Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-02551-306

Healthcare Inspection

Veterans Choice Program Dermatology Delays Captain James A. Lovell Federal Health Care Center North Chicago, Illinois

August 7, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection of alleged inefficiencies in processing Veterans Choice Program (Choice) dermatology consults that resulted in delays and duplicative procedures at the Captain James A. Lovell Federal Health Care Center (FHCC), North Chicago, IL. We reviewed the following allegations:

- Patient A was referred to the Choice program for Mohs surgery and underwent a "redundant and unnecessary biopsy" because neither the fee department staff (staff responsible for processing Choice consults) nor the Choice third-party administrator sent the patient's pathology report to the Choice dermatologist.
- Patient B was referred to the Choice program for Mohs surgery and experienced a delay in obtaining the surgery because neither the fee department staff nor the Choice third-party administrator sent the patient's pathology report to the Choice dermatologist.
- The fee department inappropriately referred Patient C for care through the Choice program rather than using traditional non-VA care funds to send the patient to the specific specialist recommended by an FHCC dermatologist.
- Patients who were referred for dermatology care through the Choice program, including those with skin cancers, experienced delays.

Skin cancer is an abnormal growth of skin cells and is a common cancer in the United States. Mohs surgery, a minor surgical procedure that involves removing layers of skin, is the treatment of choice for certain types of skin cancer. Prior to this surgery, the skin lesion is typically biopsied to confirm the cancer diagnosis.

Veterans Health Administration (VHA) policy states that a consult is a mechanism for physicians and other health care providers to create template notes for requesting an opinion, advice, or expertise regarding evaluation or management of specific problems in the care of individual patients.[1] In cases when consulted services are not available timely through the system, providers may refer patients for care to other VA medical centers, other non-VA facilities as part of sharing agreements, or community providers. VHA has several mechanisms for purchasing care from community providers, including

[1] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive was in effect during the time of the events discussed in this report but has been rescinded and replaced with VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016. The 2016 Directive contains similar language regarding the definition of a consult.

Choice and traditional non-VA care.[2] At the time that we initiated our review in May 2016, FHCC's dermatologist primarily cared for active-duty service members. Veterans who needed dermatology care generally received those services from community providers.

We substantiated that Patient A underwent a duplicate biopsy. The FHCC dermatologist biopsied the patient's nose lesion and ordered a non-VA care consult for Mohs surgery. We found that fee department staff did provide the pathology results from the original biopsy to the Choice third-party administrator. However, the Choice dermatologist did not receive information from the patient's VA EHR, including the patient's pathology results, from the Choice third-party administrator. The Choice dermatologist elected to repeat the biopsy in order to confirm the cancer diagnosis before completing the Mohs surgery.

We substantiated that Patient B experienced a delay in obtaining Mohs surgery because the Choice dermatologist did not initially receive a readable copy of the patient's pathology results. In particular, we found that fee department staff did provide a readable copy of the pathology results to the Choice third-party administrator. Those results were included in the information faxed to the Choice dermatologist, but the faxed versions were very faint and difficult to read.

Although we substantiated that fee department staff initially offered Patient C care through the Choice program and that this was appropriate, we found that the patient ultimately received care through traditional non-VA care, as requested by the FHCC dermatologist. We also found that fee department staff did not process Patient C's consult timely, which contributed to a delay in obtaining care for the patient's itching and discomfort.

We substantiated apparent delays among Choice dermatology consults. Specifically, for consults ordered from March 1, 2015 through February 29, 2016, we found 569 of 613 patients (92.8 percent) with Choice dermatology consults appeared to have experienced delays. Several factors contributed to the appearance of delays, including fee department staff not taking timely action (1) when providers ordered a consult and (2) when completing, cancelling or discontinuing consults. Through our records reviews, we did not find patients who were clinically impacted by delays.

To evaluate whether the apparent delays persisted, we reviewed Choice dermatology consults ordered from March 1, 2016 through September 30, 2016. We found that

[2] The Veterans Choice Program was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of Choice third-party administrators.

663 of 666 patients (99.5 percent) with Choice dermatology consults appeared to have experienced delays. These delays were primarily due to unresolved issues with the timeliness of administrative processing of consults by fee department staff.

We made the following recommendations:

1. We recommended that the FHCC Director ensure that fee department staff take timely action when providers order non-VA care and Choice dermatology consults.

2. We recommended that the FHCC Director ensure that fee department staff take timely action to complete, cancel, or discontinue non-VA care and Choice dermatology consults, as appropriate.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes C and D, pages 23–26 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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Assistant Inspector General for
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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection of alleged inefficiencies in processing Veterans Choice Program (Choice) dermatology consults that resulted in delays and duplicative procedures at the Captain James A. Lovell Federal Health Care Center (FHCC), North Chicago, IL.

Background

The FHCC is part of Veterans Integrated Service Network (VISN) 12. The FHCC was chartered as a 5-year Demonstration Project on October 1, 2010, after the Department of Defense (DoD) and VA agreed to merge the North Chicago VA Medical Center and the Naval Health Clinic Great Lakes.[3] At the time we initiated our review in May 2016, FHCC operated under a 2010 Executive Agreement (EA) between DoD and VA, which outlined the terms of the integration and identified VA as the lead partner with accountability for the overall operation of the FHCC.[4]

The FHCC is led by a VA Senior Executive Service Officer as Director and a U.S. Navy Captain as Deputy Director. It serves veterans, active-duty service members and their dependents, TRICARE-eligible retirees and their dependents, survivors, and Navy recruits.[5] It operates 88 inpatient beds and 120 Community Living Center beds.

Prior Relevant FHCC-Specific Publications

In March 2015, OIG published *Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois.*[6] We received multiple allegations of "turmoil and chaos" related to the 2014 reorganization of senior leadership. The investigation focused on prioritization of active duty personnel for Gastrointestinal (GI) services, unnecessary GI procedures, lack of coordination of care for non-VA GI care, and alleged quality of care deficiencies. We substantiated the allegations of prioritizing care for active duty personnel; however, this process aligned with the 2010 DoD/VA EA. We did not

[3] The National Defense Authorization Act for FY 2010 authorized the demonstration project. Pub. L. No. 111-84, § 1701(a), 123 Stat. 2190, 2567 (2009).
[4] The National Defense Authorization Act for FY 2010 required the Secretaries of VA and DoD to submit a "final report" on the merger to Congress not later than 180 days after the fifth anniversary of executing the EA, (March 2016) to include an assessment of the merger and recommendation regarding whether it should continue. At the time of this review, July 30, 2015, the Secretaries had not submitted the final report. Pub. L. No. 111-84, § 1701(d)(2), 123 Stat. 2190, 2567 (2009).
[5] TRICARE is a military health care program utilizing military health care and civilian network providers that is available to many military dependents. http://www.tricare.mil/, accessed August 1, 2016.
[6] *Healthcare Inspection: Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois*, Report No. 14-04473-132, March 3, 2015.

substantiate that GI staff performed unnecessary procedures and that the FHCC lacked a process for coordinating non-VA GI care. However, we did find inconsistencies in the posting of GI results into the VA electronic health record (EHR). As a result, we recommended that the FHCC Director "…ensure that documentation of procedure results from Non-VA gastrointestinal care providers is obtained and available in the electronic health record (EHR) for review in a timely and consistent manner." We closed the recommendations March 24, 2016.

In July 2015, OIG published *Combined Assessment Program Review of the Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois,* (Report No.15-00594-389). We reviewed the consult management process and the completion of inpatient clinical consults. As a result, we recommended the FHCC Director "…ensure that requestors consistently select the proper consult title and that facility managers monitor compliance." We closed the recommendations May 5, 2016.

In February 2016, the Government Accountability Office (GAO) published *VA and DoD Need to Address Ongoing Difficulties and Better Prepare for Future Integration*. The intent of the report was to determine the extent to which the FHCC's governance structure and leadership processes facilitated collaboration at the facility.[7]

We also have issued additional reports involving other VA facilities that evaluated consult timeliness and the impact of consult delays on patient outcomes. See Appendix A.

Skin Cancer

Skin cancer is an abnormal growth of skin cells and is a common cancer in the United States. The following are three main types of skin cancers:

- Basal cell carcinoma (BCC)
- Squamous cell carcinoma (SCC)
- Melanoma

The most common type of skin cancer is BCC. This skin cancer occurs most frequently on the head, neck, and arms, but can also occur anywhere on the body including the chest, abdomen, and legs. BCC affects more than 1 million people each year; however, early diagnosis and treatment can prevent damage to surrounding tissue. The second most common type of skin cancer is SCC. This skin cancer typically occurs on skin that gets frequent sun exposure such as the ears, face, neck, arms, chest, and back. Melanoma is cancer that develops from cells that give skin its color. Melanoma

[7] Government Accountability Office (GAO), Report to Congressional Committee, Federal Health Care Center, *VA and DoD Need to Address Ongoing Difficulties and Better Prepare for Future Integration,* February 2016.

is not as common as BCC or SCC, but is more serious. Melanoma occurs mainly on the skin but also in the mouth, genital and rectal regions, and the eye.

Skin cancer treatment generally involves surgical excision, though certain skin cancers may necessitate additional treatment(s). Surgical excision of BCC lesions is generally curative and BCC does not usually spread to other parts of the body. In contrast, early treatment of SCC and melanoma is important to prevent metastasis (spreading) to other parts of the body.

Mohs surgery is the treatment of choice for BCC and SCC. This minor surgical procedure involves removing layers of skin and examining the tissue under a microscope to determine if any cancer cells remain. If more cancer cells are present, the procedure is repeated until microscopic examination indicates that no cancer cells remain. Prior to this surgery, the lesion is typically biopsied to confirm the cancer diagnosis.

Consults

Clinicians may refer patients with skin lesions that are suspicious for skin cancer for evaluation and treatment by a dermatologist. To facilitate electronic transmission of referrals, including referrals for dermatology care, the Veterans Health Administration (VHA) implemented a consult package in its Computerized Patient Records System (CPRS) in 1999.[8] The consult package assists physicians and other health care providers to create template notes for requesting an opinion, advice, or expertise regarding evaluation or management of specific problems in the care of individual patients. Once a clinician orders a consult using the consult package, it remains unresolved until a specific action is taken to close it. A consult may be closed administratively (for example discontinued or cancelled) by non-clinical staff. Alternatively, a clinician may close the consult when he/she properly enters a note into the consult package indicating that the consult has been completed. If the clinician enters a note outside of the consult package, the consult remains open even though care has been rendered.

In cases when consult services are not available or not available timely through FHCC, FHCC staff may refer patients for care to other VA medical centers, other facilities as part of sharing agreements, or community providers. VHA has several mechanisms for purchasing care from community providers, including Choice and traditional non-VA

[8]VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive was in effect during the time of the events discussed in this report but has been rescinded and replaced with VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016. The 2016 Directive contains similar language regarding the definition of a consult.

care.[9] After providers order consults for care in the community, the consults are reviewed by an approving official and authorized by fee department staff.

At the time that we initiated our review in May 2016, the FHCC's dermatologist primarily cared for active-duty service members. Veterans who needed dermatology care generally received those services from community providers.

Allegations

In late February 2016, OIG received the following allegations regarding inefficiencies in processing Choice dermatology consults that resulted in delays and duplicative procedures at the FHCC:

- Patient A was referred to the Choice program for Mohs surgery and underwent a "redundant and unnecessary biopsy" because neither the fee department nor the Choice third-party administrator sent the patient's pathology report to the Choice dermatologist.
- Patient B was referred to the Choice program for Mohs surgery and experienced a delay in obtaining that procedure because neither the fee department nor Choice third-party administrator sent the patient's pathology report to the Choice dermatologist.
- The fee department inappropriately referred Patient C for care through the Choice program rather than using traditional non-VA care funds to send the patient to a specific specialist recommended by an FHCC dermatologist.
- Patients who were referred for dermatology care through the Choice program, including those with skin cancers, experienced delays.

We promptly notified VHA of the allegations we received because of the potential ongoing risk to patients. As a result, VA central office, VISN, and FHCC leadership had the opportunity to initiate an internal review to identify and resolve unmet patient needs. FHCC leadership subsequently reviewed all Choice dermatology consults ordered from March 1, 2015 through February 29, 2016, and concluded no adverse events or deaths associated with delays in dermatology care had occurred.

[9]The Veterans Choice Program was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of Choice third-party administrators.

Scope and Methodology

We initiated our review in early May 2016 and completed our work in January 2017. We did not conduct a site visit. Instead, we conducted interviews via teleconference with FHCC leadership, fee department staff, FHCC's dermatologist and nurse case manager, selected Choice dermatologists, and other knowledgeable individuals. We also electronically requested and reviewed documentation, including FHCC policies, findings from FHCC internal reviews, and information in selected patients' EHRs. We analyzed data on Choice dermatology consults ordered from March 1, 2015 through February 29, 2016 (study period) and March 1, 2016 through September 30, 2016 (follow-up period). The steps we took related to each allegation are described below.

Issues 1, 2, and 3: Concerns About Choice Dermatology Referrals for Patients A, B, and C

To evaluate the concerns raised regarding Patients A, B, and C, we reviewed documentation from the patients' VA EHRs and Choice third-party administrator portal. We interviewed the Choice dermatologists who evaluated and treated patients A and B, and we requested and reviewed documentation from those community providers. We also reviewed applicable VHA policy and guidance and peer-reviewed journal articles.

Issue 4: Choice Dermatology Consult Delays and Potential Impact on Patients

To respond to the concerns raised regarding consult delays, we evaluated the timeliness of Choice dermatology consults ordered through FHCC during the study period (March 1, 2015 through February 29, 2016), and the impact of delays on patients.[10]

Study Population. The study population comprised all patients at FHCC who had at least one delayed consult for Choice dermatology during the study period. We identified the study population using the Corporate Data Warehouse (CDW), which is a centralized data repository that contains VHA clinical, administrative, and financial data.[11] Because we were interested in clinical care as opposed to administrative requests, we excluded those consults with an administrative flag, such as requests for transportation. Data were extracted from CDW on July 18, 2016.

Whether Patients Experienced at Least One Consult Delay. We determined that patients experienced a consult delay if at least one of the patients' consults was not

[10] Although a review of traditional non-VA care consult delays was outside the scope of this review, we noted that FHCC may have forwarded some patients' Choice dermatology consults to traditional non-VA care in an effort to expedite services. Therefore, for completeness, we reviewed the EHRs of all patients initially referred to the Choice program with a delayed traditional non-VA care dermatology consult. We concluded that none of those patients were clinically impacted by delays using the same methodology we used to evaluate impact for other patients.
[11] For an overview of the CDW data referenced throughout this scope and methodology section, see Appendix B, Table 1.

completed within the expected timeframe based on the information in the consult's urgency field. The start date for this timeframe was the later of the dates that the consult was ordered or the clinically indicated date. The end date was the date that the patient had a clinic visit that was linked to the consult, the patient died, or the consult was discontinued or canceled. For additional information about timeliness expectations based on the documented consult urgency, see Appendix B, Table 2.

Whether Patients Experienced at Least One Health Event. For patients who experienced at least one consult delay, we analyzed CDW data that included data on traditional non-VA care. We used the CDW data to classify patients who experienced at least one delay into two subpopulations. One subpopulation included those patients who experienced at least one of the selected health events (as defined below) after the first delayed consult was requested and through the date of our data extract – July 18, 2016. The other subpopulation included those who did not experience an identified health event after the delayed consult. We included the following three health events in our review:

- Skin cancer and other dermatologic conditions that may require timely intervention
- Hospital admission
- Death

We selected these health events because they represented those that could potentially be attributed to dermatology consult delays. In addition, we could readily identify these events using VHA's administrative data.

To determine whether patients were diagnosed with skin cancer or another selected dermatologic condition, we analyzed CDW data to obtain occurrences of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and ICD-10 codes listed in Appendix B, Table 3. To identify patients who were hospitalized, we analyzed CDW data to identify inpatient admissions. Where available, we used information on patients' primary discharge diagnoses. When that information was unavailable, we used information on patients' admission diagnoses. To identify deceased patients, we analyzed CDW data to identify those patients who had a recorded date of death. For these patients, we requested death certificates to identify cause of death, if indicated. For the patients in our study population who did not experience one of the selected health events, we were unable to conclude that the consult delays had a clinical impact.

Impact of Consult Delays. Our team of clinical reviewers, which included three nurses and a physician, evaluated whether there could be a relationship between each consult delay and health event. We defined "relationship" to include consult delays that could have contributed to or led to the event as well as consult delays that could have resulted in a clinically significant delay in diagnosis of and treatment for a condition. For example, we would generally conclude that a delayed Choice dermatology consult was *unlikely* to be related to a hospitalization for a cerebrovascular accident. However, we

would generally conclude that a delayed Choice dermatology consult *could* be related to a diagnosis of melanoma. For those delayed consults that could have been related to health events, we conducted an in-depth EHR review to better understand potential clinical impact. A physician reviewed the EHRs of patients for whom we suspected consult delays resulted in a clinical impact.

Factors That Contributed to Delays and FHCC Efforts to Address Those Factors

To understand factors that contributed to delays, we reviewed documentation from EHRs, the Choice third-party administrator's portal information for the specific patient examples provided by the complainant, and other patients identified through our data analysis. We collected additional information on those factors and FHCC efforts to address those factors by interviewing the FHCC leadership and staff described previously. We also requested and reviewed documentation including documents that described fee department work flows and consult dashboards.

All Issues

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

Case Summaries

Patient A

The patient was a male in his mid-60s who had a history of BCC and SCC. The patient saw an FHCC dermatologist in 2015 for multiple skin concerns, including a "bump" on the right side of his nose. The same day, the dermatologist performed a biopsy. The biopsy results confirmed that the lesion was BCC.

The same day that the biopsy results became available, the dermatologist ordered a routine, non-VA care consult for Mohs surgery since Mohs surgery was not performed at FHCC. One week later, the consult was approved and fee department staff contacted the patient to offer him care through the Choice program. The following day, fee department staff uploaded an authorization for the non-VA care consult and the FHCC dermatologist's progress note to the Choice third-party administrator's portal. The progress note included an addendum with the pathology results from the biopsy.

Thirty-five days after the consult was ordered, the patient saw a Choice dermatologist who repeated the biopsy of the lesion on the patient's nose. The patient had been scheduled for an appointment 7 days earlier, but rescheduled. One week after the appointment, the Choice dermatologist sent a pathology report to the FHCC dermatology clinic with results of the duplicate biopsy.

Several days later, the Choice dermatologist submitted a request for additional services to the Choice third-party administrator to perform the Mohs surgery. Three days later, 55 days after the FHCC dermatologist ordered a non-VA dermatology consult, the patient underwent that procedure.

A few weeks after the procedure, the patient had a follow-up appointment with the FHCC dermatologist who confirmed that the surgery site had healed and with no recurrence of cancer.

Patient B

The patient was a male in his late 60s with a history of SCC of the scalp that was removed via Mohs surgery in 2014.

Approximately a year later, the patient saw an FHCC dermatologist for a routine follow-up appointment. At that time, the dermatologist noted the patient had a non-healing scalp lesion in the same location as the 2014 Mohs surgery. The dermatologist biopsied the lesion and confirmed recurrence of SCC.

The same day the biopsy results became available, the FHCC dermatologist ordered a routine Choice consult for Mohs surgery. The FHCC dermatologist documented encouraging the patient to undergo Mohs surgery expeditiously, though the patient expressed some reluctance to do so for occupational reasons. The consult was approved the following day. Two weeks later, fee department staff verified

administrative eligibility and contacted the patient regarding the Choice program. The same day, fee department staff uploaded an authorization, the patient's non-VA care consult, and the FHCC dermatologist's progress note, which included an addendum with the pathology results from the biopsy, to the Choice third-party administrator's portal.

Forty-four days after the FHCC dermatologist ordered the Choice consult for Mohs surgery, and 29 days after fee department staff uploaded the patient's information to the Choice third-party administrator's portal, the patient attended an appointment with a Choice dermatologist. However, the patient was unable to have the Mohs surgery completed at that time because the Choice dermatologist did not have the patient's pathology results on file.

Eight days later, at the request of the patient and Choice dermatologist, FHCC staff sent the patient's pathology results directly to the Choice dermatologist.

Ninety-eight days after the FHCC provider ordered the Choice consult, the patient underwent Mohs surgery. Several weeks later, the patient had a follow-up appointment with the FHCC dermatologist who confirmed that the surgery site had healed and that there was no recurrence of cancer.

Patient C

The patient was a male in his early 60s with a history of idiopathic hypereosinophilic syndrome that caused him intense itching and discomfort.[12] Providers managed these symptoms with a systemic steroid.

In 2016, an FHCC dermatologist assessed the patient because the patient's dermatologist was not working that day. The dermatologist noted that the patient had a flare up of itching and discomfort and planned to refer the patient to a specific non-VA dermatology and rheumatology specialist. One week later, the FHCC dermatologist ordered the routine non-VA care consult. This consult was approved the same day.

One month after the non-VA care consult was ordered and approved, a fee department staff verified administrative eligibility and contacted the patient regarding the Choice program. Later that day, the approving official instructed the fee department staff that traditional non-VA care was approved for the specific provider requested in the consult due to urgency and that the patient was to be seen in 2 weeks.

The specified non-VA care provider subsequently evaluated and treated the patient 61 days after the dermatologist assessed the patient and 54 days after the

[12] Idiopathic hypereosinophilic syndrome is an uncommon condition characterized by persistently elevated counts of eosinophils (a type of white blood cell) without an apparent underlying cause.

dermatologist ordered the non-VA care consult. The patient continues to receive ongoing care through FHCC for his complex medical and dermatologic conditions.

Inspection Results

Issue 1: Patient A Underwent a Duplicate Biopsy Which Delayed His Mohs Surgery

We substantiated that Patient A underwent a duplicate biopsy. The FHCC dermatologist biopsied the patient's nose lesion and ordered a non-VA care consult for Mohs surgery. We found that fee department staff did provide the pathology results to the Choice third-party administrator. However, the Choice dermatologist did not receive information from the patient's VA EHR, including the patient's pathology results, from the Choice third-party administrator. The Choice dermatologist furnished us a copy of the fax from the Choice third-party administrator, which only contained the authorization for services. We are unable to determine whether the Choice third-party administrator attempted to transmit the VA EHRs through a separate fax. Without the pathology results, the Choice dermatologist was unable to proceed with the planned Mohs surgery. The Choice dermatologist elected to repeat the biopsy in order to confirm the diagnosis of BCC before completing the Mohs surgery. As a result, the patient experienced a 35-day delay in obtaining the Mohs surgery, as he had to wait for new biopsy results and an additional appointment. We determined the delay did not impact the patient's outcome.

Issue 2: Patient B's Pathology Results Were Difficult to Read, Which Delayed His Mohs Surgery

We substantiated that Patient B experienced a delay in obtaining Mohs surgery in part because the Choice dermatologist did not initially receive a readable copy of the patient's pathology results. FHCC fee basis staff did not take timely action to administratively process Patient B's consult. We also found that fee department staff did provide the pathology results to the Choice third-party administrator and that those results were included in the information faxed to the Choice dermatologist. However, the text from the patient's VA EHR, including the pathology results, was very faint and difficult to read. At the request of the patient and Choice dermatologist, FHCC staff sent the patient's pathology results directly to the Choice dermatologist. Patient B subsequently received the Mohs surgery 98 days after the FHCC provider ordered the Choice consult. We are unable to determine whether this was the soonest the Choice dermatologist could perform this surgery, or the patient's preferred date due to work-related commitments. We found the delay did not impact the patient's outcome.

Issue 3: Fee Department Staff did not Process Patient C's Consult Timely and did Initially Route the Consult to the Choice Program

We substantiated fee department staff initially offered patient C care through the Choice program. However, we found this was appropriate and the patient ultimately received

care through traditional non-VA care as requested by the FHCC dermatologist. We also found that fee department staff did not process Patient C's consult timely, which contributed to a delay in obtaining care for the patient's itching and discomfort.

We found that when the FHCC dermatologist ordered Patient C's non-VA care consult, the provider requested that the patient be seen by a specific community provider. According to the FHCC dermatologist, that community provider had expertise in caring for dermatologic and rheumatologic syndromes. Initially, fee department staff disregarded that request and offered the patient care through the Choice Program, which was in accordance with VHA guidance.[13] However, the FHCC dermatologist and the approving official opposed referring Patient C to the Choice program because the Choice third-party administrator would schedule the patient with a provider in the Choice network and not necessarily with the recommended specialist. The patient's EHR reflected a misunderstanding between FHCC staff and fee department staff who continued to take several steps to refer the patient to the Choice program despite multiple entries from the approving official that the patient was approved for traditional non-VA care. In 2016, the specific non-VA specialist evaluated and treated the patient.

We also found that fee department staff did not take action to schedule the patient with the non-VA dermatologist until 32 days after the consult was ordered and approved. Another 22 days elapsed before the non-VA dermatologist evaluated and treated the patient. As a result, this patient did not receive the requested evaluation and treatment for intense itching and discomfort within 30 days, as expected (Appendix B, Table 2) for a routine consult.

Issue 4: Choice Dermatology Consult Delays and Potential Impact on Patients

We substantiated apparent delays among Choice dermatology consults from FHCC. Specifically, for consults ordered from March 1, 2015 through February 29, 2016, we found 569 of 613 patients (92.8 percent) with Choice dermatology consults appeared to have experienced delays. Consistent with the FHCC leadership's review, we did not find patients with Choice dermatology consult delays were clinically impacted.

We determined that the following factors contributed to non-VA care and Choice consult delays and the appearance of delays:

- **Timeliness of fee department actions in response to newly ordered consults**. Fee department staff did not take timely actions to contact patients and process authorizations after providers ordered consults for Patient C and

[13] Under VA's referral hierarchy, VA facilities are generally expected to refer patients for care through the Choice program if care cannot be provided timely through VA. Other mechanisms for purchasing care through community providers, including traditional non-VA care, may be used when, for example, the veteran is not eligible for care through the Choice program. See *Referral Hierarchy for VA Care in the Community: Non-VA Purchased Care*, website accessed January 21, 2017.

other patients we reviewed. This was a noteworthy contributor to the delays experienced by those patients.

- **Timeliness of fee department actions to complete or discontinue consults**. Fee department staff did not take timely actions to complete or discontinue consults when indicated. For example, for one patient whose EHR we reviewed, the patient declined scheduling an appointment through the Choice third-party administrator in late 2015, but his consult remained open in his VA EHR until several months later. For another patient we reviewed, the patient received care through Choice in 2015, and the records were available in the Choice third-party administrator's portal 8 days later. However, fee department staff did not close out the consult in the patient's EHR until several months later.
- **Difficulty reaching patients to schedule appointments**. Several patients we reviewed appeared to have experienced delays in obtaining Choice consults because of difficulty reaching the patient via phone to schedule an appointment. Those consults were subsequently discontinued.

Because of concerns regarding the timeliness of care through the Choice program, as of June 2016, FHCC was referring patients with high-risk cancers for Mohs surgery via traditional non-VA care rather than Choice. FHCC leadership and staff also took several steps intended to address factors that contributed to Choice dermatology consult delays, including temporarily assigning staff to assist with fee department operations. As of late December 2016, a new fee department staffing model was being developed to include additional staff to assist with consult processing. However, that model had not been shared with FHCC leadership, and no efforts were underway to hire additional staff at that time.

Despite FHCC leadership and staff efforts, we found that Choice dermatology consult delays persisted primarily because the issues with fee department staff actions described above went unresolved. In particular, for consults ordered from March 1, 2016 through September 30, 2016, we found that 663 of 666 patients (99.5 percent) with Choice dermatology consults appeared to have experienced delays.

Conclusions

We substantiated allegations regarding inefficiencies in the processing of Choice dermatology consults that resulted in delays and duplicative procedures at the FHCC. Specifically, we substantiated that Patient A underwent a duplicate biopsy after an FHCC dermatologist biopsied the patient's nose lesion and ordered a non-VA care consult for Mohs surgery. We found that fee department staff did provide the pathology results to the Choice third-party administrator. However, the Choice dermatologist told us that the Choice third-party administrator did not provide information from the patient's VA EHR, including the patient's pathology results.

We also substantiated that Patient B experienced a delay in obtaining a Mohs procedure because the Choice dermatologist did not initially receive a legible copy of

the patient's pathology results. In particular, we found that fee department staff did provide a readable copy of the pathology results to the Choice third-party administrator. Those results were included in the information faxed to the Choice dermatologist, but the faxed versions were very faint and difficult to read.

In contrast, although we substantiated that the fee department initially offered Patient C care through the Choice program, we found this was appropriate and the patient ultimately received care through traditional non-VA care, as requested by the FHCC dermatologist. We also found that fee department staff did not process Patient C's consult timely, which contributed to a delay in obtaining care for the patient's itching and discomfort.

We substantiated that 663 of 666 patients (99.5 percent) who were referred for Choice dermatology care by FHCC providers from March 1, 2015 through February 29, 2016, appeared to have experienced a delay. We did not find patients were clinically impacted by delays. Delays appeared to have persisted through the remainder of fiscal year 2016. Several factors contributed to these delays, including issues with the timeliness of fee department staff actions.

Recommendations

1. We recommended that the Federal Health Care Center Director ensure that fee department staff take timely action when providers order non-VA care and Choice dermatology consults.

2. We recommended that the Federal Health Care Center Director ensure that fee department staff take timely action to complete, cancel, or discontinue non-VA care and Choice dermatology consults, as appropriate.

Appendix A

Prior OIG Reviews of Consult Delays

The following list provides a chronological list of OIG oversight reports that addressed alleged consult delays and the impact of delays on patient outcomes, from FY 2014 to October 2016:

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System, Phoenix, Arizona
10/4/2016 | 15-04672-342 | Summary | Report

Combined Assessment Program Summary Report – Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities
5/23/2016 | 16-01489-311 | Summary | Report

Healthcare Inspection – Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina
5/3/2016 | 14-02890-286 | Summary | Report

Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California
3/30/2016 | 14-04897-221 | Summary | Report

Healthcare Inspection – Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, SC
1/6/2016 | 15-00992-71 | Summary | Report

Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, ME
6/17/2015 | 14-05158-377 | Summary | Report

Healthcare Inspection – Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas
12/22/2015 | 15-00268-66 | Summary | Report

Healthcare Inspection – Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California
10/28/2015 | 14-02890-497 | Summary | Report

Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ
10/15/2015 | 14-00875-03 | Summary | Report

Healthcare Inspection – Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois
9/29/2015 | 14-02952-498 | Summary | Report

Review of VHA's Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC
8/31/2015 | 15-02397-494 | Summary | Report

Healthcare Inspection - Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015 | 14-04530-452 | Summary | Report

Healthcare Inspection – Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado
7/7/2015 | 14-04049-379 | Summary | Report

Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues
7/1/2015 | 14-04116-408 | Summary | Report

Healthcare Inspection – Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, OK
6/16/2015 | 14-04573-378 | Summary | Report

Healthcare Inspection – Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
4/14/2015 | 14-03824-155 | Summary | Report

Healthcare Inspection — Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
3/3/2015 | 14-04473-132 | Summary | Report

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
2/18/2015 | 14-04194-118 | Summary | Report

Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ
1/28/2015 | 14-00875-112 | Summary | Report

Healthcare Inspection – Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, NC
11/6/2014 | 14-03298-20 | Summary | Report

Healthcare Inspection - Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA
8/12/2014 | 14-03010-251 | Summary | Report

Healthcare Inspection – Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama
5/19/2014 | 13-04474-157 | Summary | Report

Appendix B

Additional Scope and Methodology Information

This appendix provides supplemental scope and methodology information for how we evaluated the timeliness of Choice dermatology consults ordered by FHCC providers, and the impact of delays on patients. See Tables 1 - 3 below.

Table 1. CDW Data That Were Extracted and Analyzed by OIG

CDW location (database.schema.table)	How extracted data were used
CDWWORK.DIM.STA3N	Obtained station numbers for study population
CDWWORK.DIM.LOCATION	Decoded VA station physical location (for reference only)
CDWWORK.DIM.REQUESTSERVICE	Distinguished between administrative and clinical consults
CDWWORK.DIM.CLINICALTERM	Decoded clinical terminology (for reference only)
CDWWORK.DIM.PROVIDERNARRATIVE	Decoded provider narrative (for reference only)
CDWWORK.DIM.CPT	Obtained CPT codes and descriptions (for reference only)
CDWWORK.DIM.ICD9	Obtained ICD-9-CM codes
CDWWORK.DIM.ICD9DESCRIPTIONVERSION	Obtained ICD-9-CM descriptions
CDWWORK.DIM.ICD10	Obtained ICD-10 codes
CDWWORK.DIM.ICD10DESCRIPTIONVERSION	Obtained ICD-10 descriptions
CDWWORK.CON.CONSULT	Obtained all consults for selected stations
CDWWORK.CON.CONSULTACTIVITY	Identified consult activities for cancellation or closure without patient encounters
CDWWORK.SPATIENT.SCONSULTREASON	Obtained text identifying the reason for the consult
CDWWORK.SPATIENT.SPATIENT	Obtained patient identifiable information, including date of death
CDWWORK.APPT.APPOINTMENT	Identified appointments created from consults; if applicable
CDWWORK.OUTPAT.VISIT	Identified if patient physically visited station during timeframe for an outpatient encounter

CDW location (database.schema.table)	How extracted data were used
CDWWORK.OUTPAT.VDIAGNOSIS	Identified if patient had a diagnosis of any type at outpatient encounter
CDWWORK.OUTPAT.VPROCEDURE	Obtained full record of patient visit containing adverse event outpatient procedure
CDWWORK.INPAT.INPATIENT	Identified if patient had an inpatient stay during timeframe at VA station
CDWWORK.INPAT.INPATIENTDISCHARGEDIAGNOSIS	Identified if patient had a discharge diagnosis of any type during inpatient stay
CDWWORK.INPAT.INPATIENTFEEDIAGNOSIS	Obtained FEE inpatient records showing hospitalization and obtaining either discharge or admit diagnosis
CDWWORK.FBCS.DSS_AUTHSUPPDATA	Provided a to link between FEE encounters and ordered consult by authorization
CDWWORK.FEE.FEEAUTHORIZATION	Obtained FEE authorizations linked to consults by ID
CDWWORK.FEE.FEEINITIALTREATMENT	Obtained FEE visits linking the authorization to the type of treatment
CDWWORK.FEE.FEESERVICEPROVIDED	Obtained FEE outpatient records for patients
CDWWORK.FEE.FEEINPATINVOICE	Obtained FEE inpatient records showing hospitalization
CDWWORK.FEE.FEEINPATINVOICEICDDIAGNOSIS	Obtained diagnosis for FEE inpatient visits
CDWWORK.SSTAFF.SSTAFF	Obtained provider information if required (for reference only)

Source: OIG analysis of CDW data.

Table 2. Consult Urgencies and Associated Timeframes Used to Identify Delays

Consult urgency	Expected timeframe
Routine	Within 30 days
Next available	Within 30 days
Within 1 month	Within 30 days
Within 1 week	Within 7 days
Within 72 hours	Within 3 days
Within 48 hours	Within 2 days
Within 24 hours	Within 1 day
Today	Same day
STAT	Within 1 day
Emergency	Within 1 day

Source: OIG and OIG analysis of VA documents.

Note: According to VHA's consult business rules at the time of our review, STAT and emergency consults should be addressed within 6 and 4 hours, respectively. However, for the purposes of our analysis, we considered those consults to be timely if they were completed within 1 day to account for lags in entering documentation that can occur in urgent or emergent situations.

Table 3. ICD-9-CM and ICD-10 Codes Used to Identify Skin Cancers and Other Dermatologic Conditions That May Require Timely Intervention

ICD Version	Diagnostic codes
ICD-9-CM	017.00-017.06, 140.0, 140.1, 140.3-140.6, 140.8, 140.9, 149.9, 172.0-173.0, 173.00-173.02, 173.09, 173.1, 173.10-173.12, 173.19, 173.2, 173.20-173.22, 173.29, 173.3, 173.30-173.32, 173.39, 173.4, 173.40-173.42,173.49, 173.5, 173.50-173.52, 173.59, 173.6, 173.60-173.62, 173.69, 173.7, 173.70-173.72, 173.79, 173.8, 173.80-173.82, 173.89, 173.9, 173.90-173.92, 173.99, 176.0, 176.9, 198.2, 198.89, 202.01, 209.31-209.36, 209.75, 230.0, 232.0-232.9, 239.2, 279.49, 692.5, 695.13, 706.0, 782.1,995.2, 995.20
ICD-10	C43.0, C43.10-C43.12, C43.20-C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60-C43.62, C43.70-C43.72, C43.8, C43.9, C44.00-C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40-C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80-C44.82, C44.89, C44.90-C44.92, C44.99, C79.2, C79.9, C84.A1, D37.01, D48.5, D49.2, Z85.828, Z12.83, C4A.0, C4A.10-C4A.12, C4A.20-C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60-C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C7B.1, C46.0, D03.0, D03.10-D03.12, D03.20-D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60-D03.62, D03.70-D03.72, D03.8, D03.9, D04.0, D04.10-D04.12, D04.20-D04.22, D04.30, D04.39, D04.4, D04.5, D04.60-D04.62, D04.70-D04.72, D04.8, D04.9, Z85.820, D22.0, D22.10-D22.12, D22.20-D22.22, D22.30, D22.39, D22.4, D22.5, D22.60-D22.62, D22.70-D22.72, D22.9, D37.01, D48.5, D49.2, L51.1, D86.3, D86.9, D89.89, L70.0, L23.3, R21., T88.7XXA, T88.7XXD, T88.7XXS

Source: OIG analysis of ICD-9-CM and ICD-10.

Appendix C

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 25, 2017

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Healthcare Inspection—Veterans Choice Program Dermatology Delays, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

To: Director, Hotline Coordination, Office of Healthcare Inspections (54HL)

Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed the document and concur with the response as submitted.

2. If additional information is needed please contact Bincymol Kakkanad, Survey Accreditation Facilitator, Federal Health Care Center, Bincymol.kakkanad@va.gov, (224)-558-5986.

(original signed by:)
Renee Oshinski
Network Director

Appendix D

FHCC Director Comments

Department of Veterans Affairs

Memorandum

Date: May 25, 2017

From: Director, Captain James A Lovell Federal Health Care Center (556/00)

Subj: Healthcare Inspection—Veterans Choice Program Dermatology Delays, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

To: Director, VA Great Lakes Health Care System (10N12)

1. Attached is the Captain James A. Lovell Federal Health Care Center's response to the Office of Inspector General's report. I want to express my appreciation to the OIG survey team for their professional and comprehensive review.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans, active duty patients and families.

3. For any questions, please contact Bincymol Kakkanad, Survey Accreditation Facilitator, Bincymol.kakkanad@va.gov, (224)-558-5986.

(original signed by:)
Stephen R. Holt, MD, MPH, MSNRS
System Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Federal Health Care Center Director ensure that fee department staff take timely action when providers order non-VA care and Choice dermatology consults.

Concur

Target date for completion: March 30, 2018

Facility response: FHCC has added Non-VA Community Care department clinical staff to enable daily monitoring of the DOMA Health Net website portal and all NVCC (Nov-VA Community Care) consults. In December 2016, two employees were detailed to NVCC department to assist with consult processing, including Dermatology consults. With the additional staff, FHCC has reduced the number of outstanding consults by 59 percent since February 2017. FHCC will be hiring additional permanent clerical staff to facilitate timely processing of the current open and newly received NVCC consults. All dermatology consults returned from CHOICE Third Party Administrator (TPA) Health Net are scheduled through Non-VA care providers effective May 22, 2017. Additionally, VISN and FHCC representatives meet with Health Net routinely to review and reduce returns. To decrease the need for community dermatology care, the FHCC has recruited 1.0 FTEE dermatologist expected to begin employment in FY17 Q4. An additional 1.2 FTEE dermatologists are under recruitment. The additional 2.2 FTEs will add approximately 120–150 appointment slots per week. Due to the unique funding structure, the FHCC is unable to utilize provider agreements.

Recommendation 2. We recommended that the Federal Health Care Center Director ensure that fee department staff take timely action to complete, cancel, or discontinue non-VA care and Choice dermatology consults, as appropriate.

Concur

Target date for completion: March 30, 2018

Facility response: NVCC staff review the list of all Community Care consults daily from the VHA Support Service (VSSC) data portal to identify consults requiring actions. Many of the outstanding consults remain open due to lack of receipt of medical records for completed TPA Health Net episodes of care. Additional staff has been dedicated to processing consults including requesting documentation from community vendors. Upon receipt of the records, documents are scanned into FHCC medical records and attached electronically to the consult, which effectively changes the consult status to

completed. In the event the records are not received after three attempts, the NVCC staff will administratively close the consult in accordance with VHA protocol. FHCC will be hiring additional permanent clerical staff to facilitate timely processing of the current open and newly received NVCC consults.

Appendix E

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Lindsay Gold, LCSW Medina Hudson-Odoi, MSN, RN, CNM Melanie Krause, PhD, RN Judy Montano, MS Monika Spinks, BSN, RN Jennifer Tinsley, LCSW Thomas Wong, DO
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Appendix F

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