustrates a patient with a device whose VVC appointment was canceled and not rescheduled.

Example 2

A physician submitted a digital divide consult on November 4, 2020. On November 5, 2020, the social worker assessed the patient and approved and submitted a video device order. On November 6, 2020, an iPad was ordered for this patient. Facility staff then scheduled a VVC appointment for January 11, 2021. However, the requesting clinic canceled the VVC appointment, only noting the patient was unable to complete the appointment via VVC. The patient later completed many telephone and face-to-face appointments but as of October 2021 had not completed any appointments using the iPad issued for a VVC appointment.

VHA Did Not Implement Sufficiently Detailed Guidance or Effectively Communicate Updates to Staff

VHA's SOP outlines procedures for the consult process, device order and issuance, and facility device management. However, the SOP does not assign VISN and facility oversight roles and

responsibilities, lacks scheduling requirements, and does not contain timeliness goals to measure the success of the consult process. In addition, VHA program management did not effectively communicate guidance updates to facility staff to ensure all staff were adequately trained and were using the consult process prescribed under the SOP.

VHA's Digital Divide Guidance Does Not Assign Oversight Roles and Responsibilities

Connected Care's national synchronous telehealth lead and the national telehealth technology manager both stated that the program office is responsible for creating and updating the digital divide program guidance provided to the medical facilities. The SOP does not delegate oversight roles or responsibilities for Connected Care program office staff or for VISN telehealth leads to monitor whether facility social workers and telehealth staff conducted assessments, ordered devices, or monitored device use. Connected Care officials said that they hosted optional weekly meetings with VISN telehealth leads to discuss SOP guidance and updates.[25] Another Connected Care official said medical facility staff are responsible for performing and overseeing the consult process at their respective facilities.

The five VISN telehealth leads the review team interviewed said they provided some oversight of the digital divide process, such as passing along information from the program office and daily or monthly communication with facility staff to ascertain if any issues existed. Leads from four VISNs stated that the patient care team that submits the consult is ultimately responsible for ensuring a patient is scheduled for a VVC appointment. One VISN lead who did not specify who had the responsibility for scheduling VVC appointments under the consult said that VISN leads are responsible but unable to hold facility staff accountable, and devices are underutilized or duplicates may be issued.

Because facility staff from multiple offices are needed to execute the multistep consult process, establishing clear oversight roles and responsibilities is important to ensure compliance.

Recommendation 1 addresses the need for Connected Care to establish clear VISN and medical facility oversight roles and responsibilities to monitor medical facility social work and telehealth staff compliance with the SOP when processing digital divide consults.

Scheduling Procedures for Patients Sent a Loaned Device Were Undefined

According to Connected Care officials, national digital divide consult policies and procedures were written providing broad criteria to allow VHA to increase distribution of devices so that

[25] Connected Care officials said that they also communicated daily with VISN telehealth leaders, from March to October 2020, to discuss telehealth program information during the pandemic.

patients could potentially connect with care resources virtually. While medical facility providers and care teams submitting the consult are to confirm that the patient would benefit from video telehealth if provided a device to participate, they did not initially have to document an intent to schedule when approving a device order. Additionally, while the SOP does not include requirements or mechanisms for staff to schedule a VVC appointment for patients with a loaned device, it does require staff to initiate retrieval activities for unused devices if no VVC appointment has occurred within 90 days.[26]

The individuals tasked with scheduling, according to four of the five VISN telehealth leads interviewed, are those at the requesting clinic. However, national guidance does not include procedures to notify the provider and schedulers that a device has been ordered and to schedule a subsequent VVC appointment. Connected Care officials stated that they had determined that a scheduling requirement was not initially desired and did not require scheduling as part of the digital divide consultation process during the pandemic.

Then in September 2021, to ensure patients completed a video appointment within the 90-day window after a VA-loaned device was ordered, Connected Care announced the addition of a provider attestation requirement to the digital divide consult.[27] Members of the care team, a licensed independent practitioner, or a designee submitting the consult must attest that the patient will require a video telehealth appointment within 90 days. According to the announcement, Connected Care had recently determined that about 50 percent of distributed tablets since January 2021 had not been used for a VVC visit. The announcement further said that while staff must monitor and retrieve unused devices once a tablet is issued, they also want to address this before staff send a tablet.

In December 2021, Connected Care updated its SOP to reflect the requirement that staff creating the consult "must also attest that the veteran will require an appointment via video telehealth in the next 90 days." However, the update did not include a mechanism to ensure that the clinic subsequently schedules the patient for a VVC appointment.

To ensure VHA staff meet the intent of the attestation, recommendation 2 calls on Connected Care to develop and implement a mechanism to alert the requesting clinic that a patient has a loaned device and can now be scheduled for a VVC appointment.

[26] The SOP requires facility staff to contact veterans to understand any barriers they may be experiencing with their tablets and determine if the devices are no longer needed or used for VVC appointments. If not, telehealth coordinators are to initiate retrieval efforts.

[27] VHA's Office of Connected Care, "Digital Divide Update," Telehealth Technology Today internal SharePoint site, September 7, 2021.

Digital Divide Consult Processing Lacked a Clear Timeliness Goal

The workflow of VHA's digital divide consult is different from a clinical consult. A clinical consult is generally initiated by a physician or provider and submitted to another healthcare provider to obtain an opinion, advice, or expertise regarding the evaluation of a specific problem.[28] Administrative staff for the latter contact the patient and schedule the appointment. In contrast, the digital divide consult involves more people: the care team, a VHA social worker, VHA telehealth coordinators, and DLC staff. However, VHA Connected Care did not include controls or timelines to mitigate potential delays in the process and ensure patients receive a loaned device and eventually a VVC appointment.

The SOP does not include standard timelines to process the clinical consult, order the device, or schedule the VVC appointment. Instead, Connected Care officials said medical facility staff were expected to adhere to consult-processing guidelines established in VHA's national consult policy.[29] However, while some facility social workers acknowledged using the national policy when processing the clinical consult, other social workers applied locally established standards, resulting in varied practices across facilities. For example, social workers at one medical facility stated that their standard is to review the consult within 48 hours but that they did not have a timeliness standard for completing the assessment with the patient. In contrast, two social workers at a different medical facility stated they have 24 hours to review the consult. However, when asked about goals for completing a patient assessment, one social worker gave seven days, while another social worker gave 10 days.

A lack of clear timeliness standards for processing the digital divide consult and video device order presents a risk of delay in sending a video-enabled device and scheduling and completing VVC appointments. VHA stated that it believes the digital divide consult should be held to the same standards as other consults.

Recommendation 3 is for Connected Care to clarify its timeliness goal for the digital divide consult and the device ordering process.

Communication of Procedural Updates Was Ineffective

Connected Care and VISN telehealth leads did not ensure all facilities were using the SOP or verify that pertinent facility staff were adequately trained on the processing updates issued thereafter. In August 2020, VA issued a memorandum to all VISN directors requiring medical facilities to "install and activate" the digital divide consult in the patient's electronic health

[28] VHA Directive 1232(3).

[29] VHA Directive 1232(3). Consults must be reviewed and received, with a first attempt to contact the patient to schedule an appointment made within two business days.

record "no later than September 15, 2020."[30] The memo communicated the replacement of the clinical video telehealth tablet consult with the new digital divide consult. The new digital divide consult was intended to serve as the primary means of ordering video-enabled devices, peripherals, and smartphones at all medical facilities.[31] However, facility staff at seven of the 18 VISNs were using the outdated tablet consult. The review team found records of 6,260 clinical video telehealth consults created between October 1, 2020, and June 30, 2021, for 5,756 patients. These outdated tablet consults, predominantly used in VISN 20 facilities, lacked a social work assessment and a formalized device ordering process. VISN 20 staff did not use the digital divide consult or associated procedures for about 79 percent of devices issued.[32] When consults are not labeled correctly, VHA cannot effectively monitor these efforts and may be missing opportunities to improve the digital divide process. Following its own review of national consult data, Connected Care found that VISN 20 had not implemented the digital divide consult, and communicated directly with VISN 20 leaders in May 2021 to oversee the correction.

Since the digital divide procedures were implemented, the SOP has changed several times. The version issued in February 2022 was preceded by versions published in December 2021, July 2021, May 2021, and November 2020. Connected Care informs medical facilities of the updates via emails, office hours (instructor-led training calls that include a question-and-answer session), and postings to its internal SharePoint site. The review team found that changes announced in these ways were not included in the SOP until a later time, and facility staff had to review multiple sources to stay current on procedural updates and requirements. At the outset of the program, VA communicated program guidance via a memorandum; it later provided live trainings to VISN and medical facility telehealth staff and care teams in August 2020 and program updates by email in May 2021.

Most social workers the review team interviewed from eight medical facilities did not use the most recent guidance when processing digital divide consults.

- At three facilities, social workers said they followed VHA's SOP as the program's guidance, but one used the most recent SOP guidance (July 2021) while two used previous versions.
- Social workers from two facilities said they followed the August 2020 consult guidance or PowerPoint slides from Connected Care.

[30]Assistant under secretary for health for operations (10N) memo, "Expanding Access to Telehealth for Veterans through the Digital Divide Consult."

[31] Peripherals are items that can be used with VA-loaned devices, such as blood pressure monitors, weight scales, stethoscopes, pulse oximeters, and thermometers.

[32] The OIG compared the number of devices issued and tracked by the tablet dashboard to the number of digital divide consults from October 1, 2020, through June 30, 2021, for all facilities.

- Social workers from two other facilities said they followed VHA Directive 1232 for consult processing and procedures.
- At one facility, a social worker did not recall receiving any policies, directives, or handbooks related to digital divide consults but was following consult prompts in the consult tracking system when processing the consults.

Similarly, telehealth coordinators interviewed at the same eight medical facilities varied in their awareness of the most recent and required program guidance.

- At three medical facilities, coordinators indicated they were following the most recent SOP (July 2021).
- Telehealth coordinators at two facilities indicated they followed the SOP, but could not provide the version or date of the guidance applied.
- One telehealth coordinator reported following the most recent SOP (July 2021), while another coordinator at the same facility used a previous version (May 2021).
- One telehealth coordinator reported following the national digital divide and video device consult setup technical guide, while the other coordinator at the same facility could not cite any guidance.

Recommendation 4 addresses the need for Connected Care to update its digital divide consult training. The training should include procedure updates and ensure social workers and telehealth coordinators who process digital divide consults and video device orders complete the training and take refresher training as needed.

Conclusion

VHA's digital divide program was successful in distributing devices to patients, but the review team found that only about 49 percent of the patients who received devices during FY 2021 used the device to complete a VVC appointment. The broad eligibility criteria allowed VHA to increase its distribution of loaned video devices so that patients could connect with providers virtually, which was especially important during the pandemic, but VHA initially did not require scheduling VVC appointments after the device order was placed or closely monitor whether such appointments occurred. Overall, VHA loaned devices to an estimated 20,800 patients who did not use their device for VVC care, and facility staff generally could not explain why patients did not complete a VVC appointment after receiving a loaned device. Given the growing importance of virtual and remote care options and the rapid changes brought on by the COVID-19 pandemic, further improvements in this process will help VHA better fulfill the intent of the digital divide consult. Capitalizing on the best use of resources set aside for video-based care will continue to be an important aspect of this program and VHA's operations.

Recommendations 1–4

The OIG made four recommendations to the under secretary for health to ensure Office of Connected Care officials do the following:[33]

1. Establish clear oversight roles and responsibilities of the program office and of regional network telehealth and medical facility leads to monitor medical facility social worker and telehealth staff compliance with the "Digital Divide Standard Operating Procedure" for conducting assessments, ordering, and scheduling.
2. Develop and implement a mechanism to alert the requesting clinic that a patient has a loaned device and can now be scheduled for a VA Video Connect appointment.
3. Clarify timeliness goals for the digital divide consult, and video device order placement.
4. Update the digital divide consult training to include procedure updates and ensure social workers and facility telehealth and Remote Order Entry System coordinators who process digital divide consults and video device orders complete the training and take refresher training as needed.

VA Management Comments

The deputy under secretary for health, performing the delegable duties of the under secretary for health, concurred in principle with recommendation 1, concurred with recommendations 2 through 4, and submitted action plans for each recommendation. Appendix D provides the full text of the deputy under secretary's comments.

In response to recommendation 1, the deputy under secretary stated that VHA will develop policy that defines roles and responsibilities for overseeing the digital divide consult process.

For recommendation 2, the deputy under secretary reported that the Office of Connected Care will develop an electronic medical record flag that will alert staff to the veteran's telehealth capabilities, including whether the patient possesses a VA-loaned tablet. In addition, Connected Care will establish responsibilities for staff to alert referring providers that a patient's tablet has shipped and estimated time frame for completion of device delivery and setup, so that clinical teams are aware when an initial VA Video Connect visit on the device is feasible.

In response to recommendation 3, the deputy under secretary stated that Connected Care will update its digital divide guidance with references to existing applicable VA consult timeliness standards.

[33] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

For recommendation 4, Connected Care will address training gaps through updates to existing training or development of new training for social workers and telehealth coordinators who process digital divide consults and video device orders.

OIG Response

The OIG will assess the satisfactory completion of these stated actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in VHA's 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.

Finding 2: By Not Closely Tracking Device Issuance, Use, or Return, VHA Fell Short on Retrieval of Unused Devices

When VHA started the digital divide program in August 2020, staff could distribute video-capable devices to qualified veterans without a requirement to schedule VVC appointments. However, all of the issued SOPs included requirements to check for duplicate devices before ordering and also to retrieve devices if not eventually used for a VVC appointment.[34] Despite guidance limiting devices to one per patient, data show that VHA issued multiple devices to 3,119 patients.[35] VHA also did not retrieve, as required by the SOP, approximately 8,300 devices that were not used for VVC appointments. VHA medical facility staff did not consistently monitor issuance, use, or return of devices because they were using outdated versions of the SOP or stated they did not have time to monitor while balancing collateral duties.[36] VISN telehealth leads did not ensure facility staff consistently reviewed the tablet dashboard for VVC appointment activity and retrieved devices because none of the issued SOPs outline oversight roles and responsibilities.

Additional barriers in refurbishment and reporting hindered the process after devices were retrieved, delaying their return to service. The review team determined there was a backlog of about 14,800 returned devices that had not been refurbished and could not be logged into inventory and reissued to other patients. The backlog was primarily caused by software coding problems with the refurbishment system at the DLC.

When VHA does not adequately monitor loaned devices, it has no assurance that they are used to help patients obtain needed health care. The value of the nearly 8,300 loaned devices that remained without VVC activity and were not retrieved was about $6.3 million, and they incurred additional data plan costs of about $78,000 through June 30, 2021.[37] Furthermore, VHA placed a purchase order for new devices in August 2021, and as of December 2021, bought devices totaling approximately $8.1 million, despite having a backlog of devices pending refurbishment. Had staff adequately monitored and retrieved loaned devices with no VVC appointments and refurbished them for prompt return to service, Connected Care could have made better use of approximately $14.5 million in devices.[38]

[34] The October 2020 VA "Loaned Devices SOP" required a monthly review of loaned devices to determine if a patient had a VVC appointment 30 days before or after the date of review and initiate retrieval when warranted. This guidance was updated in the May 2021 "Digital Divide SOP," which indicates retrieval priorities for patient devices that have gone more than 90 days with no past or future scheduled VVC appointments.

[35] The review team examined VHA's tablet dashboard data for duplicate devices from September 2017 through June 30, 2021.

[36] As of February 2022, Connected Care had issued five versions of the SOP.

[37] Because VA continues to pay for data for these devices, this amount will continue to increase.

[38] Appendix C presents estimates of monetary benefits from implementing this report's recommendations.

What the OIG Did

The team gained an understanding of device tracking and retrieval procedures. The team also analyzed VA-loaned device activity data from the tablet dashboard to determine if each patient who received a device in the period of review completed a VVC appointment or had one scheduled.[39] The review team interviewed telehealth coordinators at eight medical facilities to identify the controls in place for device issuance, monitoring, and return. The review team also conducted a site visit and interviews with Connected Care officials and contractor and DLC staff to understand the purchasing and refurbishment processes, and conducted a site visit to assess the DLC's inventory operations.

Finding 2 builds on the following determinations:

- VHA staff issued multiple devices to some patients.
- Staff did not effectively monitor device use for return.
- VHA procedures did not confirm that devices set for retrieval were eventually returned.
- VHA had a backlog of returned devices that were not refurbished and available for patients.
- Inadequate controls over device ordering, monitoring, and retrieval resulted in missed opportunities to redistribute devices, and additional expenditures on new devices.

VHA Staff Issued Multiple Devices to Some Patients

Although a patient may be issued a replacement device due to damage or theft, VHA's SOP instructs telehealth coordinators to check for duplicate video-capable devices before ordering to ensure the patient does not already possess the equipment required to connect to video care.[40] Nonetheless, VHA's tablet dashboard data show that from September 2017 to June 30, 2021, 3,119 patients were issued multiple VA devices (totaling 6,378 devices). The dashboard showed no retrieval attempts for 940 of the 3,119 patients with multiple devices (totaling 1,898 devices).[41]

[39] The tablet dashboard can produce reports of patients with no future VVC appointments scheduled, any past VVC appointments, or appointments scheduled in the next 60 days.

[40] In February 2022, Connected Care updated the "Digital Divide Consult SOP" to include an exception to the single device guidance. Patients who own a personal device may also be issued a VA-loaned tablet to participate in mental health treatment.

[41] The tablet dashboard data did not allow the team to determine whether the duplicate devices in this population were possessed by the patients at the same time.

VHA staff were able to issue multiple devices to patients because Connected Care lacked controls at two points in the process. First, as part of their assessment, social workers ask patients whether they already possess a device, yet the SOP does not require social workers to validate patients' responses against the tablet dashboard.[42] Second, the SOP does not require VISN telehealth leads and local supervisors to ensure that telehealth coordinators follow ordering guidance by checking the system for duplicate devices before placing orders. The telehealth coordinators interviewed acknowledged they did not always check the issued device list in the system before ordering a device for a particular patient.

Recommendations 5 and 6 call on Connected Care to implement procedures that require responsible staff to check for duplicate devices before submitting a device order consult, establish an alert to notify responsible staff if a patient has already been issued a device, review all patients that have been issued multiple devices, and attempt to retrieve duplicate devices.

Staff Did Not Effectively Monitor Device Use for Return

Connected Care's SOP requires staff to retrieve devices if not eventually used for a VVC appointment.[43] Yet nearly 11,000 devices issued during the first three quarters of FY 2021 had not been used for a VVC appointment, were still with the patients, and had not been retrieved (no documentation showed retrieval kits had been sent) as of June 30, 2021.[44] The review team assessed this again in November 2021 and found that the number of devices with patients that had not been used for a VVC appointment and for which no retrieval kits had been recorded as sent was down to about 8,300. The review team also determined that although the devices were not used for VVC appointments, about 93 percent of the devices did have data usage.

According to Connected Care staff, these devices have annual unlimited cellular data plans that cost $257.50 per device, per year. The review team calculated that the nearly 8,300 devices cost VHA about $6.3 million and would have incurred about $78,000 in cellular data fees in the

[42] VHA's tablet dashboard is available to management and field staff to track, monitor, and manage VA-issued devices and match VVC appointments through the use of the Microsoft Power BI [Business Intelligence] reporting and data visualization software and incorporating multiple VA data sources.

[43] The SOP requires staff to review VA-loaned devices and retrieve those not being used for VVC care. The October 2020 "VA Loaned Devices SOP" stated that local facilities should monitor loaned devices monthly for VVC activity (30 days before or after their review) and determine what device monitoring and retrieval process worked best for them. The May 2021 update required medical facilities to use VHA's tablet dashboard to review devices based on Connected Care's retrieval priorities and retrieve the devices. The priorities include patients who have had the tablet for more than 90 days with no VVC visits completed or scheduled, and patients who have been issued duplicate devices.

[44] VHA tablet dashboard data.

review period.[45] With more robust oversight responsibilities and controls to ensure that medical facility staff monitor for VVC appointments and device usage and attempt retrieval, when necessary, VHA could ensure better use of approximately $6.3 million in devices that could be loaned to other patients and over $78,000 in data plan costs.

The SOP does not require facility managers to designate staff to review the tablet dashboard for VVC appointment activity and does not outline VISN oversight roles and responsibilities to ensure facility staff consistently review the tablet dashboard for VVC appointment activity and retrieve devices when appropriate. Connected Care sends the VISNs weekly reports with the number of devices per medical facility. However, these reports did not initially identify the patients or devices, but the total number of devices kept for more than 90 days with no VVC visits scheduled or completed plus the number of duplicate devices.[46] Interviews with five VISN telehealth leads revealed limited locally established oversight functions. The leads stated that they receive the Connected Care report with the number of devices for potential retrieval but only one VISN lead had implemented a monitoring mechanism to ensure the facilities reviewed the tablet dashboard and initiated retrieval when appropriate. All five of the VISN leads said they forwarded the report to the facilities for action. Example 3 illustrates a device that should have been retrieved and continues to incur significant data usage for non-VA purposes.

Example 3

A physician initiated a digital divide consult on March 18, 2021. A social worker then approved the device and submitted the video device order indicating the patient—who lived more than 30 miles from a VA facility and was confined to the home—would benefit from telehealth services. A device was ordered on April 19, 2021. A mental health case manager was informed on May 28, 2021, that the patient died on April 18, 2021. However, records show that data were used on this device starting in June 2021 (data usage for June 2021 alone was 664 gigabytes).[47] VHA staff had not made retrieval efforts for this device as of November 10, 2021.

To identify issued devices requiring retrieval, the tablet dashboard provides VHA staff with filters identifying patients who have not completed appointments within the past 60 days

[45] The review team calculated this value using the actual purchase cost of the device type, including full size and mini Verizon Wireless and T-Mobile iPads. Because these devices were issued but not used to provide VVC care and not retrieved, and VHA can retrieve and then lend these devices to other patients, the OIG identified the value of these devices as a potential better use of funds. The review team prorated the annual cost of unlimited cellular plans associated with the devices by the months beyond the first year of service included in the initial purchase price.

[46] During interviews with VISN leads in September 2021, the review team determined the reports did not include detailed information. VHA officials told the review team in May 2022 that the VISN weekly reports started including patient information in October 2021.

[47] The Verizon Wireless "Data Usage FAQ [Frequently Asked Questions]" notes that the average data usage for customers who stream video and are always online runs from six to eight gigabytes per month.

and do not have any scheduled for the next 60 days. Telehealth coordinators from the eight medical facilities monitored to different degrees. Coordinators from three facilities said they did not monitor the use of VA-loaned devices for VVC appointments. The guidance did not make clear which staff members are responsible for this step or how often they should do it. Others indicated they were using outdated versions of guidance and did not have time to monitor while balancing collateral duties.[48] Coordinators at five medical facilities did rely on the tablet dashboard to monitor the use of VA-loaned devices for VVC appointments to start the retrieval process when a patient had no VVC appointment completed within 90 days. One facility telehealth coordinator stated that he reviews a sample of patients monthly, checking whether their issued devices were used for VVC appointments reflected in the patient record, and initiates retrieval of a device when there are no completed or scheduled appointments for 60 days. This case demonstrates that appropriate oversight is achievable.

Recommendation 7 is for Connected Care to revise its SOP. It should designate responsible facility staff to monitor the tablet dashboard for VVC appointment activity and device use, as well as specify VISN telehealth lead oversight responsibilities to ensure facilities initiate retrieval efforts when warranted. To facilitate VISN oversight and medical facility retrieval efforts, recommendation 8 is for Connected Care to establish an automated alert using the tablet dashboard to routinely identify the devices meeting retrieval requirements and also initiate retrieval of those that already meet retrieval requirements.

VHA Procedures Did Not Confirm That Devices Set for Retrieval Were Eventually Returned

Device retrieval roles and responsibilities stopped short of device return. The DLC staff did not track the packages they sent to ensure VHA received returned devices. DLC staff stated that the ordering system does not collect tracking data for packages sent to patients other than recording the outgoing tracking number and registering when return shipping labels are scanned by the postal carrier. Consequently, if for instance the DLC staff sent out 100 retrieval kits (containing ready-to-assemble shipping containers and preprinted return labels) and received 75 returned devices, they could not determine which 25 devices were still out.

Telehealth coordinators' device retrieval efforts ended once the retrieval kit tracking number was assigned, unless staff went beyond the suggested procedures. Staff at five of the eight facilities based their process on the SOP, but it does not require the telehealth coordinator to follow up to make sure the patient has returned the device. Telehealth coordinators at three facilities independently developed their own local procedures for tracking the status of retrieval kits.

[48] Since November 2020, Connected Care has issued five versions of the SOP.

The May 2021 SOP indicated the return of the device can be tracked through the tablet dashboard once a retrieval kit is shipped. However, the process outlined in the SOP requires VHA staff, when they send a retrieval kit from the DLC, to cancel authorization of the device in the ordering system and add a note in the patient's record stating that the patient no longer possesses the VA-loaned device—*before* the DLC gets the device back from the patient. Gaps in the device retrieval process increase the risk of waste and abuse and delay turnover of devices that may be loaned to other patients.

Recommendation 9 calls on Connected Care to augment tracking mechanisms to ensure that retrieved devices are accurately recorded in inventory and available for refurbishment and reissue.

VHA Had a Backlog of Returned Devices That Were Not Refurbished and Available for Patients

For devices that were returned to the DLC, the review team determined there was a backlog to get the devices back into inventory and available to other patients. Returned devices were waiting to be refurbished, and therefore had not been logged into shippable inventory.

In October 2021, the review team identified about 11,600 devices that were returned to the DLC but had not been refurbished (some shown in figures 3 and 4). By November 2021, the count had grown to over 13,200 devices, based on weekly reports used by Connected Care and the DLC.

Figure 3. *Devices charging before refurbishment at the main DLC warehouse.*
Source: VA OIG auditor, October 5, 2021.

Figure 4. *Full pallets of devices to be refurbished at DLC's off-site storage building.*
Source: VA OIG auditor, October 5, 2021.

According to the DLC, this high volume of returned devices that were still awaiting refurbishment was initially caused by equipment issues. DLC staff use two 48-bay computer carts shown in figure 5 to forensically wipe and reset devices before refurbishment.[49] The DLC staff stated that the refurbishment system was prone to failure and acted as a choke point for the process.

Figure 5. *DLC refurbishment carts in the main DLC warehouse.*
Source: VA OIG auditor, October 5, 2021.

[49] The refurbishment carts were purchased from and serviced by the VA contractor, Iron Bow Technologies.

A DLC staff member communicated to the contractor the need for new refurbishment carts in December 2020 and reported at the time that DLC had a backlog of approximately 1,800 devices awaiting refurbishment. In January 2021, the contractor proposed a plan to the DLC to replace the current cart with two new carts within eight weeks at no additional cost to VA. That same month, Connected Care approved the plan. While awaiting the new carts, DLC's representative stated they continued to work remotely with the contractor to get as much output as possible from the existing, underperforming carts and that this required a lot of time from a warehouse employee. According to the contractor, the new carts arrived at the DLC in June 2021, while the delivery delay was attributed to the COVID-19 pandemic, testing, and shipping. Once DLC staff received the new carts, DLC's representative said they experienced incomplete downloads of VA applications, which required manual intervention to complete the installation. DLC's representative said this resulted in significant delays in the refurbishment process and an increased backlog of devices. DLC's representative said the contractor then provided an on-site specialist to determine the root causes of the problems and to process the devices through the carts.

The review team visited the DLC in October 2021 and observed a contractor working on-site on the carts' software coding. The technician informed the team at the time of the visit that the refurbishment carts had a failure rate of roughly 50 percent, but said that after the coding errors were corrected, the carts would be able to process 300 to 400 devices a day. Based on the estimate by the technician and assuming a 50 percent failure rate, the DLC still should have been able to refurbish about 750 to 1,000 devices per week. However, DLC staff indicated that during the first week of November 2021, only 23 devices were refurbished. DLC staff informed the OIG team that the technician had fixed the software coding issue on November 5, 2021. DLC's representative stated staff have not experienced any technical issues relating to the carts since that time, and devices are processed through the carts at a faster rate. Yet the review team found the DLC was still refurbishing devices well under capacity during the week of January 13, 2022. DLC's data showed that only 144 devices were refurbished that week and prepared for shipment.

Another restriction was the manual packaging of devices after they were processed through the carts. The DLC's representative explained that a second choke point occurs after the devices are processed through the carts, during repackaging and preparing for shipping. The DLC's representative said that this latter part of the overall refurbishment process lagged because of personnel shortages and delays in the delivery of required accessories that go with the devices.

The DLC maintains a weekly inventory report that includes the average number of daily device orders from the medical facilities that were fulfilled by the DLC. The review team's analysis of the weekly inventory reports from January 20, 2021, to January 7, 2022, showed declining device orders fulfilled per week, with a high of about 1,955 devices to a low of 820. Despite this trend and the increase in the backlog of devices waiting to be refurbished, chronicled in the DLC's weekly inventory report since April 2021, VHA purchased new devices from its

contractor.[50] The contracting officer's representative told the review team that she bases her purchasing decisions on the demand illustrated by the number of daily requests for devices. She also considers available supply, including devices ready to ship. However, she provided no documentation of her calculations and did not explain the process in detail.

Notwithstanding the numerous devices returned to the DLC and available for refurbishment, VHA awarded a new purchase order effective on August 9, 2021, for 15,000 iPads for a total of about $11.3 million.[51] As of December 2, 2021, VHA had paid for 9,720 of these devices, representing a total cost of approximately $8.1 million.

Figure 6 illustrates DLC's reported weekly inventory since April 2021 (separated into devices ready to ship and waiting to be refurbished) and the disparity between inventory and weekly demand.

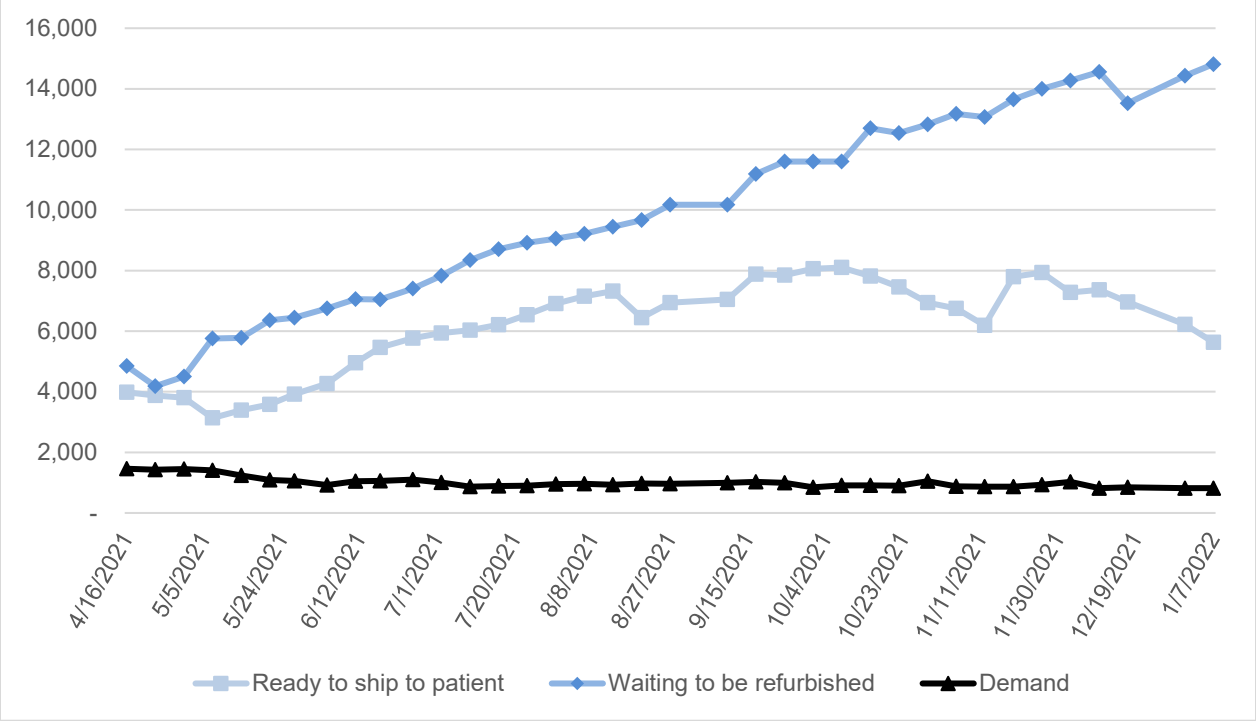


Figure 6. *Purchases out of sync with returns and demand totals.*

Source: OIG analysis of DLC Weekly VVC Inventory Reports provided by VHA.

By January 2022, DLC staff reported to Connected Care that about 14,800 devices were awaiting refurbishment. In addition to that potential inventory, the report showed there were 5,631 devices ready to ship to patients and an additional 4,845 devices purchased but not received. Overall, at

[50] VA awards purchase orders; VA's contractor, Iron Bow Technologies, ships the devices to the DLC and invoices VA in batches based on the open purchase order.

[51] The purchase order is effective August 13, 2021, to August 12, 2022, with the price per device ranging from $595 for T-Mobile devices to $835 for Verizon devices. Devices are shipped and invoiced by the contractor to the DLC until the purchase order is complete.

that time VA had a total of 25,290 devices with a weekly demand of 820 devices. Using specific cost information of supplies, labor, and retrieval kits provided by the DLC, the review team calculated that it costs about $96 to retrieve and refurbish a loaned iPad in order to reissue the device to another patient.

The contracting officer's representative should consider both the backlog and the inventory before ordering new devices, and Connected Care should ensure that any delays in refurbishment are remediated. Had these issues been resolved, VHA could have made better use of the approximately $8.1 million used to purchase new devices.

Recommendation 10 is for the Connected Care to address restrictions in the refurbishment process, report on devices awaiting refurbishment, and implement a structured purchasing model to guide new device purchases and maintain an appropriate inventory level.

Inadequate Controls over Device Ordering, Monitoring, and Retrieval Resulted in Missed Opportunities to Redistribute Devices, and Additional Expenditures on New Devices

VHA's inadequate device monitoring of about 11,000 devices that were not used for VVC appointments led to a lack of retrieval efforts and to excess data plan costs associated with these devices. As of November 10, 2021, about 8,300 of these devices remained unretrieved, representing about $6.3 million worth of devices that could potentially be loaned to other patients. As of June 30, 2021, the data plan costs for devices not used for VVC appointments and not retrieved represented about $78,000.

Lapses in refurbishment and inventory controls also led to a backlog of over 14,800 devices pending refurbishment that could not be added back to inventory for redistribution or consideration in VHA's device purchasing process. Despite having thousands of devices pending refurbishment, VHA awarded a new device purchase order in August 2021 and paid approximately $8.1 million for devices from this contract as of December 2, 2021.[52] In total, the OIG identified approximately $14.5 million in funds that could have been better used to help VHA meet the intent of the digital divide consult if it had appropriately monitored and retrieved loaned devices.

Conclusion

Because VHA did not effectively track device issuance, use, or returns, many unused devices were not retrieved and made available to other patients. Not tracking these items from distribution through retrieval limits VHA's ability to determine how many devices are available

[52] Connected Care awards orders for supplies placed against an established contract for bulk purchases of iPads to fill the individual purchase orders created through the digital divide consult process.

for patients. The review team also observed that many of the loaned devices not used for VVC appointments incurred data use. Even though more than 14,800 devices had been returned to the DLC via retrieval kits, they were not yet refurbished and VHA purchased additional devices to cover demand. VA-loaned devices represent a sizeable investment and should be closely monitored to prevent waste and abuse.

Recommendations 5–10

The OIG recommended that the under secretary for health ensure Office of Connected Care officials do the following:[53]

5. Implement procedures to require responsible staff to check for duplicate devices before submitting a device order consult.
6. Establish an alert in the Remote Order Entry System to notify the responsible staff member that a patient already has an issued device before ordering another, and initiate retrieval activities for duplicate devices.
7. Delegate in the "Digital Divide Standard Operating Procedure" facility staff to monitor the tablet dashboard for VA Video Connect appointment activity and device use, and clearly define regional network telehealth leads' oversight responsibilities to ensure facilities initiate retrieval activities when warranted.
8. Establish an automated mechanism using the tablet dashboard to routinely identify the devices that meet retrieval priorities and also initiate retrieval of those that already meet retrieval requirements.
9. Augment tracking mechanisms for packages sent to patients to ensure VA receipt of the retrieval kit so that devices are accurately recorded in inventory and available for refurbishment and reissue.
10. Address restrictions in the refurbishment process, implement accessible and trackable reporting of devices waiting to be refurbished, and implement a structured purchasing model to guide new device purchases and maintain an appropriate inventory level.

VA Management Comments

The deputy under secretary for health, performing the delegable duties of the under secretary for health, concurred with recommendations 5, 6, 7, and 10, concurred in principle with

[53] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

recommendations 8 and 9, and submitted action plans for each recommendation. Appendix D provides the full text of the deputy under secretary's comments.

In response to recommendation 5, the deputy under secretary stated that the program office will clarify responsibilities in policy, including checking for duplicate devices before ordering and retrieving duplicate devices sent in error. The deputy under secretary also noted that Connected Care will reinforce the procedures in training and implement an additional alert or tool for potential errors before they lead to the shipping of a duplicate device.

For recommendation 6, the deputy under secretary stated that Connected Care will work with the DLC to create an alert in the Remote Order Entry System that informs the ordering staff member when a new device order would result in a duplicate device, so that they can address potential errors before they lead to sending a duplicate device. Further, Connected Care has been distributing a list of patients who have been issued duplicate devices to each VISN weekly, so the duplicate devices can be retrieved or appropriately addressed. The deputy under secretary also noted that Connected Care will implement a centralized, duplicate device retrieval process and track progress on its dashboard.

In response to recommendation 7, the deputy under secretary stated that Connected Care will identify necessary staff responsible for monitoring its device dashboard and will outline such responsibilities in digital divide guidance and policy.

For recommendation 8, the deputy under secretary stated that Connected Care will require the clinical team to document in the medical record the ongoing need for a device at least annually. Connected Care will also develop an automated process to prompt healthcare professionals to document their clinical decision regarding ongoing tablet need, and depending on that assessment, the device will be renewed, or the retrieval process initiated. Additionally, the deputy under secretary stated that Connected Care will develop an automated report to help inform responsible staff when device retrieval actions are needed. For existing loaned devices, the deputy under secretary noted that Connected Care will distribute a list of patients who have devices that meet retrieval criteria to VISNs weekly so that facilities can use the list to initiate such efforts and track progress on Connected Care's device dashboard.

For recommendation 9, the deputy under secretary reported that VHA is currently tracking when retrieval kits are sent and when tablets are returned and stated that the addition of a "Check-In" process to Connected Care's tablet dashboard allows staff to identify when a veteran who has been sent a retrieval kit has returned the device. The deputy under secretary stated that Connected Care will define a process for following up with veterans who have been sent a retrieval kit but have not returned the device.

Finally, to address recommendation 10, the deputy under secretary stated that VHA will work collaboratively with the DLC and establish an inventory target for devices to help guide the timing of orders. VHA will also develop a visual display to track key device data necessary for

making informed decisions on device acquisitions—data that will be captured and documented as part of device-ordering decisions to serve as a justification for each order.

OIG Response

The OIG will assess the satisfactory completion of these stated actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in VHA's 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

This review team conducted its work from June 2021 through May 2022. The review focused on digital divide consult processing and associated device distribution and retrieval at VA medical facilities during FY 2021. The team's sample universe consisted of 61,348 digital divide consults for 56,350 patients from October 1, 2020, through June 30, 2021. The team also analyzed tablet dashboard data for September 11, 2017, through June 30, 2021.

Methodology

To accomplish its objective, the review team identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to the digital divide process. The team interviewed national program staff from Connected Care, the National Social Work Program Office, and the DLC. Additionally, the team conducted virtual site visits from August through September 2021 at the Loma Linda Healthcare System, Memphis VA Medical Center, New Mexico VA Health Care System, Omaha VA Medical Center—Nebraska-Western Iowa Health Care System, Palo Alto Health Care System, Phoenix VA Health Care System, Sierra Nevada Health Care System, and Western New York Healthcare System. The team also conducted a site visit to the DLC.

The eight facilities selected were stratified according to the volume of patients with a digital divide consult per facility, for a sample review of 120 patients with digital divide consults from October 1, 2020, through June 30, 2021. Through coordination with VA OIG statisticians, these facilities were statistically selected to represent low, medium, and high volume of patients with digital divide consults created per facility during the period of review. This stratification was chosen to allow the team to identify a wide range of practices and potential issues and to conduct virtual site visits that provided a representative look at the digital divide process across VHA.

The sample population was drawn from data in VHA's Corporate Data Warehouse, and the team completed the sample review process by accessing and reviewing patient records through the Compensation and Pension Record Interchange.[54] The team reviewed consult and device distribution and retrieval processes used by staff, determined if consults resulted in patients receiving devices when appropriate, and determined if this process ultimately helped patients

[54] The review team was unable to identify digital divide consults for the VA medical facility in Roseburg, Oregon, in the Corporate Data Warehouse and excluded the station from the sample review. The review team also attempted to identify legacy naming conventions using the keywords "CVT" and "Home" because "CVT to Home" consult was VHA's naming convention for VA-loaned devices prior to September 15, 2020. The team was unable to determine criteria that would limit the false positives in the universe and therefore did not include legacy naming conventions for sampling purposes.

access video-based care. Appendix B provides more information on the review team's statistical sampling methodology and results.

Additionally, the review team examined the tablet dashboard's underlying data, extracted by OIG's Office of Data and Analytics on July 7, 2021. The tablet dashboard includes digital divide program utilization and monitoring data by VISN and medical facility. The team reviewed the tablet dashboard data of September 11, 2017, through June 30, 2021. The team reviewed device distributions, VVC encounter status (past and future), devices retrieved, multiple devices assigned per patient, and average days since last VVC. The tablet dashboard was also used to identify a subpopulation of patients with no VVC visits, and no retrieval attempts identified. The subpopulation was used to understand if the devices were active in comparison to cellular data and program device management systems provided by the program's contractor.

Internal Controls

The review team determined that internal controls were significant to the audit objective.[55] The team assessed the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring. The team identified the following five components and 13 related principles as significant to the audit objective. The team identified internal control weaknesses and made recommendations in finding 1 and finding 2 to address deficiencies in the following:[56]

- Component 1: Control Environment
  - Principle 2—Exercise Oversight Responsibility
  - Principle 3—Establish Structure, Responsibility, and Authority
  - Principle 4—Demonstrate Commitment to Competence
  - Principle 5—Enforce Accountability
- Component 2: Risk Assessment
  - Principle 6—Define Objectives and Risk Tolerances
  - Principle 7—Identify, Analyze, and Respond to Risks
  - Principle 8—Assess Fraud Risk
  - Principle 9—Identify, Analyze, and Respond to Change

[55] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, January 2012; Government Accountability Office, *Standards for Internal Control in the Federal Government,* GAO-14-704G, September 2014.

[56] Since the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this review.

- Component 3: Control Activities
  - Principle 10—Design Control Activities
  - Principle 11—Design Activities for the Information System
  - Principle 12—Implement Control Activities
- Component 4: Information and Communication
  - Principle 14—Communicate Internally
- Component 5: Monitoring Activities
  - Principle 17—Evaluate Issues and Remediate Deficiencies

Fraud Assessment

The review team assessed the risk of fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators by

- identifying laws, regulations, and procedures related to the review subject matter to help detect noncompliance or misconduct;
- completing the Fraud Indicators and Assessment Checklist; and
- reviewing relevant OIG Hotline complaints for reports of fraud in the area under review.

The review team also discussed the issues identified in finding 2 with OIG investigators. The review team did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The review team obtained data from various sources during the audit and assessed the reliability of the data used to support findings, conclusions, or recommendations related to the review objectives. The OIG used computer-processed data from VA's Corporate Database Warehouse, from October 1, 2020, through June 30, 2021. To test for reliability, the team tested 34 records selected at random by comparing them to the patients' electronic health records to determine whether data were accurate and complete for the purposes of the review. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements.

The OIG's Office of Data and Analytics extracted data from the VHA tablet dashboard. To test for reliability, all data in the tablet dashboard was compared to the Corporate Data Warehouse

Prosthetics table based on the device serial number, social security number, first name, and last name, and resulted in a 97.5 percentage match.

The review team also assessed the reliability of inventory reports that the DLC provided weekly to the Office of Connected Care. According to DLC staff, this report was sourced from multiple active information systems with quality control processes and procedures in place. To test for reliability of reporting, the review team acquired inventory reports from the DLC and Connected Care and compared key inventory fields. The team found that these fields matched identically.

Testing of the data disclosed that they were sufficiently reliable for the review objectives. No material errors were noted, and our sampling procedures revalidated the reliability checks.

Government Standards

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

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the audit objective, the team reviewed a statistical sample of digital divide consults created by VA care teams to quantify how many patients completed a VVC appointment after the video device order was completed by a telehealth coordinator.

Population

The review team started with a population of digital divide consults created at 128 VA medical facilities identified by the station number. The review team classified each facility into three groups based on the volume of digital divide consults created at the facility during the stated period. After exclusions the population was adjusted to 61,348 digital divide consults created for 56,350 patients between October 1, 2020, and June 30, 2021 (table B.1).

Table B.1. Adjusted Population

Facility classification	Number of patients with a digital divide consult	Facilities	Digital divide consults	Patients
Low	0-299	63	10,367	9,542
Medium	300-999	52	29,050	26,705
High	>=1,000	13	21,931	20,103
Total		**128**	**61,348**	**56,350**

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

Sampling Design

The overall sampling approach included a two-stage sampling method to arrive at the statistical sample selection.

The team statistically selected eight medical facilities using probability-proportional-to-size sampling in proportion to the count of unique patients with one or more digital divide consults at each facility: two medical facilities from 63 facilities with low volume; three medical facilities from 52 facilities with medium volume; and three medical facilities from 13 facilities with high volume.

In stage two the team randomly selected 15 patients per facility for a total of 120 patients, and a total of 134 digital divide consults. This sample size was sufficient to ensure enough consults and stations existed for the analysis and projection of digital divide processing-error rates.

Table B.2. Sample Size

Station	VISN	VA facility name and station number	Volume	Digital divide consults	Patients in sample
1	22	Loma Linda Healthcare System (605)	Medium	18	15
2	9	Memphis VA Medical Center (614)	High	15	15
3	22	New Mexico VA Health Care System (501)	Low	17	15
4	23	Omaha VA Medical Center VA Nebraska-Western Iowa Health Care System (636)*	High	17	15
5	21	Palo Alto Health Care System (640)	Medium	17	15
6	22	Phoenix VA Health Care System (644)	Medium	17	15
7	22	Sierra Nevada Health Care System (654)	Low	15	15
8	2	Western New York Healthcare System (528)	High	18	15
		Total		**134**	**120**

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

** This VA medical facility is shown as "Omaha VA Medical Center --VA Nebraska Western Iowa HCS" on the VA locations list. For uniformity, the HCS acronym was spelled out.*

Weights

The OIG calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn. The OIG team used the weights to compute estimates. For example, the OIG team calculated the error rate point estimates by summing the sampling weights for all sample records that contained the error, then divided that value by the sum of the weights for all sample records.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this review with multiple sets of 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 estimates, margins of error, and confidence intervals that 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 decreases significantly 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.

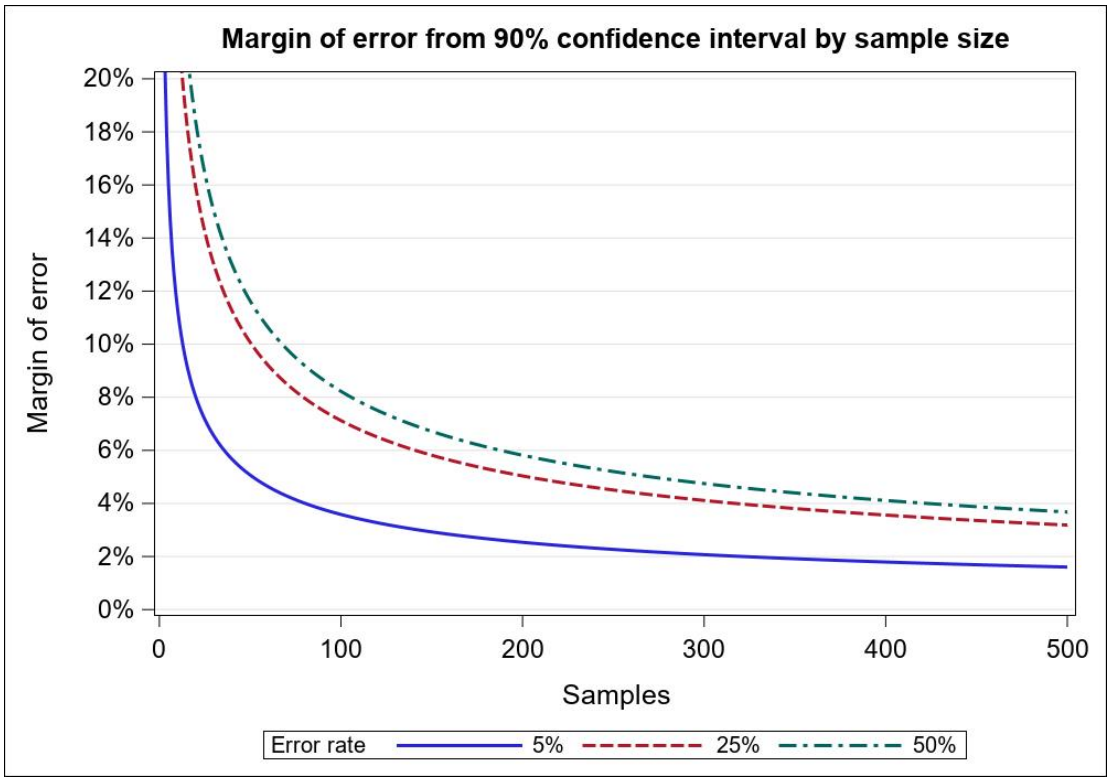


Figure B.1. *Effect of sample size on margin of error.*

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

Tables B.3 to B.9 detail the review team's analysis and projected results. The percentages and numbers listed herein are based on actual estimates and may not sum or equal those derived from rounded numbers.

Table B.3. Statistical Projections for Digital Divide Consults Processed

Consult status	Estimated (percent)	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Complete	49,591 (81)	4,124 (5)	45,467 (75)	53,717 (86)	102	49,600
Canceled*	1,951 (3)	1,725 (3)	226 (1)	3,676 (6)	4	2,000
Discontinued	9,805 (16)	2,860 (5)	6,945 (11)	12,665 (21)	28	9,800
Total	**61,348**	**2,198**	**59,150**	**63,546**	**134**	**61,300**

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

** These estimates for canceled consults are not statistically reliable because of the low sample count and high margin of error.*

Table B.4. Statistical Projections for Patients with at Least One Completed Digital Divide Consult with or without Video Device Order Consults

Consult status	Estimated (percent)	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Patients with video device order consult	42,407 (88)	3,333 (5)	39,075 (83)	45,740 (93)	85	42,400
Patients without video device order consult	5,983 (12)	2,481 (5)	3,502 (7)	8,464 (17)	15	6,000
Total	**48,391**	**2,774**	**45,617**	**51,164**	**100**	**48,400**

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

Table B.5. Statistical Projections for Patients with at Least One Completed Digital Divide Consult Not Referred for a Video Device

Consult status	Estimated (percent)	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Patients not eligible*	4,435 (74)	2,201 (20)	2,235 (55)	6,636 (94)	11	4,400
Total patients without video device order consult	**5,983**	**2,481**	**3,502**	**8,464**	**15**	**6,000**

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

** Patients who were eligible for a device but declined a device; patients who were referred to another VA program or failed to respond to VHA social worker contacts; and patients who were not eligible because they owned a device or had applicable service.*

Table B.6. Statistical Projections for Patients' Video Device Order Consult Status

Consult status	Estimated (percent)	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Patients with completed video device order consult	41,049 (97)	3,468 (3)	37,581 (94)	44,517 (100)	82	41,000
Total patients with video device order consult	**42,407**	**3,333**	**39,075**	**45,740**	**85**	**42,400**

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

Table B.7. Statistical Projections for Patients' VVC Appointment Status after Device Order or VVC Create Date

Consult status	Estimated (percent)	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Patients completed VVC appointment	20,271 (49)	4,208 (9)	16,063 (40)	24,479 (59)	40	20,300
Patients without a completed VVC appointment	20,778 (51)	4,264 (9)	16,514 (41)	25,043 (60)	42	20,800
Total patients with completed video device order consult	**41,049**	**3,468**	**37,581**	**44,517**	**82**	**41,000**

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

Table B.8. Statistical Projections for Patients without a Completed VVC Appointment

Consult status	Estimated (percent)	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Patients without scheduled VVC appointment	10,744 (52)	3,462 (13)	7,282 (39)	14,207 (65)	22	10,700
Patients with VVC scheduled appointment and no completed VVC appointment	10,034 (48)	3,423 (13)	6,610 (35)	13,457 (61)	20	10,000
Total patients without a completed VVC appointment	**20,778**	**4,264**	**16,514**	**25,043**	**42**	**20,800**

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

Table B.9. Statistical Projections for Average Processing Time for Patients with Device Orders

Processing status	Estimated	90% confidence interval			Count from sample	Rounded
		Margin of error	Lower limit	Upper limit		
Average days from consult release date to device order	14.3	4.1	10.2	18.5	82	14

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

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
5-8	Value of about 8,300 devices issued but not used to provide VVC care, and not retrieved as of November 10, 2021*	$6.3 million	$0
5-8	Data plan costs for nearly 11,000 devices issued but not used to provide VVC care as of June 30, 2021**	$78,000	$0
10	Purchase price of 9,720 new devices ordered despite having returned devices pending refurbishment***	$8.1 million	$0
	Total	**$14.5 million**	**$0**

** The OIG calculated the value of this population of devices issued but not used for VVC and not retrieved, by using the actual purchase cost of the device type, including full size and mini Verizon Wireless and T-Mobile iPads. Because these devices were issued but not used to provide VVC care and not retrieved, and VHA can retrieve and then lend these devices to other patients, the OIG identified the value of these devices as a potential better use of funds.*

*** The OIG prorated the annual cost of unlimited cellular plans associated with devices by the number of months beyond the one year of service included in the initial purchase price, resulting in $78,000 in additional data plan expenditures for these devices. Because these devices were issued but not used to provide VVC care and not retrieved, the OIG identified these excess data plan costs as potential better use of funds.*

**** The OIG determined this amount by identifying the total purchase price of devices ordered, as of December 2021, from VHA's device purchase order awarded in August 2021. The number of devices pending refurbishment was being reported weekly to Connected Care during this time.*

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 8, 2022

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

Subj: OIG Draft Report, Review of Digital Divide Consults and Devices for VA Video Connect Appointments (2021-02668-AE-0120) (VIEWS 07641158)

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 Review of Digital Divide Consults and Devices for VA Video Connect Appointments. The Veterans Health Administration (VHA) concurs or concurs in principle with all ten recommendations and provides an action plan in the attachment. The action plan for recommendations nine and ten were developed collaboratively with the Denver Logistics Center, which is under the Veterans Administration's Office of Acquisition, Logistics and Construction.
2. During the review process for this draft report, the OIG recognized the efforts of VHA leaders and staff who worked diligently in stressful conditions throughout the COVID-19 pandemic to manage and safely provide high quality services, monitor vulnerable Veterans at home and help fortify VHA's services against demand surges and staff illnesses. VHA rapidly expanded telehealth care options and continually refined the process as the pandemic continued. As noted, due to the fluidity necessitated by the COVID-19 pandemic, VHA continually updated and refined the standard operating procedure for digital divide consults and telehealth. VHA will continue to work to address changes recommended by the OIG, however, the following should be noted:
    a. As a result of VHA's digital divide efforts, at-home video visits have increased over 3,100% over a 2-year period, Veterans have been provided more than 16 million episodes of telehealth care, over 98,000 digital divide consults have been completed and over 100,000 tablets have been put in the hands of Veterans to increase access to telehealth care.
    b. A peer-reviewed study published in the Journal of the American Medical Association Network Open on April 6, 2022, found that Veterans receiving a VA tablet demonstrated increased use of mental health services via video, increased psychotherapy visits (across all modalities) and reduced suicidal behavior and emergency department visits.[1] VHA looks forward to additional future studies further analyzing the efforts taken to ensure Veterans were able to access care during this most difficult time.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D.

Attachment

[1] Mental Health Service Use, Suicide Behavior, and Emergency Department Visits Among Rural US Veterans Who Received Video-Enabled Tablets During the COVID-19 Pandemic. JAMA Netw Open. 2022 Apr 1;5(4):e226250. doi: 10.1001/jamanetworkopen.2022.6250. https://pubmed.ncbi.nlm.nih.gov/35385088.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Review of Digital Divide Consults and Devices for VA Video Connect Appointments

(OIG 2021-02668-AE-0120)

Recommendation 1. Establish clear oversight roles and responsibilities of the program office and of regional network telehealth and medical facility leads to monitor medical facility social worker and telehealth staff compliance with the "Digital Divide Standard Operation Procedure" for conducting assessments, ordering, and scheduling.

VHA Comments: Concur in principle. VHA agrees with this recommendation in principle and will develop policy that defines roles and responsibilities for overseeing and managing the digital divide consult process. While the Office of Connected Care (OCC) agrees with clarifying policy on the roles and responsibilities for the digital divide consult process, it does not believe scheduling guidance should be included in digital divide procedures, as there is existing VHA policy and guidance on scheduling of appointments.

Status: In progress Target Completion Date: May 2023

Recommendation 2. Develop and implement a mechanism to alert the requesting clinic that a patient has a loaned device and can now be scheduled for a VA Video Connect appointment.

VHA Comments: Concur. OCC is developing an electronic medical record flag (a VA Video Connect button) that will alert staff to Veteran telehealth capabilities, including a Veteran's experience with VA Video Connect and whether they possess a VA loaned tablet. Additionally, OCC will establish responsibilities for staff to alert referring health care professionals that a Veteran's tablet has shipped and an estimated timeframe for completion of device delivery and set-up, providing awareness for clinical teams about when an initial VA Video Connect visit on the device is feasible.

Status: In progress Target Completion Date: May 2023

Recommendation 3. Clarify timeliness goals for the digital divide consult, and video device order placement.

VHA Comments: Concur. OCC will update its digital divide guidance with references to existing VA consult policies. The applicable timeliness standards will apply to the digital divide consult and to the device ordering consult.

Status: In progress Target Completion Date: August 2022

Recommendation 4. Update the digital divide consult training to include procedure updates and ensure social workers and facility telehealth and Remote Order Entry System coordinators who process digital divide consults and video device orders complete the training and take refresher training as needed.

VHA Comments: Concur. OCC will assess existing digital divide and Remote Order Entry System (ROES) training to identify training gaps. OCC will address training gaps through updates to existing training or development of new training for social workers, facility telehealth coordinators and ROES coordinators who process digital divide consults and video device orders.

Status: In progress Target Completion Date: May 2023

Recommendation 5. Implement procedures to require responsible staff to check for duplicate devices before submitting a device order consult.

VHA Comments: Concur. While a procedure to check for duplicate devices before submitting a device order is outlined in the existing standard operating procedure, OCC agrees with clarifying responsibility in policy and adding mitigations that alert ordering staff to potential errors as part of a standard process. The policy responsibilities will include checking for duplicate devices before ordering in ROES and retrieval of duplicate devices sent in error. Additionally, OCC will reinforce the procedures in training content and implement an additional alert or tool to address potential errors before they lead to the shipping of a duplicate device.

Status: In progress Target Completion Date: May 2023

Recommendation 6. Establish an alert in the Remote Order Entry System to notify the responsible staff that a patient already has an issued device before ordering another, and initiate retrieval activities for duplicate devices.

VHA Comments: Concur. VHA agrees with this recommendation. The existing displays in ROES include information that allows an ordering staff member to see that a new device order would result in a duplicate device being issued to a Veteran; however, the system does not actively surface this information to the ordering staff member using an alert. OCC, in collaboration with the Denver Logistics Center, will create an alert in ROES that informs the ordering staff member that a new device order will result in a duplicate device for the Veteran, thereby addressing potential errors before they lead to the shipping of a duplicate device.

To retrieve existing duplicate devices, OCC has been distributing a list of Veterans who have been issued duplicate devices to each VISN weekly, so the duplicate devices can be retrieved from the Veteran or appropriately addressed (for example, identifying a device as lost). While the ROES alert to prevent duplicate device ordering errors is being implemented and policy responsibilities for duplicate device retrieval defined, OCC will implement a centralized, duplicate device retrieval process and track progress on the device dashboard.

Status: In progress Target Completion Date: May 2023

Recommendation 7. Delegate in the "Digital Divide Standard Operating Procedure" facility staff to monitor the tablet dashboard for VA Video Connect appointments activity and device use, and clearly define regional network telehealth leads' oversight responsibilities to ensure facilities initiate retrieval activities when warranted.

VHA Comments: Concur. VHA agrees with this recommendation and recognizes that the rapid growth of the digital divide consult process during the pandemic and the rapid expansion of connected care services in general led to limitations on staff availability to manage connected care functions at many facilities. OCC will identify necessary staff to respond to and assume responsibility for monitoring of the device dashboard which will be outlined in digital divide guidance and policy.

Status: In progress Target Completion Date: June 2023

Recommendation 8. Establish an automated mechanism using the tablet dashboard to routinely identify the devices that meet retrieval priorities and also initiate retrieval of those that already meet retrieval requirements.

VHA Comments: Concur in principle. VHA has trusted Veterans and their treating health care professionals to determine when a VA loaned tablet is needed and when the device is no longer needed. To address this recommendation, OCC will require the clinical team to document the ongoing need for the device intervention in the medical record at least annually. As part of this action, OCC will develop an automated process to prompt health care professionals, within the context of their regular care delivery, to document their clinical decision regarding ongoing tablet need. Depending on the health care professional's assessment and documentation, the device will be renewed or the retrieval process will be initiated. Additionally, OCC will develop an automated report to help inform responsible staff that device retrieval actions are needed.

To retrieve existing devices while clarifying policy on the roles and responsibilities for the digital divide consult processes, OCC will distribute a list of Veterans who have devices that meet reconciliation criteria to each VISN weekly. Each facility will be responsible for utilizing this list to initiate reconciliation efforts, with progress tracked on the device dashboard by OCC.

Status: In progress Target Completion Date: June 2023

Recommendation 9. Augment tracking mechanisms for packages sent to patients to ensure VA receipt of the retrieval kit so that devices are accurately recorded in inventory and available for refurbishment and reissue.

VHA Comments: Concur in principle. VHA agrees with this recommendation in principle. The Denver Logistics Center implemented a new "Check-In" process in August 2021 to track devices returned as part of the reconciliation process. Once a device is returned, its status is updated in ROES and is transmitted daily to the VHA Tablet Dashboard. VHA is currently tracking when devices are shipped, when retrieval kits are sent and when tablets are returned. The addition of the "Check-In" process to the tablet dashboard allows VHA to identify Veterans that have not returned their device following provision of a retrieval kit. OCC will define a process for following-up with Veterans who have been sent a retrieval kit but from whom a tablet has not been returned.

Status: In progress Target Completion Date: May 2023

Recommendation 10. Address restrictions in the refurbishment process, implement accessible and trackable reporting of devices waiting to be refurbished, and implement a structured purchasing model to guide new device purchases and maintain an appropriate inventory level.

VHA Comments: Concur. VHA agrees with this recommendation and will work collaboratively with the Denver Logistics Center to identify and remedy barriers to device refurbishment. Additionally, OCC will establish an inventory target for devices to help guide the timing of orders. OCC will also develop a visual display to track and trend key device data necessary for making informed decisions on device acquisitions (such as, issued devices, ordering trends/demand, devices pending refurbishment, devices ready to be shipped and devices on order). This data will be captured and documented as part of device ordering decisions to serve as a justification for each order.

Status: In progress Target Completion Date: May 2023

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

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Daniel Morris, Director Clark Beecken Josh Belew Glenn Dawkins Christy Donahue Andrea Sandoval
Other Contributors	Victor Rhee Clifford Stoddard Allison Tarmann Yongling Tu

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Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
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