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VETERANS HEALTH ADMINISTRATION

Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight

Review | **24-01143-44** | **March 19, 2025**

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Executive Summary

Under the MISSION Act of 2018, veterans are eligible to receive community care under certain circumstances, such as when their local VA medical facility does not provide the requested service or when a provider determines community care is in their best medical interest.[1] Consideration is also given to wait times for appointments and the time veterans spend driving to appointments.[2]

In October 2020, the Veterans Health Administration's (VHA) Office of Integrated Veteran Care (IVC) began implementing the Veteran Self-Scheduling (VSS) process at VA medical facilities for community care consults. This process allows eligible veterans to schedule their appointments directly with community providers once they receive an authorization for a community care provider and an approved consult. An authorization is approval from VA for a veteran to receive care from a community provider. A consult is a request for clinical services made on behalf of a patient.[3] If a veteran is eligible for community care, chooses to receive care in the community, and has a basic level of care coordination, VHA staff may ask a veteran whether they would like to schedule their own appointment through VSS. If the veteran chooses self-scheduling and opts in, VHA staff collect the veteran's additional scheduling preferences, such as which community providers the veteran wants to see, and then informs the veteran they will receive a letter about scheduling their own appointment—with instructions on how to notify VHA staff of their appointment details.

Many facilities implemented the VSS process in October 2020, but staff were not required to offer the scheduling option until September 2023.[4] IVC is responsible for overseeing the VSS process. The VA Office of Inspector General (OIG) conducted this review to determine whether IVC had adequate controls in place and provided effective oversight of the VSS process.

[1] Veterans may be eligible for community care in locations such as Alaska and Hawaii because VA does not have any full-service medical facilities in those states.

[2] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

[3] According to VHA Directive 1232, *Consult Processes and Procedures* (issued August 24, 2016, and amended December 5, 2022), a consult is a request for clinical services on behalf of a patient from a physician or provider (sender) seeking an opinion, advice, or expertise regarding the evaluation or management of a specific problem that is answered by another physician or other healthcare provider (receiver). VHA Directive 1232 was republished on November 22, 2024, but this requirement did not change.

[4] As of September 29, 2023, VHA required all VA medical facilities to implement the VSS process in at least one category of care. The recommended categories of care are physical therapy, occupational therapy, chiropractic, optometry, audiology, primary care, acupuncture, massage, and podiatry. VSS has been available as an option for facilities to use since October 2020.

What the Review Found

The OIG found that IVC needs to improve its oversight of the VSS process to strengthen support and mitigate the risk of potential misuse of the scheduling option. First, IVC did not adequately support facilities to use and monitor VSS before requiring them to implement it in September 2023, nearly three years after IVC initially encouraged facilities to offer VSS to veterans. Second, neither IVC nor facility leaders implemented controls to identify the potential misuse of VSS. For example, staff at the four facilities the team visited processed VSS consults inappropriately by selecting the VSS option for veterans without their permission.[5]

Staff also opted veterans into VSS with urgent and complex consults, despite veterans with urgent care coordination needs not being eligible for the VSS process. In addition, clinical staff are required to initiate contact with veterans with complex consults before opting them into VSS, a step the review team found was not generally completed at the facilities they visited.[6] Third, neither IVC nor facility leaders provided effective oversight of VSS. Without better oversight, inappropriate use of the VSS option may go undetected, and veterans may experience delays in care. These findings were based on interviews, site visits, documentation reviews, and examination of VA guidance. Details on the review's scope and methodology are in appendix A.

IVC Did Not Effectively Support Facilities as They Implemented VSS

IVC developed some VSS training materials, but it did not require facility staff to take this training before implementing the new scheduling process.[7] Facility leaders and staff from the four facilities the review team visited confirmed they did not take any formal training on the VSS process. Furthermore, some facility leaders and staff said IVC never reached out to them to

[5] The four facilities the team visited or conducted a virtual site visit at were sites with high use of VSS: the Clement J. Zablocki Veterans' Administration Medical Center facility in Milwaukee, Wisconsin; the Oklahoma City VA Medical Facility in Oklahoma City, Oklahoma; the Spark M. Matsunaga Department of Veterans Affairs Medical Center in Honolulu, Hawaii; and the W.G. Hefner Salisbury Department of Veterans Affairs Medical Center in Salisbury, North Carolina. Additionally, the team interviewed community care leaders from four other facilities that the OIG considered mid- or low-VSS usage to learn about their process for implementing VSS or their hesitation to use the new scheduling option. The team did not fully evaluate the VSS process at these four lower-use facilities.

[6] Office of Community Care Field Guidebook, § 3.16.

[7] According to VHA Directive 1217, *VHA Operating Units*, September 10, 2021, section 5 "Responsibilities," subsection c "VHA Program Office," IVCs internal program office is required to develop training and set standards for education. This directive was updated on August 14, 2024, to share this responsibility with Veterans Integrated Service Network (VISN) directors and medical facility directors.

identify the potential benefits and disadvantages of the VSS process.[8] Facility staff also said IVC did not provide them with best practices for processing or overseeing VSS consults. Had IVC staff reached out to facilities that had a high percentage of VSS consults, they may have learned of the challenges and confusion staff experienced.

Controls of the VSS Process Were Ineffective

IVC was not able to provide evidence that it established controls to ensure facility staff were processing VSS consults consistently or appropriately.[9] Facility leaders and staff from all four sites the review team visited said IVC had never contacted them with any questions or concerns related to their use of the VSS process. IVC also did not require facilities to evaluate VSS consults to ensure they were being processed appropriately.

The team determined staff from some of the facilities used VSS inappropriately when processing VSS consults. First, staff reported to the team that they opted veterans into VSS without their permission. This practice does not align with IVC's field guidebook, which says "VSS begins once a Veteran indicates they would like to schedule their appointment directly with the community provider."[10] Facility staff should ask veterans whether they would like to schedule their own appointments, giving veterans the choice to opt in. If veterans are opted in without their knowledge, they may not reach out to community providers for scheduling. This increases the risk that a veteran's care is delayed or that VHA staff could cancel their consults when no scheduling efforts have been made.

The team also determined that staff opted veterans who had urgent and complex consults into the VSS process.[11] For example, the team found that about 6,800 of the 49,000 VSS consults at the Salisbury facility were urgent or complex (about 14 percent). Opting veterans who have urgent and complex consults into VSS presents a significant risk. Veterans who need immediate care

[8] VHA Directive 1217 requires IVC's program offices to identify and address issues identified by local offices, oversee consistent implementation, and identify risks and unintended variances; requires the program offices to document all identified deficiencies and ensure corrective actions are taken; and requires the program offices to adopt evidence-based strategies based on population needs. The August 2024 update to the directive ensured VISN and medical facility directors are responsible for overseeing consistent implementation, identifying risks and unintended variances, and adopting evidence-based strategies. The updated directive also holds VISN directors responsible for documenting identified deficiencies.

[9] According to VHA Directive 1217, IVC is required to set quality measures, performance measures, and key indicators for performance and risk. The directive also requires IVC to ensure performance within its span of control and promote a culture of integrity within a high-reliability organization. The August 2024 update ensured VISN and medical facility directors are responsible for completing these actions.

[10] Office of Community Care Field Guidebook, § 3.16.

[11] Office of Community Care Field Guidebook, § 3.16. IVC's field guidebook says, "urgent level of care coordination Veterans should not self-schedule their appointment" and "for complex level of care coordination, contact the Veteran to provide the needed care coordination." VHA clinical staff use triage tools to determine a veteran's level of care coordination.

and have difficulty coordinating their care may experience delays in care, which could result in adverse outcomes.

According to IVC's field guidebook, VSS consults will be excluded from the scheduling timeliness metric, a standard that requires appointments to be scheduled within seven days from the file entry date. The VSS process could naturally help facilities decrease their consult backlogs and improve how quickly staff can schedule non-VSS consults with community providers. However, the exclusion provided an opportunity for facilities to use VSS inappropriately by automatically opting veterans into VSS without their knowledge to reduce backlogs of unscheduled consults and improve scheduling timeliness metrics. Opting veterans in this way was an action that one community care leader from a facility the team visited admitted to doing. In these instances, veterans may experience delays in care, or their consults may be canceled when they fail to schedule their own appointments. Facility staff can realize the benefits of using the VSS process—but not at the expense of a veteran's choice of whether to schedule their own appointment.

VSS Implementation and Use Lacked Proper Oversight

During a May 2024 meeting with the review team, an IVC leader said that facilities are expected to conduct their own reviews to identify potential problems they might have with VSS consults. However, IVC could not provide the review team with guidance that facilities must follow to ensure VSS consults are being processed correctly and to identify potential inappropriate uses of the scheduling process.

None of the facility leaders from the sites the team visited could provide evidence to show they conducted reviews of VSS consults to identify potential issues. In fact, leaders from all four facilities told the review team they appreciated the OIG's review because it helped them identify problems and improve processes. Until IVC and facility leaders improve their oversight and establish effective controls for the VSS process, attempts to use the VSS process inappropriately will continue to go unnoticed. As a result, veterans' care could be delayed, potentially causing adverse outcomes.

According to one internal IVC document, IVC's intent behind requiring staff to implement the VSS process was to (1) improve the quality and timeliness of care; (2) improve veteran satisfaction; and (3) improve collaboration, education, and engagement among IVC leaders, VA medical facility staff, and community providers. Although IVC did not take steps to measure the success of VSS based on the second and third goals, IVC staff reviewed scheduling metrics to determine whether VSS improved scheduling timeliness, which is part of IVC's first VSS goal. However, IVC could not effectively assess how long it took for VSS consults to be scheduled because facility staff encountered process and system limitations that generally prevented them from being able to accurately record the date an appointment was scheduled. For example, if a veteran scheduled an appointment on March 1 but did not notify facility staff until March 15,

then VHA's system of record would show the veteran scheduled the appointment on March 15—which is 14 days later than the appointment was actually scheduled. Facility staff told the review team there is no way to backdate a scheduled date to accurately reflect the date an appointment was scheduled. The inability to record the actual date veterans schedule appointments is a technical limitation of VSS that prevents IVC from evaluating both the time it takes for consults to be scheduled and the very data point the system was designed to improve.

In July 2024, IVC canceled its requirement for facilities to offer the VSS option shortly after the OIG briefed IVC leaders on its preliminary findings and because staff did not have access to accurate lists of community providers who were accepting VA patients. But IVC leaders said facilities still had the option to implement VSS—meaning it is still important for IVC leaders to take steps to address the deficiencies identified in this report.

What the OIG Recommended

VHA needs to ensure that IVC, in coordination with VHA's chief operating officer and the Veterans Integrated Service Networks, take appropriate steps to better assist VA medical facilities with implementing the VSS process, improve controls over VSS to ensure the scheduling process is being used appropriately, and improve oversight of the process to make sure it is working as intended. The OIG recommended IVC evaluate and improve its VSS training program, ensure VSS guidance is clear and consistent, establish a mechanism to track and address VSS-related challenges, and develop best practices and lessons learned from the VSS process. The OIG also recommended IVC develop controls to ensure staff have the tools in place to identify potential misuse of the VSS process, direct facilities to conduct their own reviews of the VSS process and develop a plan to accurately assess whether the VSS process is working as intended.

VA Management Comments and OIG Response

The acting under secretary for health concurred with all eight recommendations.[12] VHA provided action plans for all recommendations. The OIG found the action plans acceptable and will monitor progress and close each recommendation when adequate documentation demonstrates sufficient implementation steps have been taken. See appendix B for the full responses from the acting under secretary.

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[12] 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.

Contents

Abbreviations

FY	fiscal year
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSS	Veteran Self-Scheduling

Introduction

The Veterans Health Administration (VHA) provides care to over nine million veterans enrolled in VA's healthcare system. Although VA's medical centers and clinics offer a wide range of services, veterans who meet specific eligibility criteria—such as wait-time or drive-time standards—might instead choose to receive care from a community care provider. VHA's Office of Integrated Veteran Care (IVC) is responsible for overseeing veterans' access to VA and community care.[13] In October 2020, IVC implemented the Veteran Self-Scheduling (VSS) process for community care consults, a way for veterans who are eligible to receive community care to schedule their appointments directly with community providers.[14] Through this process, IVC aimed to expedite scheduling appointments for veterans who seek care outside VA by enabling them to make their own appointments.[15] The VA Office of Inspector General (OIG) conducted this review to determine whether VHA had adequate controls in place and provided effective oversight of the VSS process.

Community Care Eligibility

Under the MISSION Act and related VA regulations, veterans are eligible to receive community care in multiple circumstances, including the following:[16]

- A veteran's local VA medical facility does not provide the requested services.
- A veteran lives in a US state or territory without a full-service VA medical facility.
- The service line at the local VA medical facility does not meet specific quality standards.
- A veteran's referring provider, with agreement from the veteran, determines community care is in the veteran's best medical interest.
- A veteran must drive at least 30 minutes for primary care, mental health care, or noninstitutional services or 60 minutes for specialty care to get to a VA medical facility.

[13] "About Us," VHA IVC's internal web page, accessed December 20, 2023.

[14] Memorandum from Assistant Under Secretary for Health Operations on Community Care Scheduling Enhancements, October 28, 2020, accessed October 10, 2023.

[15] Memorandum from Acting Assistant Under Secretary for Health for Integrated Veteran Care on Community Care Veteran Self Scheduling Enhancements, appendix A "Office of Integrated Veteran Care (IVC) Summary of Veteran Self Scheduling (VSS) Enhancements and Process Dependencies," September 6, 2023, accessed October 10, 2023.

[16] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019, accessed August 2, 2023.

- A veteran's wait time for an appointment at a local VA medical facility or clinic is more than 20 days for primary care, mental health care, or noninstitutional services or 28 days for specialty care.

Veteran Self-Scheduling Process Implementation

The following sections outline the initially proposed phases and details of VSS process implementation, which began in October 2020. Through the VSS process, veterans can schedule their appointments directly with community providers after these providers receive an authorization and an approved consult, also known as a request for clinical services on behalf of a patient.[17] An authorization is the approval from VA for a veteran to receive care from a community provider.

October 2020: IVC Introduced the VSS Process for Optional Use

In October 2020, IVC leaders sent a memo to VA medical facilities encouraging VHA staff to implement the VSS process, and many facilities did so.[18] IVC allowed facilities to implement the VSS process for all categories of care (for example, cardiology, neurology, and chiropractic care) for veterans who meet the eligibility requirements for VSS.

The memo did not yet require facilities to offer the new self-scheduling option to veterans, and therefore, usage varied among facilities. In fiscal year (FY) 2023, 82 facilities had fewer than 1,000 VSS consults, 44 facilities had between 1,000 and 30,000 VSS consults, and eight facilities had over 30,000 VSS consults. Table 1 shows the eight facilities that had the most consults that were created using the VSS process.

Table 1. VHA Facilities with the Highest Number of VSS Consults in FY 2023

Facility location	Number of consults created using VSS	Total community care consults	Percentage of consults created using VSS
Honolulu, HI	90,694	99,519	91%
Fort Harrison, MT	75,070	92,686	81%
Salisbury, NC	49,392	69,910	71%
Milwaukee, WI	40,794	44,749	91%

[17] VHA Directive 1232(5), *Consult Processes and Procedures*, amended December 5, 2022. According to the directive, VHA providers use consults as the mechanism to request care for or seek an opinion, advice, or expertise regarding evaluation or management of a specific problem that is answered by another physician or other healthcare provider (receiver). VHA Directive 1232 was republished on November 22, 2024, but this requirement did not change.

[18] Office of Integrated Veteran Care, "The Community Care Scheduling Enhancements," memorandum to VA medical facilities, October 28, 2020.

Facility location	Number of consults created using VSS	Total community care consults	Percentage of consults created using VSS
Oklahoma City, OK	35,231	43,015	82%
Aurora, CO	35,134	87,378	40%
Richmond, VA	34,176	53,968	63%
Tomah, WI	30,560	36,224	84%

Source: OIG analysis of VHA's Corporate Data Warehouse, September 2023.

September 2023: IVC Required Facilities to Offer the VSS Option

As of September 29, 2023, IVC required VA medical facilities to offer the VSS option for at least one category of care.[19] According to an internal IVC document, the intent behind this requirement was to (1) improve the quality and timeliness of care; (2) improve veteran satisfaction; and (3) improve collaboration, education, and engagement among IVC leaders, VA medical facility staff, and community providers. Although IVC recommended categories of care for implementation, it did not limit VSS to these categories and allowed facilities to continue offering the option to veterans for all categories of care.

IVC also required medical facilities to implement the VSS process in phases to allow time for IVC to train relevant VA medical facility staff and for facilities to improve the process as they encountered difficulties related to the new scheduling process.[20] The bullets below depict IVC's original phased approach to implementing VSS.

- **Phase 1 (Implemented on September 29, 2023).** All facilities must implement the VSS process in at least one category of care. Facilities can implement VSS in as many categories of care as they would like.
- **Phase 2 (Implementation planned for December 31, 2023).** All facilities must implement the VSS process in four additional categories of care. At least three of the categories must be from IVC's recommended list: physical therapy, occupational therapy, chiropractic, optometry, audiology, primary care, acupuncture, massage, and podiatry.
- **Phase 3 (Implementation planned for March 29, 2024).** All facilities must implement the VSS process for the categories of care shown in phase 2. In addition,

[19] The recommended categories of care are physical therapy, occupational therapy, chiropractic, optometry, audiology, primary care, acupuncture, massage, and podiatry.

[20] On September 6, 2023, the acting assistant under secretary for health for IVC sent a memo to all Veterans Integrated Service Network (VISN) directors requiring that facilities implement the VSS process in compliance with phase 1 by September 29, 2023. An internal IVC web page details the requirements of phase 2 and phase 3.

facilities are allowed to implement the VSS process for categories of care not on the recommended list.

Before phase 2 could be implemented, in December 2023, an IVC leader informed the review team that IVC decided to pause the requirement for facilities to implement VSS. IVC leaders explained that IVC's Community Provider Locator, the resource that was designed to help facility staff identify community providers who are accepting VA patients, needed further work to improve accuracy. During this pause, IVC allowed facilities to use VSS but eliminated the requirement.

July 2024: Facilities No Longer Required to Offer VSS

In July 2024, IVC canceled its requirement for facilities to offer the VSS option after the OIG briefed IVC leaders on its preliminary findings, as detailed in this report, and because staff did not have access to accurate lists of community providers who were accepting VA patients. While IVC decided to eliminate its requirement to implement the VSS process, it still allows facilities to use the process on an optional basis. An IVC leader said IVC plans to replace the Community Provider Locator tool with External Provider Scheduling software to resolve the issue with inaccurate provider information. IVC is piloting the new software and could not give the review team an estimated date when this action would be completed. In the interim, facilities can continue to offer VSS as an option. Accordingly, it is important that IVC resolves the deficiencies identified in this report to better support and oversee facilities that choose to implement the process.

Veteran Self-Scheduling Process

At many VHA facilities, the VSS process begins when a member of the Referral Coordination Team, which consists of nurses and schedulers, determines whether a veteran is eligible for community care and the level of care needed.[21] To determine eligibility, VHA Directive 1110 says patients should be grouped into three categories—basic, moderate, and complex—based on the level of care necessary.[22] For a basic level of care, case managers collect information and create consults, while moderate and complex levels of care involve the coordination of more activities.

[21] According to VHA Directive 1110.04 (1), *Integrated Case Management Standards of Practice*, amended May 18, 2020, patients are arranged into categorical groups based on specified criteria, such as acuity, risk, and intensity.

[22] VHA Directive 1110.04. According to this directive, a "basic level of care includes system navigation, information, and referral." A "moderate level of care includes basic care coordination, plus disease management and prevention, health promotion and education, and resource management." A "complex … level of care includes moderate care coordination, plus biopsychosocial rehabilitation, which emphasizes coaching/mentoring and counseling/treatment aspects of the patient/clinician relationship."

If a Referral Coordination Team member determines a veteran has a basic level of care coordination and is eligible for community care, that team member will discuss care options with the veteran within VA or in the community. If the veteran chooses to receive care in the community, then the Referral Coordination Team member will ask the veteran whether they would like to schedule their own appointment by opting into VSS.[23] If the veteran opts in, the Referral Coordination Team member identifies available community providers, captures the veteran's additional community provider preferences, and discusses care options with the veteran. The team member will also ask the veteran how they would like to receive information and status updates on their consult (such as through text, email, or mail) and lets the veteran know they will receive a letter with details about the VSS process. The team member also forwards the veteran's consult to the medical facility's community care department for further processing.

Beginning in 2019, the Referral Coordination Initiative shifted responsibility for handling specialty care consults from patients' healthcare providers to facility-based referral coordination teams. Not all medical facilities have fully implemented the Referral Coordination Initiative, however. In the facilities that have not implemented the initiative, staff in the community care department complete some of the actions the Referral Coordination Team would. These can include verifying a veteran's eligibility when the consult is sent to the community care department, using a screening/triage tool to determine whether a veteran has a basic level of case complexity that qualifies them for VSS, and contacting veterans to discuss their options for getting care in the community. Community care staff then focus on identifying providers in the community who can meet the veteran's needs and ask the veteran whether they would like to schedule their own appointment by opting into VSS.

For veterans whose care coordination is basic and who opt into the VSS process, the next steps are completed by the community care staff, whether the veteran opted in through the Referral Coordination Team or through the community care staff. In particular:

- Community care staff contact the veteran to confirm provider preferences.
- Within one business day of receiving the consult, staff send a letter to the veteran about how to self-schedule and document in the Consult Toolbox that the veteran will self-schedule.[24] The veteran is asked to schedule their appointment within

[23] Veterans with moderate and complex care coordination needs are not eligible for VSS. If a Referral Coordination Team member determines a veteran is not eligible for community care, then the member will schedule the veteran for care within VA.

[24] The self-scheduling letter gives veterans the contact information for their preferred community care providers and instructs them to contact their local facility's community care office with the date and time of the community appointment.

seven days from the date the letter is sent and to contact the community care department to notify VA staff of the appointment details.

- After contacting the veteran, staff send a package with the documentation required for a consult to the community provider the veteran chose to see.
- If the veteran has not communicated with community care staff to tell them that they scheduled an appointment, staff follow up with the veteran within seven business days of sending the self-scheduling letter to determine whether the veteran has scheduled the appointment and, if so, to confirm the appointment date. If the veteran has not scheduled the appointment, staff may ask the veteran whether they need more time to schedule the appointment or whether they no longer need the care. If the veteran did make the appointment, the process of contacting the veteran to confirm an appointment ends.
- Within 14 business days of sending the letter, staff follow up with the veteran again to find out whether the veteran scheduled the appointment and to obtain appointment details. After three failed contact attempts, or if the veteran says they have not scheduled the appointment, staff notify the veteran that their consult will be canceled if they do not schedule an appointment within the next seven business days.
- Staff may cancel the consult after 21 business days from the time the letter was sent if the appointment has not been scheduled.[25]
- After the scheduled appointment with the community care provider, staff follow up with the veteran to ensure they attended their appointment and request medical records as needed.

Throughout the VSS process, veterans may ask facility staff to schedule their appointment if they decide they need assistance. However, there are no formal process steps for facility staff to ask the veteran if they want to opt out of VSS once the veteran agrees to self-schedule.

IVC Responsibilities and Oversight of VSS

IVC is the office responsible for oversight of the VSS pursuant to VHA Directive 1217. As a principal office, IVC is responsible for setting strategy for national programs and operations and delegating appropriate authority to their program offices. IVC's program offices are responsible for setting quality measures, performance measures, key indicators for performance and risk, and

[25] According to VHAs Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure, July 28, 2022, a low-risk appointment request may be canceled after one appointment cancellation or no-show and a non–mental health and non–low-risk appointment can be canceled after the second cancellation or no-show without contacting the veteran.

ultimately ensuring medical facilities use VSS appropriately.[26] However, IVC relied on staff at individual facilities to implement VSS and did not develop VSS-specific roles and responsibilities for Veterans Integrated Service Networks (VISNs) to follow when overseeing VSS implementation across facilities.[27]

An internal IVC document says IVC planned to monitor timeliness metrics on a quarterly basis for all categories of care where VSS had been implemented.[28] However, IVC's field guidebook said VSS consults would be excluded from the scheduling timeliness metric (within seven days from the file entry date). An IVC leader confirmed IVC did not conduct any assessments or establish controls to ensure VSS consults were processed appropriately and monitored for timeliness as planned.

[26] VHA Directive 1217, *VHA Operating Units*, September 10, 2021, § 5 "Responsibilities," subsection c "VHA Program Office." This directive requires IVC's program offices to identify and address issues identified by local offices, oversee consistent implementation, and identify risks and unintended variances; requires the program offices to document all identified deficiencies and ensure corrective actions are taken; and requires the program offices to adopt evidence-based strategies based on population needs. This directive was updated on August 14, 2024. The August 2024 update ensured VISN and medical facility directors are responsible for overseeing consistent implementation, identifying risks and unintended variances, and adopting evidence-based strategies. The updated directive also holds VISN directors responsible for documenting identified deficiencies.

[27] VHA divides the United States into 18 regional networks, known as VISNs, which are regional systems of care working together to meet local health care needs and provide greater access to care.

[28] Community Care Veteran Self-Scheduling, Enhancement Implementation Timeline, October 1, 2023.

Results and Recommendations

Finding: IVC Should Provide More Support to Facilities, Develop Better Controls, and Improve Oversight of the VSS Process

The review team determined IVC did not adequately support facilities as they started to use the VSS process before requiring them to implement the new scheduling option in September 2023. Facility leaders and staff reported to the review team that they had not received effective training and that guidance on VSS was conflicting. In addition, IVC did not provide facilities with best practices or examples of how to successfully implement the new scheduling option.

Further, neither IVC nor facility leaders implemented controls to identify the potential misuse of the VSS process. The OIG found that staff at the four facilities the team visited processed VSS consults inappropriately by opting veterans into VSS without their permission. They also allowed veterans with urgent and complex consults to schedule their own appointments when, in fact, veterans with urgent consults were not eligible to use the VSS process and clinical staff are required to contact veterans with complex consults before opting them into VSS, a step the review team found was not generally completed at the facilities they visited. For example, staff at some facilities told the review team they were using VSS primarily to reduce their consult backlogs and improve their scheduling timeliness—even though IVC implemented the VSS option to allow veterans to schedule their own appointments directly with community providers.

Although using the VSS process could improve appointment-scheduling metrics, IVC could not effectively evaluate whether the VSS process was meeting its goal of improving scheduling timeliness because the process and system generally prevented staff from recording the exact date a veteran scheduled an appointment. In July 2024, IVC canceled its requirement for facilities to offer the VSS option after the OIG briefed IVC leaders on its preliminary findings for this review and because staff only had access to inaccurate lists of community providers who were accepting VA patients. An IVC leader explained that facilities can still use VSS as an option. But without better oversight, facilities' attempts to use VSS inappropriately may go undetected and veterans may experience delays in care.

The following determinations support the OIG's finding:

- IVC did not effectively support facilities as they implemented VSS.
- IVC should develop better controls.
- Neither IVC staff nor facility leaders provided effective oversight of the VSS process.

What the OIG Did

The review team conducted over 60 interviews with leaders and staff from VHA's IVC and from eight VA medical facilities. The team conducted in-person site visits at three VA healthcare systems: Clement J. Zablocki Veterans' Administration Medical Center (Milwaukee, Wisconsin), Oklahoma City VA Medical Facility (Oklahoma City, Oklahoma), and the Spark M. Matsunaga Department of Veterans Affairs Medical Center (Honolulu, Hawaii).[29] The team also conducted a virtual site visit with the W.G. Hefner Salisbury Department of Veterans Affairs Medical Center (Salisbury, North Carolina). All four facilities were heavy users of VSS.

Additionally, the team interviewed community care leaders from the Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center (Philadelphia, Pennsylvania), Tuscaloosa Veterans Affairs Medical Center (Tuscaloosa, Alabama), Manchester Veterans Affairs Medical Center (Manchester, New Hampshire), and the VA El Paso Healthcare System (El Paso, Texas). The OIG considered these four facilities to have mid- or low-VSS usage. The team met with leaders from these facilities to learn about their process for implementing VSS or their hesitation to use the new scheduling option. The team did not fully evaluate the VSS process at these four additional facilities, such as determining whether staff at these four facilities used the VSS process appropriately. Appendix A provides additional information about the team's scope and methodology.

IVC Did Not Effectively Support Facilities as They Implemented VSS

Facility leaders and staff from the four facilities the review team visited told the team that IVC did not require training on the VSS process to be completed by relevant facility staff, update its field guidebook to be consistent with other guidance, or obtain feedback and share best practices for implementing and managing the new scheduling process.

Facility Staff Were Not Required to Complete Training on the VSS Process Before Implementation

According to VHA Directive 1217, IVC is required to develop training and set standards for education.[30] While IVC did develop some VSS training materials before it announced the VSS process to facilities, it did not require facility staff to take this training before implementing the new scheduling process. Based on site-visit interviews, the review team determined 15 of 26 community care employees the team spoke with did not take the training on the VSS process before their facilities started offering the scheduling option (58 percent). The following are examples to show how facility staff had a lack of formal training on the VSS process before they

[29] Veterans may be eligible for community care in locations such as Alaska and Hawaii because VA does not have any full-service medical facilities in those states.

[30] VHA Directive 1217, September 10, 2021. This requirement did not change in the August 14, 2024, version.

implemented it, which may have contributed to the facilities' inappropriate processing of consults.[31]

- **Milwaukee.** The community care chief said IVC staff did not provide VSS training materials to her facility until June 2023—nearly three years after the facility started offering the VSS option to its patients. Although the facility received these materials in June 2023, when the team interviewed the facility's community care nurse manager in January 2024, she said she never received any VSS training from IVC and noted that training on VSS would be helpful. The other four community care employees the team spoke with said they received only on-the-job training from their colleagues and not formal training.
- **Oklahoma City.** The community care chief said IVC did not provide training materials on the VSS until June 2023. However, none of the employees that the team spoke with at this facility said they received VSS training from IVC or training based on any materials prepared by IVC. Instead, the chief said her facility started using VSS after the Cheyenne, Wyoming, VA medical center (a facility in the same VISN) gave her facility a presentation on how it had implemented VSS. The facility's community care nurse manager confirmed the facility received training from the VISN but said the training was based on how Cheyenne was using VSS. The review team did not evaluate whether the Cheyenne facility provided adequate training to the Oklahoma City facility.
- **Honolulu.** The facility started using the VSS process when it was first available, in 2020. The community care chief said IVC trained his facility on VSS in 2023, just before IVC required facilities to offer the VSS option in at least one category of care. While leaders at this facility said they initially trained their staff on the VSS process before IVC developed its own training, the community care chief acknowledged discrepancies within IVC's field guidebook and said he did not notify IVC or the VISN of these discrepancies.

IVC Did Not Fully Update Its Field Guidebook

Based on information gathered from interviews and their own assessment, the review team determined IVC did not fully update its field guidebook upon requiring the enhanced VSS process in 2023. The field guidebook directs facilities to follow up with veterans 30 days after self-scheduling preferences have been captured to obtain the veterans' appointment details. However, the VSS internal SharePoint site—for which a link is provided in the VSS mandatory implementation memorandum—instructs staff to follow up with veterans every seven days to

[31] The inappropriate processing of consults is discussed in further detail in the report section titled "IVC Should Develop Better Controls."

obtain appointment details. According to an IVC leader, this field guidebook does not align with IVC's seven-days-to-schedule metric. Having different deadlines presents a risk that facilities may interpret the rules of the process differently, making it difficult to hold facilities accountable for meeting the requirements or identifying those facilities that need assistance. During a May 2024 meeting with the review team, an IVC leader said the office is updating its field guidebook and would include the most recent guidance about the VSS process in the document. The leaders could not provide an estimate for when those updates would be completed.

As the office responsible for implementing the VSS process, IVC could do more to ensure relevant facility staff have the knowledge to use the VSS process appropriately. IVC should evaluate whether its VSS training is effective, make improvements as needed, hold facilities' leaders accountable for ensuring staff complete VSS-specific training courses to prepare them to manage the VSS process appropriately, and then ensure staff are processing VSS consults appropriately.

IVC Did Not Obtain Feedback and Share Best Practices on the VSS Process

VHA Directive 1217 requires IVC to identify and address issues identified by local offices, oversee consistent implementation, and identify risks and unintended variances. The directive also requires IVC to document all identified deficiencies and ensure corrective actions are taken. However, facility leaders and staff from the four facilities the review team visited said that IVC never reached out to them to identify the potential benefits and disadvantages of the VSS process. In addition, an IVC leader acknowledged IVC did not provide facilities with any best practices for overseeing or processing VSS consults, something facility staff said would have been helpful.

VHA Directive 1217 also requires IVC to adopt evidence-based strategies based on population needs. Had IVC reached out to facilities that had a high percentage of VSS consults, IVC staff may have learned of the challenges and confusion that staff experienced and relayed to the review team. Initiating communication with facilities could help IVC identify potential best practices and strategies to share with everyone.

After visiting sites with a high percentage of VSS consults, the review team spoke with facility leaders and staff from the Philadelphia VA Medical Center and the Tuscaloosa VA Medical Center, two facilities that had a low percentage of VSS consults. At the Philadelphia facility, the associate chief nurse for community care said very few veterans want to schedule their own appointments, the VSS process requires a significant amount of follow-up with veterans to ensure they scheduled their appointments, and she did not feel her facility had enough staff to support the process. The community care chief at the Tuscaloosa facility had similar feedback, saying that most veterans are not interested in VSS as it is easier for them when facility staff

schedule their appointments. IVC should reach out to those facilities that had a low percentage of VSS consults to learn why they hesitated to use the option.

IVC Should Develop Better Controls

The team determined that staff from the four heavy-use facilities they visited used the VSS process inappropriately. Such improper use consisted primarily of opting veterans in for self-scheduling without getting their permission, including those who had urgent and complex consults. In some cases, facilities used VSS to decrease backlogs and improve scheduling metrics for non-VSS consults. Staff should opt veterans in for self-scheduling only when veterans say they prefer to schedule their own appointments.

Facilities Opted Veterans into VSS Without Their Permission

IVC's field guidebook says, "VSS begins once a Veteran indicates they would like to schedule their appointment directly with the community provider."[32] Staff should ask veterans whether they would like to schedule their own appointments—giving them the choice to opt in. The guidance is underscored by the Consult Toolbox, which directs VSS is "only applicable for Veterans that are truly self-scheduling."

Instead of giving veterans a choice, community care staff at the four facilities the team visited reported to the team that they generally opted veterans into VSS without their permission. Community care staff are responsible for determining a veteran's eligibility to schedule their own appointment and then discussing that process with the veteran, even if other VA staff speak with the veteran before transferring their consult to the community care department. The following examples highlight the inaccurate processes staff followed when opting veterans in.

- **Milwaukee.** During the review team's site visit to this facility, the team learned that the community care triage nurses were almost always selecting the VSS option without asking patients whether they wanted to schedule their own appointments. These nurses told the review team they did not generally speak with any patients, and they also believed this was the correct process. During the visit, and after the team told a VISN leader about the findings that the facility was indiscriminately opting veterans into VSS, the facility's community care leaders agreed with this finding and said they were designing training to make sure staff ask veterans whether they want to schedule their own appointments before opting them in.
- **Oklahoma City.** The review team learned that medical support assistants at this facility were almost always selecting the VSS option without asking the patient whether they wanted to schedule their own appointment and they did not let the

[32] Office of Community Care Field Guidebook, § 3.16.

patients know the facility could schedule their appointments if they preferred that option. Instead, they said they contacted the patients to let them know they would receive a letter to schedule their own appointments. They believed this was the correct process.

- **Honolulu.** During the site visit to this facility, the review team learned that one former community care leader told staff to select eligible community providers who were listed as accepting veterans, opt the veterans into VSS, and send letters to them that included providers' contact information. Staff completed these steps without speaking to the veterans. The facility's new community care leaders said they did not change how staff used the VSS process until they recently discovered that staff were not following the correct process, which the review team determined came after years of relying on facility staff to train their colleagues on an inaccurate process. The review team determined this facility's percentage of VSS consults decreased significantly after the team notified the facility that it had been chosen for a site visit.

Indiscriminately opting veterans into the VSS option presents the risk that veterans' care may be delayed or not provided at all. If veterans are unaware they were opted into VSS, they may not try to contact a community provider to schedule their appointments, may have difficulties identifying appropriate providers who are accepting patients, and may not know to follow up with VHA staff for help scheduling their appointments. Ultimately, staff may cancel a consult if they do not receive a confirmed appointment date within the 21-day requirement.

IVC staff recognized the risks of opting veterans into the process without permission. During a May 2024 meeting with the review team, an IVC leader voiced the concern to the review team that veterans were being opted into VSS without their permission and without proper notification that they needed to schedule their own appointments. The IVC leader acknowledged this could have led to some consults being canceled.

Facilities Opted Veterans into VSS Who Had Urgent and Complex Consults

IVC's field guidebook says, "Urgent level of care coordination Veterans should not self-schedule their appointment" and "for complex level of care coordination, contact the Veteran to provide the needed care coordination."[33] VHA clinical staff use triage tools to determine a veteran's level of care coordination. Through data analyses and interviews with staff from the four high-use facilities, the team determined that staff opted veterans into VSS who had urgent and complex consults.

[33] Office of Community Care Field Guidebook, § 3.16.

- **Oklahoma City.** Of the 35,231 VSS consults in FY 2023, 5,311 were coded as urgent or complex (over 15 percent).
- **Salisbury.** Of the 49,393 VSS consults in FY 2023, 6,854 were coded as urgent or complex (about 14 percent).
- **Honolulu.** Of the 90,694 VSS consults in FY 2023, 6,097 were coded as urgent or complex (about 7 percent).
- **Milwaukee.** Of the 40,794 consults in FY 2023, 2,353 were coded as urgent or complex (about 6 percent).

Opting in veterans with urgent or complex consults for VSS presents a significant risk that veterans who need more immediate care and may have challenges coordinating their care may experience delays—which could result in adverse outcomes.

During a May 2024 meeting with the OIG team, IVC leaders said they did not think care coordination levels should affect whether veterans are opted into VSS. However, this opinion conflicts with IVC's guidance, and in a June 2024 email to the review team, an IVC staff member said they recognized an opportunity for better alignment.

Facilities May Have Used VSS to Decrease Backlogs and Improve Scheduling Metrics for Non-VSS Consults

According to IVC's field guidebook, VSS consults should be excluded from the scheduling timeliness metric (within seven days from the file entry date). In a June 2024 email, IVC confirmed that VSS consults had been excluded from a report used to identify unscheduled consults exceeding 30 days and from some national scheduling timeliness reports.

In July 2024, an IVC leader told the review team that IVC was updating consult reports and internal oversight dashboards to ensure each one captured VSS consult metrics. While IVC also reported that VISN and facility leaders should monitor all unscheduled consults, it did not require facilities to separately review the timeliness of VSS consults scheduling, and the review team determined that facilities were focused on meeting non-VSS consult metrics that IVC monitored. Additionally, based on an internal email among several IVC leaders in April 2024, two leaders suspected that facilities may be using VSS inappropriately to improve metrics. One leader said, "I suspect it's a combination of some sites choosing VSS in order to move consults out of a data metric bucket," while the other leader wrote that "these [VSS] consults are keeping facilities from getting flagged on metrics" and that IVC and facilities need to be tracking those consults. Despite the risk of facilities using VSS primarily to improve metrics, one leader said that IVC "cannot stop offering a scheduling avenue to the Veterans just because VA has not had good check and balances in place."

Excluding VSS consults from scheduling timeliness metrics provided an opportunity for facilities to use VSS to reduce their backlog of unscheduled consults and improve their scheduling timeliness metrics, as discussed in the examples below.

- **Honolulu.** The community care chief said that from 2015 through 2022, staff improved their scheduling metrics from 64 days to 14 days after implementing VSS. As mentioned previously, this facility was opting veterans into VSS without their permission.
- **Salisbury.** The community care chief sent an email to staff in January 2022 directing them to automatically select the VSS option so the facility's scheduling metrics would improve. This former leader told the review team she decided to use the VSS process to improve the facility's numbers and decrease backlogs of unscheduled consults after her facility lost one-third of its community care staff and their scheduling timeliness was negatively affected.

Based on an analysis of VSS consult data and interviews with community care leaders, the review team determined that facilities with high VSS use generally have better scheduling metrics (table 2). According to the VHA Consult Timeliness Standard Operating Procedure referenced in VHA Directive 1230, the community care consult timeliness expectations are that community care consults must be scheduled within seven days of the file entry date.[34]

Table 2. Percentage of VSS Consults Scheduled in Seven Days from the File Entry Date (April 2023 through September 2023)

Percentage of VSS use	Percentage of all consults scheduled within seven days
Less than 33%	44%
33% to 66%	53%
Greater than 66%	66%

Source: OIG analysis of VHA's Corporate Data Warehouse and VHA Support Service Center Capital Assets database.

Because consults that go through the VSS process are excluded from the scheduling timeliness metrics, facilities that use VSS are more likely to schedule consults within seven days and meet the timeliness metric, as shown in table 2. The review team determined, and an IVC leader agreed, that the ability to meet this metric by using the VSS process is an incentive for facilities to potentially misuse it by automatically opting veterans into the process. VISN and facility

[34] VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022, and Consult Timeliness Standard Operating Procedure, July 8, 2024.

leaders should take steps to ensure facilities are following proper VSS guidance and conduct evaluations to mitigate the risk that staff are using VSS to reduce backlogs and improve metrics.

The review team determined that veterans from some facilities may have waited longer to receive their care when they were opted in for VSS. The team identified six facilities where veterans waited, on average, 28 more days to receive appointments linked to VSS consults compared to non-VSS consults from October 2022 through June 2024.

IVC and facility leaders should take steps to learn why the differences exist. If leaders become aware of staff who use VSS inappropriately or find opportunities to improve the new scheduling process, then leaders should take action to improve the process.

Neither IVC Staff nor Facility Leaders Provided Effective Oversight of the VSS Process

According to VHA Directive 1217, IVC is required to set quality measures, performance measures, and key indicators for performance and risk. The directive also requires IVC to ensure performance within its span of control and promote a culture of integrity within a high-reliability organization. IVC leaders said they did not conduct any assessments or establish controls to ensure facility staff were processing VSS consults consistently or appropriately. Facility leaders and staff from all four sites the review team visited said IVC had never contacted them with any questions or concerns related to their use of the VSS process. IVC also did not require facilities to specifically evaluate VSS consults to ensure the consults were being processed appropriately. Facility staff said IVC did not provide any tools or checklists for them to ensure they were not misusing the self-scheduling process.

During a May 2024 meeting between the review team and IVC, an IVC leader said facilities are expected to conduct their own reviews of consults to identify potential issues with VSS consults. The leader also said that local oversight would be especially important for those facilities with a high percentage of VSS consults. However, this expectation never seems to have been communicated effectively to facility leaders.

None of the facility leaders from the sites the team visited could provide evidence to show they reviewed VSS consults to identify potential issues. In fact, leaders from all four facilities told the review team they appreciated the OIG's review because it helped them identify problems and improve processes. Until IVC and facility leaders improve their oversight and establish effective controls for the VSS process, attempts to use the VSS process inappropriately will continue to go unnoticed.

Facilities Decreased Their Use of VSS upon OIG Engagement

The review team determined that the four facilities they visited had used VSS less frequently from the time after the team's first conference with IVC leaders in January 2024 through the team's final site visit in March 2024. The decrease in VSS use may be an indication that after the OIG brought awareness to the issue, facility staff improved their processing of VSS consults by opting in only eligible veterans and only after asking them whether they wanted to schedule their own appointments. Figure 1 shows how the percentage of VSS consults decreased during this period.

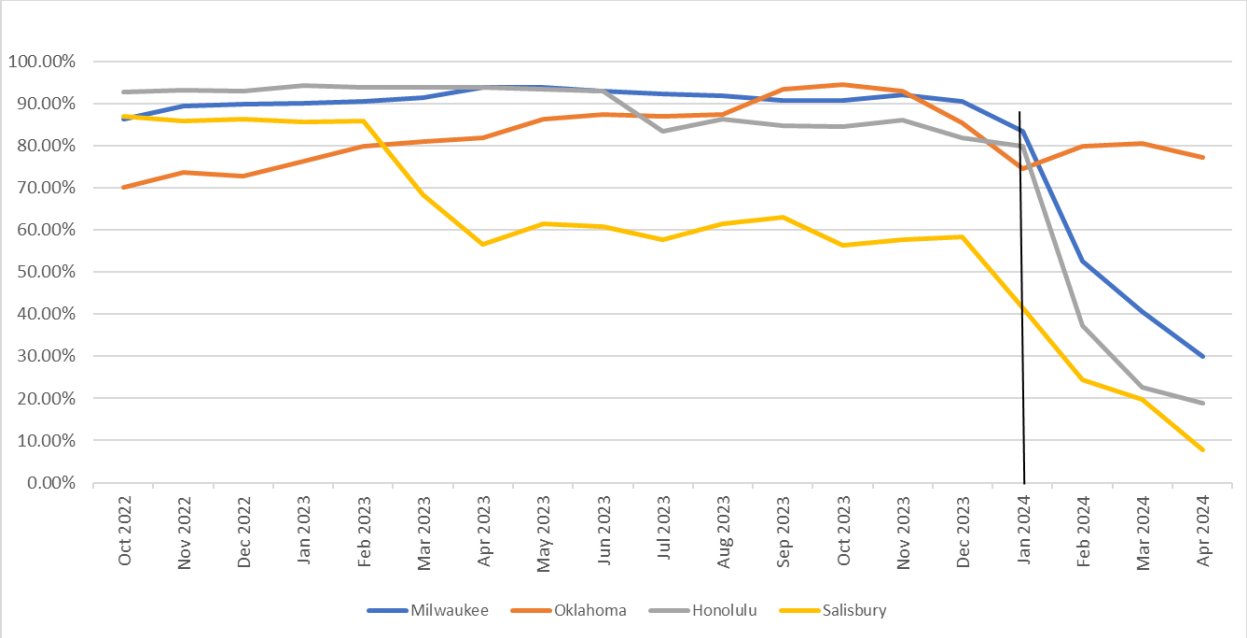

Figure 1. *Percentage of VSS Usage, October 2022 through March 2024.*

Source: OIG analysis of VHA's Corporate Data Warehouse.

Note: The vertical line represents the date of the OIG's entrance conference for this project.

IVC Did Not Fully Assess the Effectiveness of VSS

According to one internal IVC document, IVC's intent behind requiring staff to implement the VSS process was to (1) improve the quality and timeliness of care; (2) improve veteran satisfaction; and (3) improve collaboration, education, and engagement among IVC leaders, VA medical facility staff, and community providers. Although IVC did not measure the success of VSS based on the second and third goals, IVC leaders said they reviewed scheduling metrics to determine whether VSS improved scheduling timeliness, which is part of IVC's first VSS goal. However, IVC could not effectively assess whether it was meeting this goal because the process and system itself did not generally allow facility staff to accurately record the date an appointment was scheduled.

According to VHA Directive 1217, IVC is required to evaluate the effectiveness of outcomes and efficiency of outputs, including assessing the accuracy of data used for evaluation.[35] However, leaders and staff from the four facilities the review team visited said they could not rely on the data to determine whether the VSS process helped veterans to secure appointments more quickly. Specifically, facility staff cannot enter the date a veteran scheduled their appointment for their VSS consult until the veteran or their community provider notifies facility staff, and veterans or providers may not notify facility staff of an appointment until weeks after an appointment was scheduled.

For example, if a veteran scheduled their appointment on March 1 but did not notify facility staff until March 15, then VHA's system of record would show that the veteran scheduled their appointment on March 15—14 days later than the appointment was scheduled. Facility staff told the review team there is no way to backdate the scheduled date to reflect the date an appointment was scheduled. In these cases, when the system cannot reflect the actual scheduled date, including VSS consults in a facility's scheduling metrics would likely make the metrics look worse than they are.

Although one of the main goals of VSS is to support appointment-scheduling—an objective reflected in VHA's documentation and recognized by an IVC leader—the inability to record the actual date veterans schedule an appointment is a technical limitation of the VSS that prevents IVC from evaluating the time it takes for consults to be scheduled and the very data point that the system was designed to improve.

In July 2024, IVC canceled its requirement for facilities to offer the VSS option after the OIG briefed IVC leaders on its preliminary findings, as detailed in this report, and because staff did not have access to accurate lists of community providers who were accepting VA patients. An IVC leader said facilities can still use VSS as an option—yet without better oversight, facilities' attempts to use VSS inappropriately may go undetected and veterans may face delays in care.

Conclusion

While IVC developed and implemented a new scheduling process to enable veterans to schedule their own community care appointments and reduce the time it takes to secure an appointment, IVC needs to provide better support and improve its oversight of the VSS process. IVC allowed facilities to offer VSS to veterans from October 2020 until September 2023 without providing effective training or evaluating facilities' processes for implementing VSS to identify potential problems and best practices. The OIG review team determined facilities were processing VSS consults inappropriately by, for example, opting veterans into VSS without their permission. Neither IVC nor facility leaders provided effective oversight to identify potential misuse of the

[35] VHA Directive 1217, September 10, 2021. This version did not include specific requirements for VISN directors. The August 2024 version was updated to add the same responsibility for the VISN and medical facility directors.

VSS option. Further, IVC could not effectively evaluate whether the VSS process was meeting its goal of improving scheduling timeliness because the process and the system generally prevented staff from recording the exact date a veteran scheduled their appointment. Without better oversight, facilities' attempts to use the VSS process inappropriately may go undetected and veterans may experience delays in care.

Recommendations 1–8

The OIG recommended the under secretary for health make sure the Office of Integrated Veteran Care, in coordination with VHA's chief operating officer and the Veterans Integrated Service Networks, does the following:[36]

1. Evaluate its Veteran Self-Scheduling training and identify improvements if they are needed.
2. Make certain that staff who are involved in the Veteran Self-Scheduling process are trained on how to assess eligibility for the scheduling option, communicate key information to veterans on the option, and conduct appropriate consult follow-up procedures.
3. Ensure all guidance related to the Veteran Self-Scheduling process is clear, consistent, and disseminated to all VA medical facilities.
4. Establish a mechanism to effectively track and monitor each VA medical facility's challenges with implementation of the Veteran Self-Scheduling process and then develop a plan to address reported issues.
5. Develop best practices and lessons learned for implementing the Veteran Self-Scheduling process and disseminate them to all VA medical facilities.
6. Develop controls to ensure VA medical facility staff have the tools in place to identify instances of potential inappropriate processing or inappropriate use of Veteran Self-Scheduling consults.
7. Direct facilities to conduct routine reviews of Veteran Self-Scheduling consults to identify potential inappropriate processing or use of the Veteran Self-Scheduling option and notify VHA's Office of Integrated Veteran Care of instances of inappropriate use.
8. Develop a plan to accurately assess whether the Veteran Self-Scheduling process is meeting its intended goals.

[36] 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.

VA Management Comments

The acting under secretary for health concurred with all eight recommendations and submitted action plans for each recommendation. Appendix B includes the full text of the comments, which are summarized here.

For recommendation 1, IVC will evaluate the current VSS training program to identify improvements and take action as warranted. For recommendation 2, IVC will make sure all staff who are actively scheduling take the Schedulers Onboarding Training, which includes a section on VSS. IVC and the Office of Integrity and Compliance will collaborate to close any gaps in the current process to make sure the training is completed.

For recommendation 3, IVC will review the field guidebook and identify opportunities to strengthen content related to VSS procedures for clarity and consistency. IVC will also explore opportunities to gather feedback on the VSS process using established channels with the VISN.

For recommendation 4, IVC, in coordination with the chief operating officer, will work with VISNs to capture their respective medical facilities' challenges related to VSS implementation. IVC will then take appropriate action to improve the VSS process based on issues reported by the VISNs. For recommendation 5, IVC, in coordination with the chief operating officer, will ensure best practices and lessons learned for VSS are collected from VA medical facilities and then shared as appropriate. For recommendation 6, IVC, in coordination with the chief operating officer, is reviewing reporting options to potentially assist with oversight opportunities to support policies and standard operating procedures for VSS. VISNs will make sure processes are appropriately and accurately deployed within their medical facilities. For recommendation 7, IVC, in coordination with the chief operating officer, will work with VISNs and compliance stakeholders to identify next steps to include reviewing VSS consults.

For recommendation 8, IVC will work with VHA leaders to determine whether VSS will continue to be part of IVC's strategic direction.

OIG Response

The acting under secretary for health provided acceptable action plans for all eight recommendations. All recommendations remain open at this time. The OIG will continue to evaluate VHA's actions and close recommendations when VHA provides complete documentation and sufficient evidence addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The review team conducted its work from January 2024 through December 2024. This review determined whether the Veterans Health Administration (VHA) had adequate controls in place and provided effective oversight of the Veteran Self-Scheduling (VSS) process.

Methodology

The review team identified and reviewed the Office of Integrated Veteran Care's (IVC) assessments, applicable laws and regulations, VA policies and procedures, and processes related to VSS. The team conducted three interviews and held two interim briefings with IVC leaders responsible for oversight of VSS. The team conducted more than 60 interviews of leaders and staff from the three sites the team visited in person: the Clement J. Zablocki Veterans Administration Medical Center facility in Milwaukee, Wisconsin; the Oklahoma City VA Medical Facility in Oklahoma City, Oklahoma; and the Spark M. Matsunaga Department of Veterans Affairs Medical Center in Honolulu, Hawaii.[37] The team also conducted a virtual site visit of the W.G. Hefner Salisbury Department of Veterans Affairs Medical Center in Salisbury, North Carolina. The team interviewed community care leaders from four additional facilities that the OIG considered mid- or low VSS–usage facilities to learn about their process for implementing VSS or their hesitation to use the new scheduling process. The team did not determine whether staff at these four facilities used the VSS process appropriately.

Internal Controls

The team assessed IVC's internal controls that are significant to the review's objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[38] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following five components and 12 principles as significant to the objective.[39]

The team identified internal control weaknesses during this review and proposed recommendations to address the following control deficiencies:

[37] The review team visited four of the facilities that used the VSS option the most before IVC required facilities to offer VSS in September 2023.

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

[39] Because 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 1: Control Environment
    - Principle 2: Exercise oversight responsibility.
    - Principle 3: Establishes structure, authority, and responsibility.
    - Principle 5: Enforce accountability.
- Component 2: Risk Assessment
    - Principle 7: Identify, analyze, and respond to risk.
    - Principle 9: Identify, analyze, and respond to change.
- Component 3: Control Activities
    - Principle 10: Design control activities.
    - Principle 11: Design activities for information systems.
    - Principle 12: Implement control activities.
- Component 4: Information and Communication
    - Principle 13: Use quality information.
    - Principle 14: Communicate internally.
    - Principle 15: Communicate externally.
- Component 5: Monitoring
    - Principle 16: Perform monitoring activities.

Data Reliability

The review team relied on computer-processed data to support the finding, conclusion, and recommendations of this review. Electronic data retrieved from VHA's Corporate Data Warehouse and the VHA Support Service Center Capital Assets database were used to evaluate VSS consults. The review team checked for the completeness and accuracy of the data from both electronic data systems by checking for missing or duplicate entries, text, and number format accuracy and by testing consult records' data entries against source consult documentation in Veterans Health Information System Technology Architecture electronic medical records. The review team's assessment determined the electronic data the team relied on were complete, accurate, and relevant for supporting the review objective and results.

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: VA Management Comments, Under Secretary for Health

Date: January 28, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Veteran Self-Scheduling Process Needs Better Support, Stronger Controls and Oversight. (VIEWS 12534218)

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Veteran Self-Scheduling Process Needs Better Support, Stronger Controls and Oversight. Veterans Health Administration (VHA) concurs with recommendations 1-8. An action plan is provided in the attachment.

2. VHA appreciates OIG's assistance in identifying an opportunity to improve its oversight of the Veteran Self-Scheduling process to strengthen support and mitigate the risk of potential misuse of the scheduling option. Capturing Veteran preferences is a critical component of all scheduling processes, and all scheduling avenues must include discussions about Veteran preferences.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, MD

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Veteran Self-Scheduling Process Needs Better Support, Stronger Controls and Oversight

(OIG Project Number 2024-01143-AE-0043)

Recommendation 1: Evaluate its Veteran Self-Scheduling training and identify improvements if they are needed.

VHA Comments: Concur. The VHA Office of Integrated Veteran Care (IVC) will evaluate the current Veteran Self-Scheduling (VSS) training program to identify improvements and take action as warranted. This evaluation will focus on three key areas: completeness of training materials and curriculum, accuracy of content and procedures, and the integration of standard and enhanced VSS processes into a unified training framework.

Target Completion Date: July 2025

Recommendation 2: Make certain that staff who are involved in the veteran self-scheduling process are trained on how to assess eligibility for the scheduling option, communicate key information to veterans on the option, and conduct appropriate consult follow-up procedures.

VHA Comments: Concur. VHA Chief Operating Officer (COO) would like to point out that “staff who are involved” are not the same as “staff who are actively scheduling”. IVC can identify all staff who are actively scheduling, and Veteran Self-Scheduling is part of the Schedulers Onboarding Training. This training is mandatory for all schedulers. IVC can identify all staff that are scheduling, and VHA Operations leadership, including Veterans Integrated Services Network (VISN) leadership, can ensure sites are following national guidance. VSS is part of the Schedulers Onboarding Training, this training is mandatory for all schedulers. Facility Integrity and Compliance Officers can access reports from Business Intelligence Service Line (BISL) and facility Scheduling Trainers to review training completion. IVC and the Office of Integrity and Compliance will collaborate to close any gaps in the current process. IVC will review the current information in the training to ensure the relevant areas identified in the recommendation are included.

Target Completion Date: July 2025

Recommendation 3: Ensure all guidance related to the veteran self-scheduling process is clear, consistent, and disseminated to all VA medical facilities.

VHA Comments: Concur. IVC will review the Field Guidebook (FGB) and identify opportunities to strengthen content related to Community Care VSS procedures for clarity and consistency. IVC will update the FGB as indicated by the review and distribute the updated guidance through established channels. In addition, IVC will explore opportunities to gather feedback on the VSS process using established channels with the VISN.

Target Completion Date: July 2025

Recommendation 4: Establish a mechanism to effectively track and monitor each VA medical facility's challenges with implementation of the veteran self-scheduling process and then develop a plan to address reported issues.

VHA Comments: Concur. In accordance with Directive 1217, VISNs are responsible for the oversight of Department of Veterans Affairs (VA) Medical Facilities with support and policy guidance from the principal and program offices (for example, IVC and Integrated Access Optimization). IVC works extensively with VISNs and VA Medical Facilities through established channels on a variety of both direct and community care processes to address areas of opportunity. Implementation of this mechanism at medical facilities is the responsibility of the VISNs. In coordination with the Office of the Chief Operating Officer, IVC will work with VISNs who will capture their respective medical facilities' challenges related to VSS implementation. If issues reported by the VISN would benefit from a national intervention, IVC will take action as needed.

Target Completion Date: July 2025

Recommendation 5: Develop best practices and lessons learned for implementing the veteran self-scheduling process and disseminate them to all VA medical facilities.

VHA Comments: Concur. In accordance with Directive 1217, VISNs are responsible for overseeing consistent implementation and operationalization of VHA national policies, guidance, and best practices. IVC sets policy and shares tools with the VISNs, and the VISN communicates with the facilities. Best practices and lessons learned, to include VSS, are vetted through the Integrated Continuous Access Optimization (ICAO) Subcommittee (co-led by IVC) and are disseminated through Elevated & Exchange session as part of the Access Community of Practice Call. In coordination with the Office of the Chief Operating Officer, IVC will reiterate to the VISN of the existence of the ICAO process to encourage submissions of best practices and lessons learned from VA Medical Facilities.

Target Completion Date: July 2025

Recommendation 6: Develop controls to ensure VA medical facility staff have the tools in place to identify instances of potential inappropriate processing or inappropriate use of veteran self-scheduling consults.

VHA Comments: Concur. In accordance with Directive 1217, VISNs are responsible for overseeing consistent implementation and operationalization of VHA national policies, guidance, and best practices, as well as documenting and reporting significant enterprise risks, issues, and deficiencies to the appropriate VHA Principal Offices and Program Offices. In coordination with the Office of the Chief Operating Officer, IVC is reviewing reporting options to potentially assist with oversight opportunities to support policies and standard operating procedures. IVC focuses on monitoring VISN activities. VISNs, in turn, are responsible for assuring appropriate and accurate deployment of processes within their medical facilities.

Target Completion Date: July 2025

Recommendation 7: Direct facilities to conduct routine reviews of veteran self-scheduling consults to identify potential inappropriate processing or use of the veteran self-scheduling option and notify VHA's Office of Integrated Veteran Care of instances of inappropriate use.

VHA Comments: Concur. Under VHA Directive 1217, the VISN, in coordination with Program Offices, is responsible for overseeing consistent implementation and operationalization of VHA national policies, guidance, and best practices and systematically identifying risks and unintended variances at VA Medical Facilities within the VISN. VISN and other VHA compliance stakeholders are supported by IVC for the

monitoring and compliance process. VHA Directive 1232, Consult Management, directs VISN Directors to oversee VA Medical Facilities process and outcomes, and adherence to national consult policies. In coordination with the Office of the Chief Operating Officer, IVC will work with VISNs and compliance stakeholders to identify next steps to include reviewing VSS consults.

Target Completion Date: July 2025

Recommendation 8: Develop a plan to accurately assess whether the veteran self-scheduling process is meeting its intended goals.

VHA Comments: Concur. COO acknowledges the need for a plan to assess whether VSS is meeting its intended goals. IVC will work with VHA leadership to determine if VSS will continue to be part of IVC's strategic direction within the context of VHA priorities and legislative requirements outlined in Cleland Dole 131-134, Community Care Self-Scheduling Pilot Program.

Target Completion Date: July 2025

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

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