



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Review of Access to  
Telehealth and Provider  
Experience in VHA Prior to  
and During the COVID-19  
Pandemic



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## Executive Summary

The COVID-19 pandemic accelerated the Veterans Health Administration's (VHA's) efforts to expand telehealth, resulting in the number of daily video visits increasing from about 2,500 in February 2020 to 38,000 in September 2020.<sup>1</sup> In the report *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*, the VA Office of Inspector General (OIG) found that during the initial stages of the COVID-19 pandemic (pandemic), telephone use represented 81 percent of VHA primary care encounters and VA Video Connect (VVC) represented 3 percent.<sup>2</sup> In this current review, the OIG further analyzed encounter data to assess the implementation and use of VVC prior to and during the pandemic.<sup>3</sup> Specifically, the OIG explored factors affecting why primary and specialty care providers used telephone communication more frequently than VVC upon the onset of the pandemic and in lieu of in-person encounters, and how VHA resolved technology issues. The OIG also examined VHA provider experience with VVC prior to and during the pandemic to identify benefits of and barriers to VVC use.

The OIG found that while VHA did not explicitly articulate the possibility of a pandemic in the telehealth strategic plans, VHA identified the exigent nature of the pandemic in the March 2020 COVID-19 Response Plan, and described the pandemic as an emergent situation with documented goals to support increased outpatient care via telehealth, where appropriate.<sup>4</sup> The OIG concluded that the pandemic served as the impetus for increased focus on telehealth services and improvements in the utilization and sustainability of VVC.

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<sup>1</sup> VHA Office of Emergency Management, *COVID-19 Response Plan*, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, ver. 1.6, March 23, 2020. VA, Agency Financial Report Fiscal Year 2021, November 15, 2021.

<sup>2</sup> VA OIG, *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*, Report No. 20-02717-85, March 11, 2021. VHA Directive 1082, *Patient Care Data Capture*, March 24, 2015. An encounter, or appointment, is when a patient receives care from a clinical provider, which can be in-person at a clinic or via telehealth care modalities. "VA Video Connect," VA Mobile, accessed December 30, 2021, <https://mobile.va.gov/app/va-video-connect>. VVC is a video telehealth application that "allows Veterans and their caregivers to quickly and easily meet with VA healthcare providers through live video on any computer, tablet, or mobile device with an internet connection." *Merriam-Webster.com Dictionary*, "pandemic," accessed May 18, 2022, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is "an outbreak of a disease that occurs over a wide geographic area and affects a significant proportion of the population."

<sup>3</sup> The OIG examined the use of video telehealth care from October 2016 through July 2021. The OIG chose this time frame to review the history of the VVC application and the effectiveness of its implementation at the onset of and during the pandemic. For the purpose of this report, the onset of the pandemic included the period January through July 2020. The OIG team chose January 2020, which was congruent with VHA's pandemic preparations.

<sup>4</sup> VHA Office of Emergency Management, *COVID-19 Response Plan*. VHA planning included, "Clinical Operations other than emergency and inpatient services will have shifted to primarily virtual/telehealth modalities."

## OIG Analysis of Encounter Modalities

The OIG conducted a review of presumed in-person, telephone, and VVC encounters and found

- VVC encounter use increased prior to the pandemic but was the least used modality of care,
- telephone and VVC encounter use increased as presumed in-person encounters decreased at the onset of the pandemic, and
- telephone encounter use decreased and presumed in-person and VVC encounters continued to increase following the initial months of the pandemic.<sup>5</sup>

The OIG found that prior to the pandemic, VHA developed telehealth strategic plans, which focused on improving technology to support VVC, increasing provider capability and identifying emergency preparations for disaster scenarios requiring the provision of health care remotely.<sup>6</sup> However, the OIG learned that upon the onset of the pandemic, VHA was not readily able to support the increased demand of VVC use, leading providers to perform patient care through telephone encounters.

The OIG determined the number of providers using telephone encounters surpassed the number of providers using in-person encounters in March, and telephone encounters remained the highest used modality through July 2020.<sup>7</sup> The OIG found the number of VHA providers using telephone encounters for patient care rose from 55,483 in February 2020, to 81,211 in July 2020, an increase of approximately 46 percent.<sup>8</sup> When the OIG asked if the scenario of a pandemic was included in emergency preparedness plans and why providers utilized telephone encounters more than VVC at the beginning of the pandemic, VA Office of Connected Care (OCC) leaders

- did not recall having discussions about plans for VVC use in response to a pandemic,

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<sup>5</sup> “Presumed in-person” is a VHA term used to represent patient encounters other than VVC, telephone, and other telehealth or non-in-person encounters. For the purpose of this report, prior to the pandemic included the period from October 2016 through December 2019. The onset of the pandemic included the period beginning in January 2020 and through July 2020. The initial months of the pandemic included the period from August 2020 through June 2021.

<sup>6</sup> VA Office of Connected Care, “VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update,” October 2018. VA Office of Connected Care, “VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update,” ver. 1, May 2019.

<sup>7</sup> For the purposes of this report, the OIG identifies an in-person encounter as taking place between a provider and patient physically located together at a VA facility or clinic. A VVC encounter occurs over video through the VVC application to a patient’s computer, tablet, or mobile device (non-VA location). VHA administrative data does not identify the specific video application utilized to conduct video encounters. The OIG considered all video encounters between a provider and patient located at a non-VA location to be VVC, regardless of video application utilized, including encounters occurring prior to the VVC application launch in August 2017.

<sup>8</sup> OCC, “VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update.” OCC, “VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update.”

- commented that telephone encounters are quicker and easier to use than VVC encounters and that the telephone clinics were already established, and
- stated the goal of telehealth expansion is not to transition fully to video telehealth, but to ensure awareness by clinicians and patients that video care is available.<sup>9</sup>

Additionally, OCC leaders told the OIG that the cloud capacity to support VVC technology could not meet the provider demand at the beginning of the pandemic. The OCC Chief Officer recalled video visits increasing from 2,000 to 40,000 per day and stated, “the technical infrastructure was not scaled to that kind of. . . unexpected and unplannable [*sic*] for growth.”

To sustain the increased demand of VVC use, VHA issued memorandums allowing for the use of non-public facing video chats for the duration of the pandemic, supplied resources such as workstations with the equipment necessary to perform VVC visits, and provided additional funding for bandwidth expansion.<sup>10</sup> VHA’s efforts led to increased VVC use throughout the pandemic allowing for continuity of care that presented alternatives to in-person and telephone encounters.

The OIG concluded that the growth in providers’ use of VVC that began in tandem with the pandemic was sustained during the pandemic, as providers appear to have integrated VVC as a routine modality in patient care. Provider utilization of VVC almost doubled, from 4.75 to 9.37 percent of all monthly encounters, from August 2020 through June 2021.

## VHA Provider Experience

The OIG identified providers who used VVC between 15 and 85 percent for all outpatient encounters from October 2016 through July 2021. The OIG then selected a subset of providers whose VVC utilization trends included an increase or decrease in VVC use as compared to telephone use.<sup>11</sup> This selection of providers ensured the OIG met with providers who were familiar with VVC and could presumably identify barriers and benefits prior to and during the pandemic.<sup>12</sup>

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<sup>9</sup> Leaders in OCC included the Chief Officer, National Technology Integration Lead, National Connected Care Help Desk Manager, and former Synchronous Telehealth Lead. OCC told the OIG that the Deputy Director for Clinical Services served as the Synchronous Telehealth Lead until November 21, 2021.

<sup>10</sup> VHA Assistant Secretary for Office of Information & Technology, Chief Information Officer memorandum, “Use of Video Communication Technology Under COVID-19,” March 19, 2020. Non-public facing video chats include, but are not limited to, “Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype.”

<sup>11</sup> The OIG also interviewed additional providers identified during the review’s VHA entrance briefing who expressed interest in sharing their experiences.

<sup>12</sup> The providers selected and interviewed were not statistically representative of the VHA provider population and interview questions varied somewhat between providers based on their responses.

## Benefits

During interviews, providers stated the pandemic served as a turning point, pivoting VHA health care from in-person to telehealth modalities. Providers also commented on the benefits available when using VVC, such as convenience and increased patient engagement. The OIG learned providers

- viewed the pandemic as an implement of change that encouraged VVC use,
- recognized the expediency in using VVC, such as increased access to care and ease of use for both patients and providers, and
- appreciated patient and family engagement during VVC use.

The OIG determined that VVC use changed the way providers delivered patient care, particularly during the pandemic, as providers found VVC allowed continued visual contact with patients, increased access to care, and improved patient engagement.

## Barriers

Through provider interviews, the OIG also learned of barriers to VVC use such as patient obstacles with VVC technology, VVC appointments not emulating in-person appointments, and provider difficulty with scheduling VVC appointments. The OIG found providers identified barriers that presented challenges that could affect patient care.

### *Patient Difficulties with VVC Technology*

Providers described two challenges with VVC technology: a lack of patient training, and issues with patients' connectivity to the internet or access to a mobile device. The OIG found that despite OCC efforts to support patients by introducing patient tools for VVC use, such as creation of the Digital Divide Consult and Connected Devices Support Program, several providers told the OIG of unfamiliarity with these VHA initiatives.<sup>13</sup> OCC staff told the OIG the Connected Devices Support Program was put into place in early 2021 and was considered an extension of test calls provided through the Digital Divide consults; however, the service was not articulated in VHA procedure until August 2022. The OIG determined that deficiencies in

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<sup>13</sup> OCC, "Digital Divide Standard Operating Procedure," August 2022 accessed January 25, 2022, <https://connectedcare.va.gov/sites/default/files/2021-10/telehealth-digital-divide-fact-sheet.pdf>. The digital divide refers to people who have limited or no ability to connect to "internet service or technology needed for VA telehealth." The Digital Divide Consult links patients to a program to determine eligibility for free mobile connectivity. OCC, "Digital Divide Standard Operating Procedure," August 2022. The Connected Devices Support Program, formerly known as White Glove service, uses national helpdesk employees to train patients on how to set up a VA-loaned device and operate the VVC application. The Connected Devices Support Program staff then perform a VVC test call with the patient.

provider VVC knowledge and utilization of VVC technology, including resource tools, affected patients' access to care.

### *VVC Emulating In-Person Encounters*

VHA's telehealth strategic plans outlined that telehealth encounters must be similar to in-person encounters in regard to scheduling and integrating virtual care "into routine operations."<sup>14</sup>

Providers reported

- lack of support with checking-in the patient, taking vitals, and scheduling follow-up care;
- absence of support to address patient expectations and understanding of what a VVC visit is; and
- patient frustration while waiting for the provider to join the appointment as there is no ability to communicate the provider's status.

The OIG found that VVC encounters did not always mirror in-person encounters and concluded that the lack of clinical and administrative support during VVC encounters could impede patient care.

### *VVC Scheduling*

The OIG found that despite OCC efforts to remove scheduling barriers to VVC use, such as *VVC Now*, providers described scenarios that suggested an unawareness of these improvements and had difficulty with scheduling VVC appointments.<sup>15</sup> The OIG concluded scheduling barriers may impact a provider's ability to ensure timely and clinically appropriate patient care.

The OIG made three recommendations to the Under Secretary for Health related to knowledge and utilization of VVC technology, clinical and administrative support, and VVC scheduling processes.

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<sup>14</sup> OCC, "Anywhere to Anywhere VA Telehealth, Strategic Plan: FY 2018-2020 Update." OCC, "Anywhere to Anywhere VA Connected Care, Strategic Plan: FY 2020-2022 Update."

<sup>15</sup> *VVC Now* is an application that allows providers to instantly invite patients to a VVC appointment.

## Comments

The Under Secretary for Health concurred with the recommendations and provided an acceptable action plan (see appendix B). The OIG will follow up on the planned actions until they are completed.

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion. For this report, VHA provided technical comments to the OIG during the draft phase. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to OIG findings and recommendations.



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## Abbreviations

CDW	Corporate Data Warehouse
CVT	clinical video telehealth
OCC	Office of Connected Care
OIG	Office of Inspector General
PACT	patient aligned care team
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VVC	VA Video Connect



## Introduction

The VA Office of Inspector General (OIG) conducted a review to assess the implementation and use of VA Video Connect (VVC) prior to and during the COVID-19 pandemic (pandemic).<sup>1</sup> The OIG also examined Veterans Health Administration (VHA) provider experience with VVC technology.<sup>2</sup>

### Evolution of VVC as a Telehealth Modality

Telehealth is a modality that allows a healthcare provider to provide care to patients virtually “. . . in a separate location using two-way voice and visual communication (as by [*sic*] computer or cell phone.)”<sup>3</sup> Per VHA, telehealth allows providers “to enhance and extend care and case management to facilitate access to care and improve the health of designated individuals and populations with the specific intent of providing the right care in the right place at the right time.”<sup>4</sup>

In 2016, VHA Telehealth Services and Connected Health combined to become the VA Office of Connected Care (OCC), linking “VA health care system at all levels—from simple transactions and requests for information, to full-out virtual care.”<sup>5</sup> In 2017, the former VA Secretary, Dr. David Shulkin, announced initiatives to expand telehealth use, including the expansion of care

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<sup>1</sup> “VA Video Connect,” VA Mobile, accessed December 30, 2021, <https://mobile.va.gov/app/va-video-connect>. VVC is a video telehealth application that “allows Veterans and their caregivers to quickly and easily meet with VA health care providers through live video on any computer, tablet, or mobile device with an internet connection.” *Merriam-Webster.com Dictionary*, “pandemic,” accessed May 18, 2022, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is “an outbreak of a disease that occurs over a wide geographic area. . . affect[ing] a significant proportion of the population.” “WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020,” World Health Organization, accessed August 3, 2021, <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. The World Health Organization declared a world-wide pandemic on March 11, 2020, citing “alarming levels of spread and severity” of COVID-19.

<sup>2</sup> VA QUERI, Partnered Evidence-based Policy Resource Center policy brief, “Virtual Health Care: Using Telehealth to Provide Care in VHA,” August 2021. VHA Deputy Under Secretary for Health for Operations and Management memorandum, “COVID-19: Protecting Veterans and the Department of Veteran Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home,” March 11, 2020. “VA secure messaging,” VA Health Care, accessed August 12, 2021, <https://www.va.gov/health-care/secure-messaging/>. Although patients may receive telehealth through modalities such as telephone, store and forward (a remote provider accessing a patient’s health information from a secure network), and secure messaging (protected communications between a patient and provider), this report will focus on video-based telehealth to non-VA locations used during the COVID-19 pandemic to reduce the spread of infection as VHA limited in-person visits.

<sup>3</sup> *Merriam-Webster.com Dictionary*, “telehealth,” accessed September 8, 2022, <https://www.merriam-webster.com/dictionary/telehealth>.

<sup>4</sup> VHA Directive 1082, *Patient Care Data Capture*, March 24, 2015.

<sup>5</sup> VHA Office of Policy and Services, OCC (10P8), “Inaugural Strategic Plan ver. 1.12,” February 2017. VHA’s Connected Health Office consisted of My HealthVet, VHA Innovation, and VA Web and Mobile Solutions.

into the home for patients to “receive a portion of their care through video telehealth” and capability for “a rapid telehealth response to disasters.”<sup>6</sup>

In June 2018, Congress supported the expansion of telehealth services and passed the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (VA MISSION Act), aimed “to address the access barriers that veterans may experience when accessing VA telehealth services.”<sup>7</sup> VHA’s June 8, 2018, notice of telehealth expansion stated

- the purpose of video telehealth is to provide care, when clinically appropriate, in a patient’s preferred location, such as their home;
- “all care providers who deliver ambulatory care, including Specialty Care providers, [are] to be capable of providing services into the home, to a Veteran’s mobile device, or other locations through telehealth by the end of FY [fiscal year] 2021;” and
- a VHA provider may “exercise their authority” to provide telehealth care for any outpatient appointment not requiring a hands-on physical examination.<sup>8</sup>

On June 11, 2018, VA amended healthcare provider regulations to allow remote telehealth patient encounters, “irrespective of the state or location within a State where the health care provider or the beneficiary is physically located.”<sup>9</sup> The regulation allowed for preemption of certain state laws regulating health care providers and removed barriers related to the interstate provision of healthcare.<sup>10</sup>

VA telehealth strategic plans from October 2017 through September 2022, outlined collaborations between VHA and VA’s Office of Information and Technology (OI&T), in that OI&T would host and manage VHA’s cloud-based healthcare technologies, such as VVC, and

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<sup>6</sup> VA, “President, VA secretary announce Veteran telehealth initiatives designed to provide greater access, care,” *VAntage Point* (blog), August 3, 2017, <https://blogs.va.gov/VAntage/40113/president-va-secretary-announce-veteran-telehealth-initiatives-providing-greater-access-care/>. OCC, “VA Anywhere to Anywhere VA Telehealth, Strategic Plan: FY 2018-2020 Update.” OCC, “VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update,” ver. 1, May 2019. Although both strategic plans outline similar goals regarding video telehealth expansion, the current strategic plan does not use numbers as metrics to articulate goals.

<sup>7</sup> “S.2372 – VA MISSION Act of 2018,” Library of Congress, accessed April 4, 2022, <https://www.congress.gov/bill/115th-congress/senate-bill/2372/text>. Congressional Research Service, “Department of Veterans Affairs (VA): A Primer on Telehealth,” July 26, 2019.

<sup>8</sup> VHA Notice 2018-25, *Expansion of Telehealth Services into the Home and Other Non-VA Settings*, June 8, 2018. The notice expired on June 30, 2019, but the rescinded notice stated the information was to remain in effect. VHA explains a VVC appointment is clinically appropriate when the provider considers the patient’s care needs and preferences and determines the care “does not require a hands-on physical exam or services.” Fiscal year 2021 refers to the time frame October 1, 2020—September 30, 2021.

<sup>9</sup> For the purposes of this report, a patient encounter is synonymous with a patient visit.

<sup>10</sup> 38 C.F.R. § 17.417, Health care providers practicing via telehealth. The regulation also articulated exemptions to telehealth practice such as compliance with controlled substance regulations and other federal laws. VHA Notice 2018-25.

provide capacity for telehealth care to meet the demand.<sup>11</sup> In July 2018, OI&T assessed bandwidth requirements at VA outpatient clinics to conduct VVC sessions. VHA requested Veterans Integrated Service Networks (VISN) staff assign “priority levels” to outpatient clinics for bandwidth upgrades to support VVC use.<sup>12</sup>

## Provider Capability

Coinciding with the June 2018 Congressional legislation, VHA announced a timeline for telehealth expansion. Specifically, 75 percent of Patient Aligned Care Teams (PACTs) and outpatient mental health providers must be “capable of delivering telehealth services into the home, to a Veteran’s mobile device, or other locations” by September 30, 2019, and 100 percent by September 30, 2020. Additionally, “all care providers who deliver ambulatory care,” including specialty care providers, are to be capable by September 30, 2021.<sup>13</sup> Consistent with the timeline for telehealth expansion, VHA updated the telehealth strategic plan emphasizing these milestones.<sup>14</sup> VHA defined capable providers as those who have

- an established clinic for VVC appointments,
- the necessary equipment to complete a VVC appointment, and
- the required training in VVC use.<sup>15</sup>

Other VA expansions to support provider capability and use of VVC included

- prioritizing increased bandwidth at VHA outpatient locations to accommodate providers that are performing VVC encounters,<sup>16</sup> and

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<sup>11</sup> OCC, “VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update.” OCC, “VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update.” The strategic plans defined telehealth care demand: for every clinic serving 1,000 veterans, VA providers could conduct one and a half video telehealth sessions at the same time. “Charting a New Course for Digital Transformation,” VA OI&T, accessed June 14, 2022, <https://www.oit.va.gov/news/article/?read=charting-a-new-course-for-digital-transformation>. The VA OI&T is responsible for creating and maintaining IT products and services for VA customers, including VHA and their patients. *Merriam-Webster.com Dictionary*, “cloud computing,” accessed July 12, 2022, <https://www.merriam-webster.com/dictionary/cloud%20computing>. Cloud based refers to cloud computing, which is the accessing of computer data, stored on multiple servers, through the internet.

<sup>12</sup> VHA Deputy Under Secretary for Health for Operations and Management memorandum, “Veterans Integrated Service Network (VISN) Bandwidth Prioritization for Telehealth Expansion,” July 23, 2018.

<sup>13</sup> VHA Notice 2018-25. “Patient Aligned Care Team (PACT),” VHA, accessed February 15, 2022, <https://www.patientcare.va.gov/primarycare/PACT.asp>. VHA provides primary care through PACTs, which coordinate all aspects of a patient’s care and include a primary care provider, nurse case manager, additional clinician(s) as determined necessary, and an administrative clerk.

<sup>14</sup> OCC, “Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update.”

<sup>15</sup> VHA Notice 2018-25.

<sup>16</sup> VHA Deputy Under Secretary for Health for Operations and Management memorandum, “Veterans Integrated Service Network (VISN) Bandwidth Prioritization for Telehealth Expansion.” The effort to identify bandwidth capacity included support from OI&T.

- building community partnerships to grow telehealth care in rural areas.<sup>17</sup>

In February 2019, VHA informed VISNs that OCC would start tracking the progress toward telehealth expansion goals through reviews of provider capability. VISNs not meeting expectations were expected to submit action plans to improve provider capability.<sup>18</sup>

To measure VISN progress toward VHA telehealth goals, OCC Telehealth Quality Team developed a National Quality Data Scorecard that included “essential data elements that are linked to the Conditions of Participation.”<sup>19</sup> VISN and facility telehealth staff collaborate to complete the Conditions of Participation tool annually to track providers’ overall progress in delivering telehealth.<sup>20</sup>

## Emergency Preparedness

Emergency preparedness is the process of continuous efforts, including planning, training, and evaluating, taken by medical facilities to ensure a coordinated response to emergencies.<sup>21</sup> In 2017, VHA established Telehealth Emergency Management to utilize telehealth during disasters such as hurricanes.<sup>22</sup> VA telehealth strategic plans for fiscal years 2018 through 2022 also included emergency preparedness plans enabling VHA providers to remotely activate community emergency response for patients as needed, and for a telehealth workforce capable of rapid response to areas affected by disasters.<sup>23</sup>

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<sup>17</sup> VA, “Telehealth: Adapting tech to improve VA health care,” *Vantage Point* (blog), December 20, 2018, <https://blogs.va.gov/Vantage/55049/va-telehealth/>. At the December 2018 *Anywhere to Anywhere, Together* Summit, VA brought industry, government, and non-profit leaders together “to discuss how telehealth can drive innovation in American health care.”

<sup>18</sup> VHA Acting Deputy Under Secretary for Health for Operations and Management memorandum, “Veterans Integrated Service Network Progress Status Check: Expansion of Telehealth Services into Home and Other Non-VA Settings,” February 11, 2019.

<sup>19</sup> VHA Telehealth Services, “Office of Connected Care: Quality Program Standard Operating Procedures,” September 2019. The aim of the scorecard includes reviewing implementation and planning strategies, as well as standardization of telehealth operations. The OIG learned from OCC that although Conditions of Participation tracking began in FY17 (October 1, 2016—September 30, 2017), it was not until April 2018 that OCC began oversight of the Conditions of Participation.

<sup>20</sup> VHA Telehealth Services, “Office of Connected Care: Quality Program Standard Operating Procedures.” The Conditions of Participation tool examines the presence of executive leadership support, number of staff trained in and capable of telehealth care, scheduling processes, and technical support for providers.

<sup>21</sup> “Emergency Management,” The Joint Commission, accessed June 23, 2022, <https://www.jointcommission.org/resources/patient-safety-topics/emergency-management/>.

<sup>22</sup> “How the VA laid the groundwork for a pandemic-fueled telehealth spike,” HIMSS Media - Healthcare IT News, accessed June 23, 2022, <https://www.healthcareitnews.com/news/how-va-laid-groundwork-pandemic-fueled-telehealth-spike>.

<sup>23</sup> OCC, “VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update.” OCC, “VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update.”

On January 31, 2020, the Secretary of the U.S. Department of Health and Human Services declared a nationwide public health emergency due to COVID-19.<sup>24</sup> VHA's subsequent COVID-19 Response Plan stated VHA would coordinate with the Department of Health and Human Services in the pandemic response, and "provide most outpatient care for Veterans through telehealth services as appropriate. This approach minimizes the risk of infection, supports expansion to meet an increasing need for COVID-19 services, and provides veterans in routine VA care consistent access to VA care."<sup>25</sup>

## Prior OIG Reports

In *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*, the OIG found that during the initial stages of the pandemic, from February 7 through May 6, 2020, veteran telephone and VVC encounters increased. Of all primary care visits, telephone encounter use represented 81 percent and VVC encounters represented 3 percent.<sup>26</sup> The OIG identified the main factor affecting primary care providers use of VVC was the difficulty veterans had navigating the VVC application without training and support. The OIG made two recommendations to the Under Secretary for Health related to access, equipment, and VVC training and support for veterans.<sup>27</sup> The recommendations resulted in VHA's release of an electronic health record screening tool for the Digital Divide consult, to address veterans' needs for equipment, internet access, and training and support to use VVC.<sup>28</sup> Both recommendations are closed.

On June 24, 2021, the OIG published *Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic*, finding "a majority of patient-clinic locations were missing some or all emergency procedures

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<sup>24</sup> "Determination that a Public Health Emergency Exists," U.S. Department of Health and Human Services, accessed June 27, 2022, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

<sup>25</sup> VHA Office of Emergency Management, *COVID-19 Response Plan*, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, ver. 1.6, March 23, 2020.

<sup>26</sup> VA OIG, *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*, Report No. 20-02717-85, March 11, 2021. The remaining 16 percent of all primary care encounters reviewed included face-to-face and VA-to-VA virtual encounters. VHA Directive 1082, *Patient Care Data Capture*, March 24, 2015. An encounter, or visit, is when a patient receives care from a clinical provider, which can be in-person at a clinic or via telehealth care modalities.

<sup>27</sup> VA OIG, *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*.

<sup>28</sup> VA OIG, *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*. OCC, "Connecting Veterans to Telehealth Care," accessed January 25, 2022. The digital divide refers to patients that have limited or no ability to connect to "internet service or technology needed for VA telehealth," whether due to living in rural areas or needing assistance with the cost of internet and/or phone services. The Digital Divide Consult links patients to a program to determine eligibility for technology support, including electronic devices and internet data subscriptions. VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021. Consults are placed, by a provider, in a patient's electronic health record and serve as a request for assistance, evaluation, or management of a patient's care needs.

required in telehealth emergency plans.” The OIG concluded that without defined telehealth roles and responsibilities, “patient care may be delayed or inadequate due to a poorly coordinated emergency response.”<sup>29</sup> The OIG made five recommendations to the Under Secretary for Health related to national processes for a telehealth emergency response.<sup>30</sup> The recommendations are closed.

On May 4, 2022, the OIG published the report, *Purchases of Smartphones and Tablets for Veterans’ Use during the COVID-19 Pandemic*. The OIG found veterans’ demand for iPhones was lower than OCC predictions.<sup>31</sup> The OIG made two recommendations, related to device storage and cost-benefit analyses of new data plans. These two recommendations remain open as of November 2022.<sup>32</sup>

## Scope and Methodology

The OIG initiated a review on June 10, 2021, and conducted interviews from October 4 through November 8, 2021. Interviewees included VHA telehealth leaders and selected primary and specialty care providers. (See [appendix A, table 2](#) for further details on clinical specialties and disciplines.)<sup>33</sup>

The OIG examined the use of video telehealth care from October 2016 through July 2021. The OIG chose this time frame to review VHA’s video telehealth care during the evolution of the VVC application and how the application was used prior to and during the pandemic. For the purposes of this report, the OIG uses the term VVC to refer to all video telehealth care to non-VA location(s), including other video applications used prior to the launch of VVC in August

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<sup>29</sup> VA OIG, [Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic](#), Report No. 19-09808-171, June 24, 2021.

<sup>30</sup> VA OIG, [Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic](#).

<sup>31</sup> VA OIG, [Purchases of Smartphones and Tablets for Veterans’ Use during the COVID-19 Pandemic](#), Report No. 21-02125-132, May 4, 2022. “About Connected Care,” OCC, accessed June 30, 2022, <https://connectedcare.va.gov/about>. The OCC brings all VA digital health technologies together, focusing on improvement of telehealth care.

<sup>32</sup> VA OIG, [Purchases of Smartphones and Tablets for Veterans’ Use during the COVID-19 Pandemic](#).

<sup>33</sup> “Specialty Care Services,” VA Health Benefits, accessed on September 6, 2022, [https://www.va.gov/healthbenefits/access/specialty\\_care\\_services.asp](https://www.va.gov/healthbenefits/access/specialty_care_services.asp). Specialty care providers have specific knowledge of and training “in unique or complicated courses of care,” providing focused care in areas such as cardiology. Specialty care providers interviewed included clinical pharmacists, a dietician, physical therapists, social workers, speech pathologists, a surgeon, as well as providers from cardiology, pain management, and VHA’s Whole Health program.

2017.<sup>34</sup> The OIG team also reviewed relevant OCC policies and procedures, strategic plans, committee charters, and organizational charts.<sup>35</sup>

The OIG interviewed VHA telehealth leaders, including, OCC Chief Officer, Director of Quality and Training, former Synchronous Telehealth Lead; VHA Telehealth Services Data and Virtual Care Managers; and OCC's Technology National Connected Care Help Desk Manager and a National Technology Integration Lead.<sup>36</sup>

The OIG reviewed data from the VHA Corporate Data Warehouse (CDW) to identify all VHA providers who use video to non-VA location encounters.<sup>37</sup> VHA defines video to non-VA location care encounters by specific stop codes, including patient care conducted through the VVC application. (See [appendix A, table 1](#).)<sup>38</sup> As administrative data does not identify the application used for video to non-VA locations, the OIG uses the term VVC to include any video encounter to a non-VA location.

The OIG recognized that although VVC utilization data provides valuable analytical information, exploring the experience of VHA providers who use VVC allows for additional context and insight into functionality and operability for users. To review provider experiences with VVC prior to and during the pandemic, the OIG identified 60 VHA providers who used VVC between 15 and 85 percent for all outpatient encounters from October 2016 through July 2021.

The OIG then selected a subset of 30 providers based on provider type and geographic location, whose VVC utilization trends included an increase or decrease in VVC use as compared to telephone encounter use. The OIG also interviewed three additional providers identified during the review's entrance briefing who expressed interest in sharing their experiences. (See [appendix](#)

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<sup>34</sup> VA, "President, VA secretary announce Veteran telehealth initiatives designed to provide greater access, care," *Vantage Point* (blog), August 3, 2017, <https://blogs.va.gov/VAntage/40113/president-va-secretary-announce-veteran-telehealth-initiatives-providing-greater-access-care/>. Congressional Research Service, "Department of Veterans Affairs (VA): A Primer on Telehealth." VA also uses Clinical Video Telehealth (CVT), a precursor to VVC. For the purposes of this report and data analysis, CVT includes only those telehealth services offered to patients at different VA sites of care.

<sup>35</sup> The OIG did not review facility policies.

<sup>36</sup> The OIG learned from OCC that the former Synchronous Telehealth Lead transitioned on November 21, 2021, to the role of OCC Health Deputy Director for Clinical Services.

<sup>37</sup> "Corporate Data Warehouse," VA Health Services Research and Development, accessed on December 30, 2021, [https://www.hsrd.research.va.gov/for\\_researchers/vinci/cdw.cfm](https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm). The CDW is a large-scale data warehouse that collects real-time health care data from VHA's electronic health record system.

<sup>38</sup> VHA Managerial Cost Accounting Office, "VistA Stop Codes Instructional Guide," accessed December 30, 2021, [http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp). A stop code is a VHA term used to characterize VHA outpatient encounters. Stop codes, used to identify workload, and may indicate which provider(s), clinical service(s), and clinic(s) took part in the patient care. "The primary stop code designates the main clinical group responsible for the care" while the secondary stop code further defines the clinical group, including the provider type and modality of care, such as if the providers delivered service via video-based telehealth. (This is an internal website not publicly accessible.)

[A, table 2](#) for further details on clinical specialties and disciplines.)<sup>39</sup> This selection of 33 providers ensured the OIG met with providers who were familiar with VVC and could presumably identify barriers and benefits prior to and during the pandemic.<sup>40</sup>

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401–24). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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<sup>39</sup> The OIG selected the 33 VHA providers from VISN and facilities nationwide and of various clinical specialties and disciplines. The OIG excluded mental health providers as the OIG recently released a report, VHA Office of Inspector General, [Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic](#), Report No. 19-09808-171, June 24, 2021.

<sup>40</sup> The providers selected and interviewed were not statistically representative of the VHA provider population and interview questions varied somewhat between providers based on their responses. The OIG examination of VHA provider experience with VVC is intended to be informative and is not statistically significant. The OIG elected to exclude VHA providers with little or no experience with VVC.

## Review Results

VHA recognized the need for technology in health care and established Telehealth Services in 2003. VHA telehealth services continued to evolve as outlined by OCC strategic plans.<sup>41</sup>

The OIG reviewed the evolution of telehealth to analyze the use of VVC prior to and during the pandemic, and to examine provider perspectives on their VVC experiences.

The OIG found that prior to the pandemic, VHA developed telehealth strategic plans, which focused on improved technology to support VVC, and increased provider capability and emergency preparations for scenarios requiring the provision of health care remotely.<sup>42</sup> The OIG found that from October 2016 through June 2021

- VVC use increased, although it was the least used modality of care,
- VVC use increased with the occurrence of the pandemic, and
- VVC use continued to increase through June 2021.

The OIG found that while VHA did not explicitly articulate the possibility of a pandemic in the telehealth strategic plans, VHA identified the exigent nature of the pandemic in the March 2020 COVID-19 Response Plan, and noted the pandemic as an emergent situation with documented goals to support increased outpatient care via telehealth, where appropriate.<sup>43</sup> The OIG concluded that the pandemic served as the impetus for increased focus on telehealth services and improvements in the utilization and sustainability of VVC.

The OIG interviewed providers who used VVC and learned of benefits, as well as operational barriers, that made VVC appointments a challenge and disrupted the provision of telehealth-based care at the onset of the pandemic. Providers also informed the OIG of ongoing barriers.

### 1. OIG Analysis of Encounter Modalities

Prior to the pandemic, VHA established VVC provider capability goals and tools to measure and track the progress of telehealth implementation. However, the OIG learned that upon the onset of the pandemic, VHA was not readily able to support the increased demand of VVC use leading providers to perform patient care through telephone encounters. To sustain the increased demand of VVC use, VHA issued memorandums allowing for the use of non-public facing video chats,

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<sup>41</sup> Hearing on VA Home Telehealth: Looking Behind the Numbers, Before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, 115<sup>th</sup> Cong. (August 30, 2017) (statements of Dr. Kevin Galpin, Executive Director, Telehealth Services, OCC, and Dr. Thomas Wong, Senior Physician, VA Office of Inspector General).

<sup>42</sup> OCC, "VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update." OCC, "VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update."

<sup>43</sup> VHA, *COVID-19 Response Plan*. VHA planning included, "Clinical Operations other than emergency and inpatient services will have shifted to primarily virtual/telehealth modalities."

supplied resources such as workstations with the equipment necessary to perform VVC visits, and provided additional funding for bandwidth expansion.<sup>44</sup> Throughout the pandemic VHA providers continued to increase their VVC use as VHA mitigated some barriers to the delivery of care via telehealth.

The OIG conducted a review of in-person, telephone, and VVC encounters from October 2016 through June 2021.<sup>45</sup> For the purposes of this report, the OIG identified the review periods as follows:

- Phase 1 – prior to the pandemic, from October 2016 through December 2019
- Phase 2 – the onset of the pandemic in January 2020 and continued through July 2020
- Phase 3 – following the onset of the pandemic, from August 2020 through June 2021<sup>46</sup>

The OIG analyzed VHA encounters, unique providers, and monthly utilization averages by modality of care used from October 2016 through June 2021, and found

- VVC encounter use increased but was the least used modality of care in Phase 1,
- VVC and telephone encounter use increased as presumed in-person encounters decreased in Phase 2, and
- VVC encounter use and presumed in-person encounters continued to increase, and telephone encounter use decreased in Phase 3.<sup>47</sup>

As of June 2021, VVC use had not returned to pre-pandemic levels. (See figure 1.)

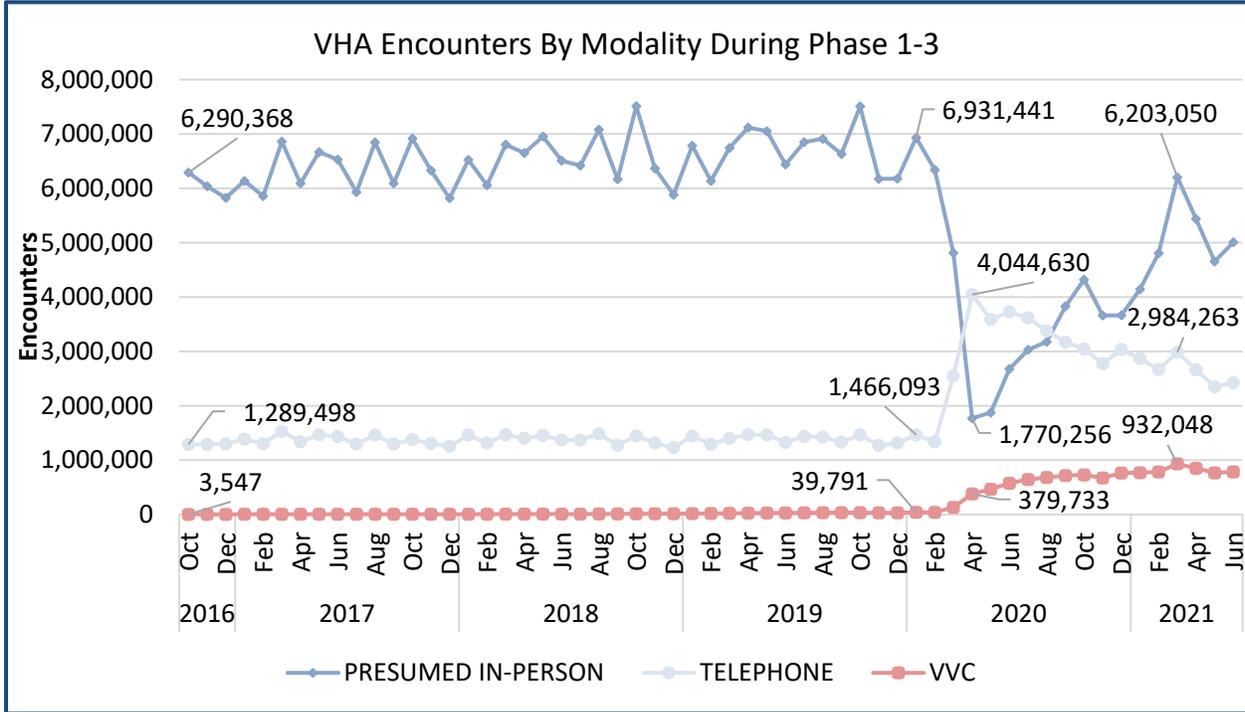
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<sup>44</sup> VHA Assistant Secretary for Office of Information & Technology, Chief Information Officer memorandum, “Use of Video Communication Technology Under COVID-19,” March 19, 2020. Non-public facing video chats include, but are not limited to, “Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype.”

<sup>45</sup> For the purposes of this report, the OIG identifies an in-person encounter as taking place between a provider and patient physically located together at a VA facility or clinic. “VA Video Connect,” VA Mobile, accessed December 12, 2022, <https://mobile.va.gov/app/va-video-connect>. A VVC encounter occurs over video through the VVC application to a patient’s computer, tablet, or mobile device (non-VA location). VHA administrative data does not identify the specific video application utilized to conduct video encounters. The OIG considered all video encounters between a provider and patient located at a non-VA location to be VVC, regardless of video application utilized, including encounters occurring prior to the VVC application launch in August 2017.

<sup>46</sup> The OIG defines the onset of the pandemic for this report as the period beginning in January 2020 and through July 2020.

<sup>47</sup> “Presumed in-person” is a VHA term used to represent patient encounters other than VVC, telephone, and other telehealth or non-in person encounters.



**Figure 1.** VHA encounters by modality during Phases 1-3, from October 2016 through June 2021; modalities limited to presumed in-person, telephone, and VVC.

Source: VA OIG analysis of VHA CDW patient encounter data.

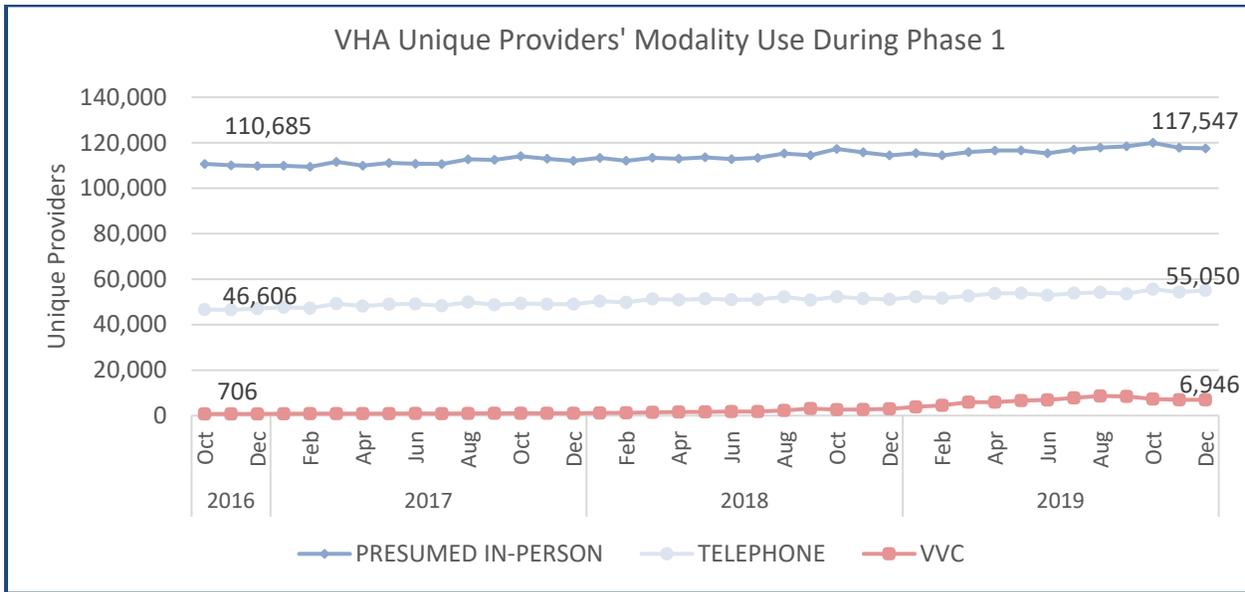
## Phase 1 – October 2016 through December 2019

Prior to the pandemic, OCC established telehealth modalities and tools to measure and track goal performance and further developed technology and provider capability to use VVC.

### OIG Analysis of VVC Use

The OIG analyzed encounter data and VHA providers’ VVC use and found the number of VHA providers using VVC during Phase 1 increased from 706 to 6,946, approximately 884 percent. The most notable increase in VVC use occurred between January 2019 and December 2019, which coincided with VHA’s efforts to boost provider VVC capability. Comparatively, the number of providers using in-person and telephone encounters gradually increased, then generally remained consistent. (See figure 2.) The OIG determined that provider VVC use increased from October 2016 through December 2019, however, compared to other modalities, providers used VVC the least.<sup>48</sup>

<sup>48</sup> For the purposes of this report, the OIG counts each provider once, regardless of how many in-person, telephone, or VVC encounters the provider had, or at how many services or facilities the provider may have worked.



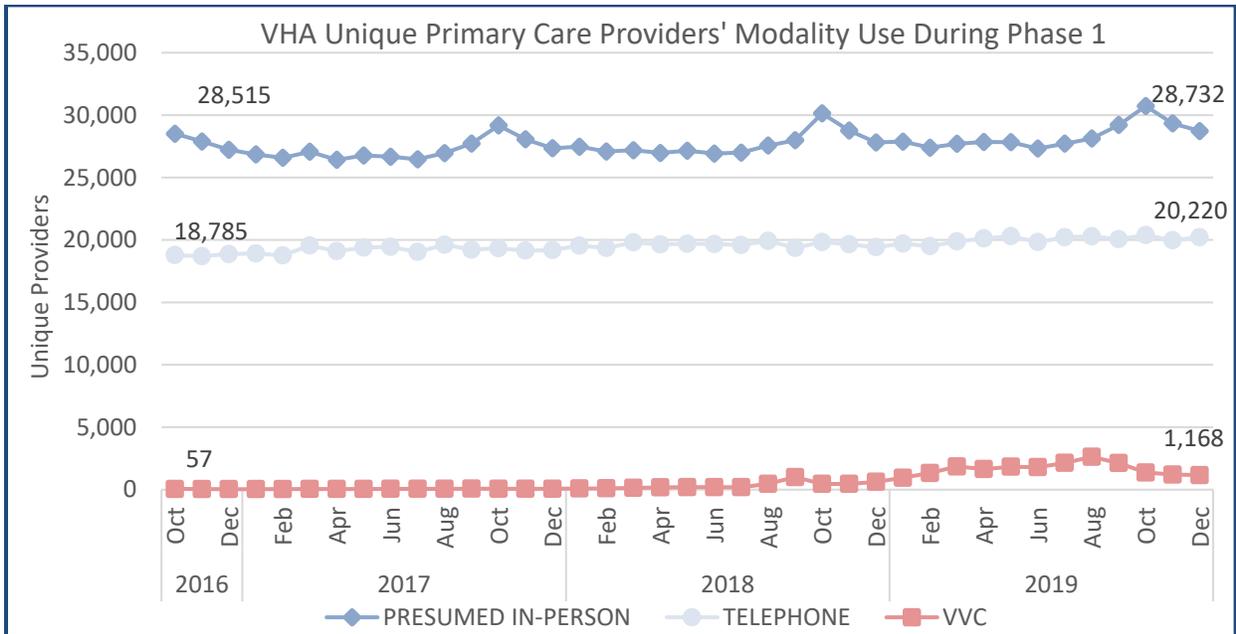
**Figure 2.** VHA unique providers' modality use during Phase 1, from October 2016 through December 2019; modalities limited to presumed in-person, telephone, and VVC encounters.

Source: VA OIG analysis from VHA CDW patient encounter data.

### Primary Care Providers

The OIG reviewed primary care provider VVC use in Phase 1 and found the number of providers using VVC increased from 57 to 1,168, almost 2,000 percent. VVC's highest use occurred in August 2019, when used by 2,629 primary care providers. Comparatively, the number of providers using in-person encounters increased from 28,515 to 28,732, almost 1 percent; and the number of providers using telephone encounters increased from 18,785 to 20,220, almost 8 percent. (See figure 3.)<sup>49</sup> The OIG determined that during Phase 1 most primary care providers used modalities other than VVC to provide patient care.

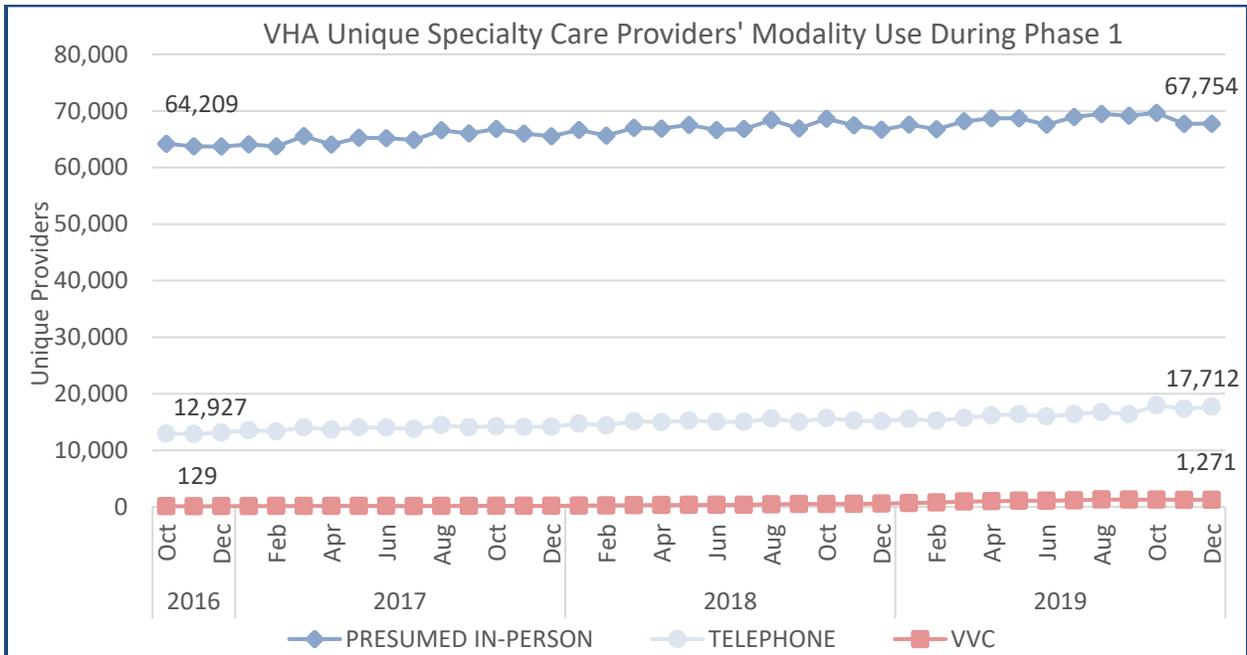
<sup>49</sup> The OIG recognizes the cyclical increase and decrease of in-person encounters occurring in October and finds more likely than not is due to seasonal illnesses, such as cold and flu.



**Figure 3.** VHA unique primary care providers' modality use during Phase 1, from October 2016 through December 2019; modalities limited to presumed in-person, telephone, and VVC encounters.  
Source: OIG analysis from VHA CDW patient encounter data.

### Specialty Care Providers

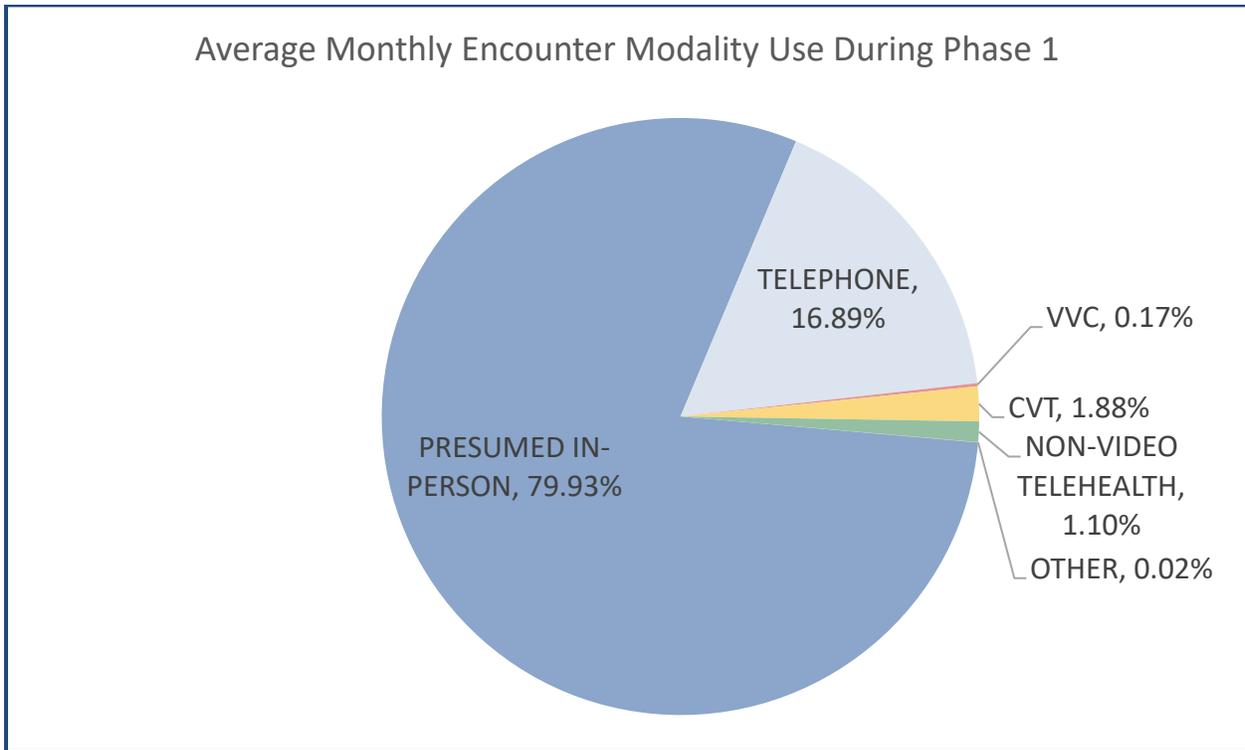
The OIG reviewed specialty care provider VVC use during Phase 1 and found the number of providers using VVC increased from 129 to 1,271, 885 percent. Comparatively, the number of providers using in-person encounters evidenced a slight increase from 64,209 to 67,754, almost 6 percent, while the number of providers using telephone encounters increased from 12,927 to 17,712, 37 percent. (See figure 4.) The OIG determined that during Phase 1, most specialty care providers used modalities other than VVC to provide patient care.



**Figure 4.** VHA unique specialty care providers' modality use during Phase 1, from October 2016 through December 2019; modalities limited to presumed in-person, telephone, and VVC encounters.

Source: OIG analysis from VHA CDW patient encounter data.

The OIG also found that although primary care and specialty care provider use of VVC increased during Phase 1, VVC remained the least used modality of care. (See figure 5.)



**Figure 5.** Average monthly encounter modality use for all VHA providers, during Phase 1; from October 2016 through December 2019.

Note: “All” includes Primary Care, Specialty Care, Mental Health, and other VHA Services. CVT in this graph represents video telehealth between VA facilities and other than a patient’s home. Non-video telehealth, and other modalities, while included in this graph, were excluded from the primary data set used for analysis as the OIG does not consider these modalities to be direct patient care.

Source: VA OIG analysis of VHA CDW patient encounter data.

The OIG concluded that VHA provider use of VVC grew prior to the pandemic, which coincided with VA telehealth strategic goals. However, for primary care and specialty care providers, VVC use was the lowest of all modalities and, on average, only 0.17 percent of all monthly encounters.

## Phase 2 – January 2020 through July 2020

VHA’s pandemic preparations began in January 2020.<sup>50</sup> On March 23, 2020, the VHA COVID-19 strategic response plan highlighted leveraging technology and communications during the pandemic including the use of VA applications for virtual patient care. However, the plan did not mandate VVC use as a modality of care and allowed for in-person encounters when clinically appropriate.<sup>51</sup> Throughout March 2020, VHA continued to facilitate VVC use. The former Deputy Under Secretary for Health for Operations and Management called for improvements to

<sup>50</sup> GAO, COVID-19: Implementation and Oversight of Preparedness Strategies at Veterans Affairs Medical Centers, GAO-21-514, June 2021. VHA, COVID-19 Response Plan.

<sup>51</sup> VHA, COVID-19 Response Plan.

ensure availability of telehealth capable workstations to conduct VVC appointments, and the former Assistant Secretary for OI&T provided approval for VHA providers to use non-public facing video chats.”<sup>52</sup> Although other video chat technology was approved, the Assistant Secretary for OI&T stated VVC was “the preferential method to conduct video Telehealth encounters between the veteran and provider.”<sup>53</sup>

### *OIG Analysis of VVC Use*

The OIG reviewed encounter data to analyze VHA providers’ VVC use during the beginning of the pandemic and reviewed additional VHA requirements for pandemic response. The OIG found the number of VHA providers using VVC encounter increased from 7,511 to 36,810, up 390 percent. Conversely, the number of providers using in-person encounters declined from January through April 2020 from 118,781 to 85,734, almost 28 percent and directly coinciding with the beginning of the pandemic and VHA’s March 2020 operational memorandums promoting VVC use and limiting in-person care.<sup>54</sup> Providers’ use of telephone encounters also increased from 56,091 in January to 81,211 in July, approximately 45 percent. (See figure 6.)<sup>55</sup>

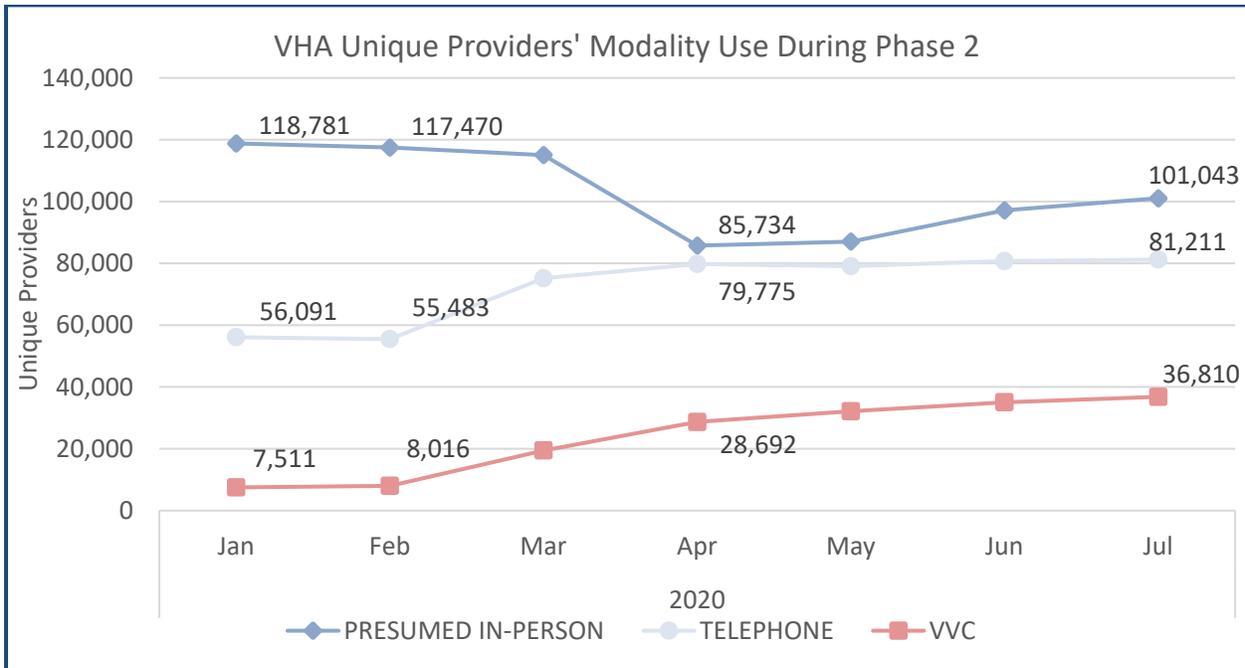
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<sup>52</sup> VHA Deputy Under Secretary for Health for Operations and Management memorandum, “Leveraging Video Telehealth from VA Clinics and Home.” This memorandum addressed VVC capability of tier 1 healthcare providers, which includes medical doctors, doctors of osteopathic medicine, physicians’ assistants, and nurse practitioners in the service lines of primary care, primary care mental health, as well as home based primary care and homeless PACTs. VHA Assistant Secretary for Office of Information & Technology, Chief Information Officer memorandum, “Use of Video Communication Technology Under COVID-19.” VHA Deputy Under Secretary for Health for Operations and Management memorandum, “Leveraging Capacity to Support Surges in Demand for COVID-19,” March 29, 2020. In addition to Tier 1 healthcare providers from previous guidance, this memorandum addressed VVC capability of additional healthcare providers to include nurses and pharmacists, as well as “any other healthcare providers who have been authorized to perform telehealth.” At the time of these memorandums, Renee Oshinski served as the Deputy Under Secretary for Health for Operations and Management and James P. Gfrerer served as the Assistant Secretary for the Office of Information and Technology (Chief Information Officer).

<sup>53</sup> VHA Assistant Secretary for Office of Information & Technology memorandum, “Use of Video Communication Technology Under COVID-19.”

<sup>54</sup> VHA Deputy Under Secretary memorandum, “Leveraging Video Telehealth from VA Clinics and Home.” VHA Deputy Under Secretary memorandum, “Leveraging Capacity to Support Surges in Demand for COVID-19.” VHA Assistant Secretary for Office of Information & Technology memorandum, “Use of Video Communication Technology Under COVID-19.”

<sup>55</sup> The OIG recognizes the increased use of telephone encounters was due to providers’ need to continue patient care easily during the beginning of the pandemic.

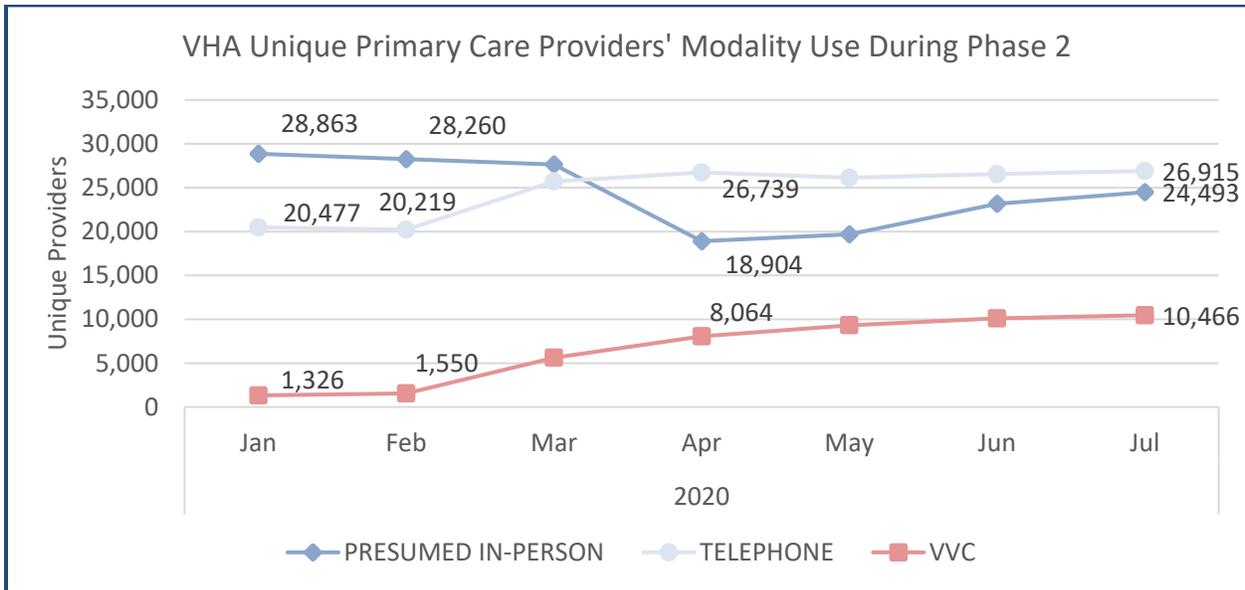


**Figure 6.** VHA unique providers' modality use during Phase 2, from January through July 2020; modalities limited to presumed in-person, telephone, and VVC encounters.

Source: VA OIG analysis of VHA CDW patient encounter data.

### Primary Care Providers

The OIG reviewed primary care provider use of VVC and found an increase in VVC use from 1,326 providers to 10,466 providers, 689 percent. Comparatively, the number of providers using in-person encounters decreased from 28,863 in January, reaching the lowest point of 18,904 in April, and then increasing to 24,493 in July, almost 30 percent. The number of providers using telephone encounters also increased in January from 20,477 to 26,915 in July, or 31 percent. The OIG determined the number of providers using telephone encounters surpassed in-person encounter use in March and remained the highest used modality through July 2020. (See figure 7.)

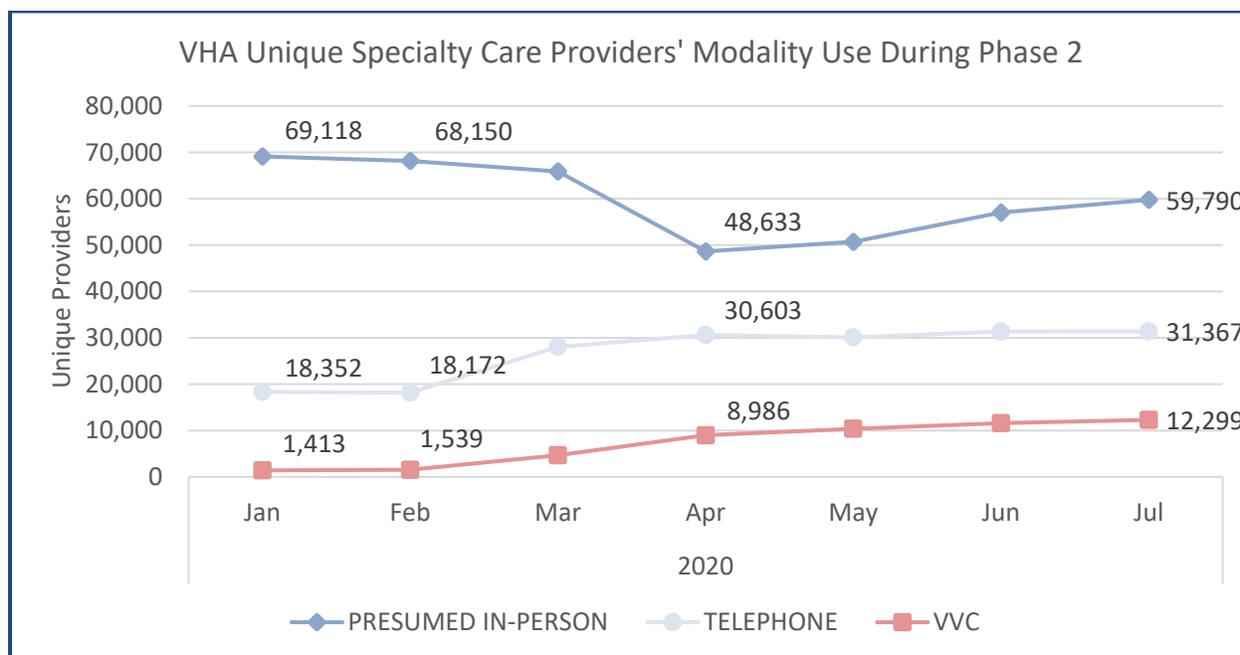


**Figure 7.** VHA unique primary care providers' modality use during Phase 2, from January 2020 through July 2020; modalities limited to presumed in-person, telephone, and VVC encounters.

Source: VA OIG analysis of VHA CDW patient encounter data.

### Specialty Care Providers

The OIG reviewed specialty care provider use of VVC and found the number of providers using VVC rose from 1,413 to 12,299, an increase of 770 percent. Comparatively, the number of providers using in-person encounters decreased from 69,118 in January, reaching the lowest point of 48,633 in April, before increasing to 59,790 in July, almost 23 percent. The number of providers using telephone encounters also increased between January and July from 18,352 to 31,367, almost 71 percent, but did not surpass the use of in-person encounters. (See figure 8.)



**Figure 8.** VHA unique specialty care providers' modality use during Phase 2, from January 2020 through July 2020; modalities limited to presumed in-person, telephone, and VVC encounters.

Source: VA OIG analysis of VHA CDW patient encounter data.

### Increased Provider Telephone Use When Compared to VVC

Although VHA emergency preparedness plans emphasized VVC use for emergency response and during disasters, the number of VHA providers using telephone encounters rose from 55,483 in February 2020, to 81,211 in July 2020, an increase of approximately 46 percent.<sup>56</sup> When the OIG asked if the scenario of a pandemic was included in emergency preparedness plans and why providers utilized telephone more than VVC encounters at the beginning of the pandemic, OCC leaders

- did not recall having discussions about plans for VVC use in response to a pandemic,
- commented that telephones are quicker and easier to use than VVC and that the telephone clinics were already established, and
- stated the goal of telehealth expansion is not to transition fully to video telehealth, but to ensure awareness by clinicians and patients that video care is available.<sup>57</sup>

<sup>56</sup> OCC, "VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update." OCC, "VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update."

<sup>57</sup> Leaders in OCC included the Chief Officer, National Technology Integration Lead, National Connected Care Help Desk Manager, and former Synchronous Telehealth Lead who, at the time of the inspection was the Deputy Director for Clinical Services. OCC staff told the OIG that the Deputy Director for Clinical Services served as the Synchronous Telehealth Lead until November 21, 2021.

Additionally, OCC leaders told the OIG that the cloud capacity to support VVC technology could not meet provider demand at the beginning of the pandemic.<sup>58</sup> The OCC Chief Officer recalled video visits increasing from 2,000 to 40,000 per day and stated, “the technical infrastructure was not scaled to that kind of. . . unexpected and unplannable [*sic*] for growth.”

OI&T staff told the OIG of monitoring cloud capacity since 2019, and reported VVC’s pre-pandemic cloud capacity as 3,400 concurrent calls. In response to the increased demand for VVC at the beginning of the pandemic, OI&T finalized an expansion plan in early April 2020 to quickly scale cloud capacity. To meet the demand, OI&T developed a plan to increase cloud capacity by 60 percent, with an increase from 3,400 to 17,500 concurrent calls. In early June of 2020, VVC’s capacity increased to 17,500 concurrent calls.<sup>59</sup>

In a prior report, the OIG identified that the large increase in telephone encounter use among primary care providers during the pandemic, “reflected VHA’s transition to virtual primary care delivery.”<sup>60</sup> Factors limiting VVC use included inadequate training, support, and connectivity for veterans, lack of electronic equipment, and challenging scheduling processes.<sup>61</sup> In this current review, the OIG discovered additional factors contributed to an increase in telephone encounters in the initial months of the pandemic, including provider preference for telephone use, and the insufficient cloud capacity to support expanded VVC use.

Modality utilization data indicates that the spike in telephone encounters prior to and at the beginning of the pandemic leveled out in May 2020, while VVC use continued to increase beginning in February 2020. However, VVC remained the least used modality of care as compared to in-person and telephone. (See figure 9.)

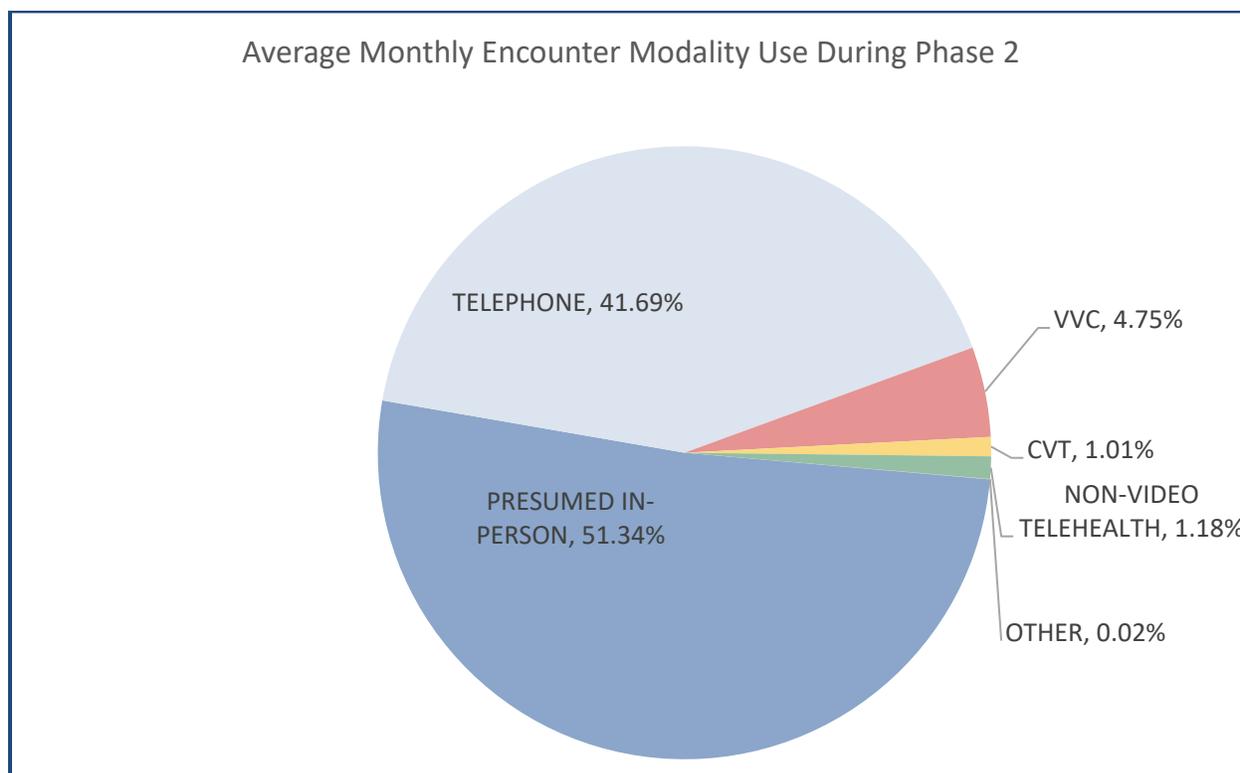
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<sup>58</sup> OCC leaders included the Chief Officer, former Synchronous Telehealth Lead, and VHA Telehealth Virtual Care Program Manager.

<sup>59</sup> VHA OI&T told the OIG that in March 2021, the VVC cloud received another increase to capacity, allowing 21,000 calls at a time.

<sup>60</sup> VA OIG, *Review of Veterans Health Administration’s Virtual Primary Care Response to the COVID-19 Pandemic*. The OIG reviewed primary care encounters for two 45-day periods, from February 7, 2020, through March 22, 2020, and from March 23, 2020, through May 6, 2020.

<sup>61</sup> VA OIG, *Review of Veterans Health Administration’s Virtual Primary Care Response to the COVID-19 Pandemic*.



**Figure 9.** Average monthly encounter modality use for all VHA providers during Phase 2, from January 2020 through July 2020.

Note: “All” includes Primary Care, Specialty Care, Mental Health, and other VHA Services. CVT in this graphic represents video telehealth between VA facilities and other than a patient’s home. Non-video telehealth, and other modalities, while included in this graph, were excluded from the primary data set used for analysis as the OIG does not consider these modalities to be direct patient care.

Source: VA OIG analysis of VHA CDW patient encounter data.

The OIG concluded that providers’ VVC use grew significantly at the beginning of the pandemic and, on average, increased from 0.17 to 4.75 percent of all monthly encounters during Phase 2.

### Phase 3 – August 2020 through June 2021

On August 21, 2020, the former VHA Assistant Under Secretary for Health for Operations issued a memorandum requiring

- staff who schedule VVC appointments complete VVC scheduling training by September 30, 2020, and
- VHA facilities incorporate VVC training into new scheduling employees’ orientation by October 1, 2020.<sup>62</sup>

<sup>62</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Scheduler Readiness – Department of Veteran Affairs (VA) Video Connect (VVC); Outpatient Appointment Scheduling Management Moving Forward Post COVID-19; Resuming of National Scheduling Audits,” August 21, 2020.

Four days later, the former VHA Assistant Under Secretary for Health for Operations issued another memorandum, specific to specialty care, which stated “[v]irtual care should remain the primary modality of care for willing Veterans when clinically appropriate to mitigate COVID-19 related risks for both Veterans and staff.”<sup>63</sup> The memorandum further outlined requirements for specialty care providers’ completion of VVC training and performance of at least one VVC appointment by December 31, 2020. Additionally, facilities were expected to

- establish clinical workflows for specialty care VVC visits identical to in-person visits, and
- attest to development of a “Test Call Program Standard Operating Procedure” to “assure Veterans and/or their caregivers have the information, technology and internet connection required for an optimal VVC experience.”<sup>64</sup>

In the fall of 2020, VHA required facilities to have an organizational structure “robust enough to effectively support the delivery of high-quality health care through telehealth modalities,” which included a workforce capable of supporting telehealth.<sup>65</sup> By spring 2021, the *VHA Connected Care Strategic Plan, 2021-2025*, highlighted use of telehealth technologies such as VVC, stating “[c]onnected care will be effectively integrated into the daily lives of both VA staff members and the Veterans they serve.”<sup>66</sup>

### *OIG Analysis of VVC Use*

The OIG reviewed pandemic related requirements and encounter data to analyze providers’ VVC use during Phase 3. The OIG found the number of providers using VVC increased, from 38,217 to 41,228, almost 8 percent. The OIG determined VVC use did not return to pre-pandemic levels, indicating a sustained growth and continued use of VVC as an encounter modality.

Comparatively, the number of providers using in-person encounters increased from 103,300 to 112,134, almost 9 percent, approaching pre-pandemic in-person encounter levels. The number of providers using telephone encounters decreased from 80,862 to 77,578, 4 percent, and remained similar to provider use during the beginning of the pandemic. (See figure 10.)

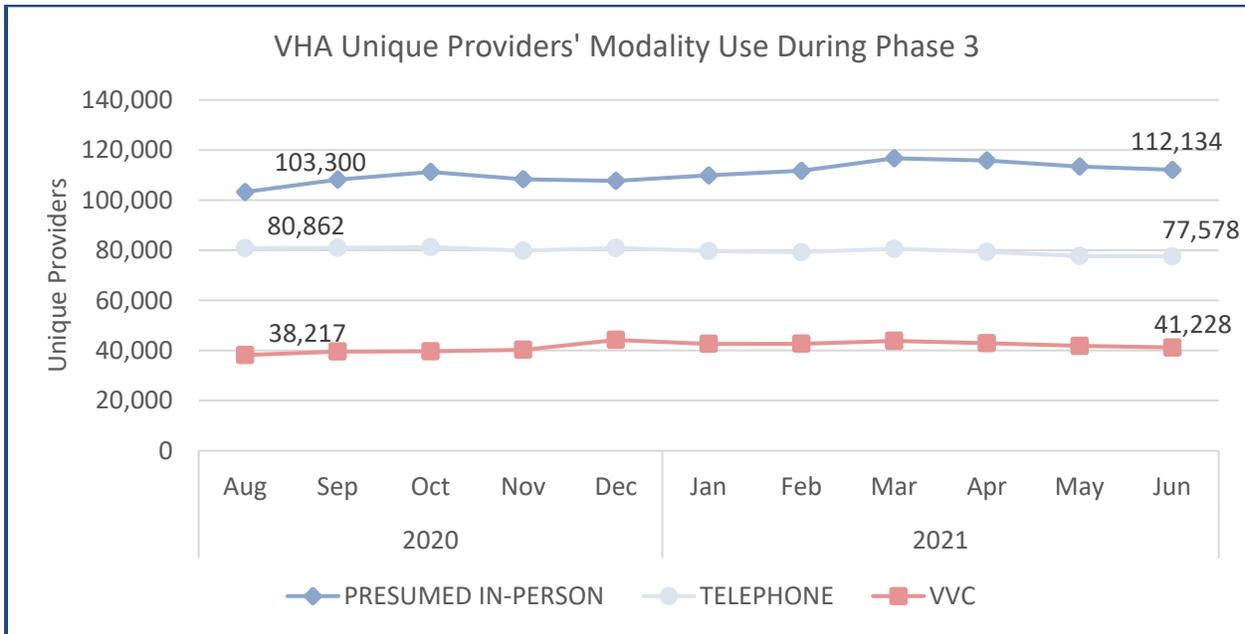
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<sup>63</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Specialty Care Department of Veteran Affairs (VA) Video Connect (VVC) Expansion,” August 25, 2020.

<sup>64</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Specialty Care VVC Expansion.” Melinda M. Davis, et. al., “Clinical Workflows and the Associated Tasks and Behaviors to Support Delivery of Integrated Behavioral Health and Primary Care,” *J Ambul Care Manage*, 42(1), (January 2020): 51-65. Clinical workflows are the processes of tasks performed by clinical and administrative health care staff to deliver patient care. Test calls occur prior to the VVC appointment and allow patients to tryout the VVC platform, on a cell phone, computer, or tablet with facility staff or the OCC Help Desk.

<sup>65</sup> VHA, “Office of Connected Care Telehealth Manual,” Updated September 2020.

<sup>66</sup> OCC, “Trusted Care: Anytime, Anywhere: VHA Connected Care Strategic Plan 2021-2025,” March 5, 2021.

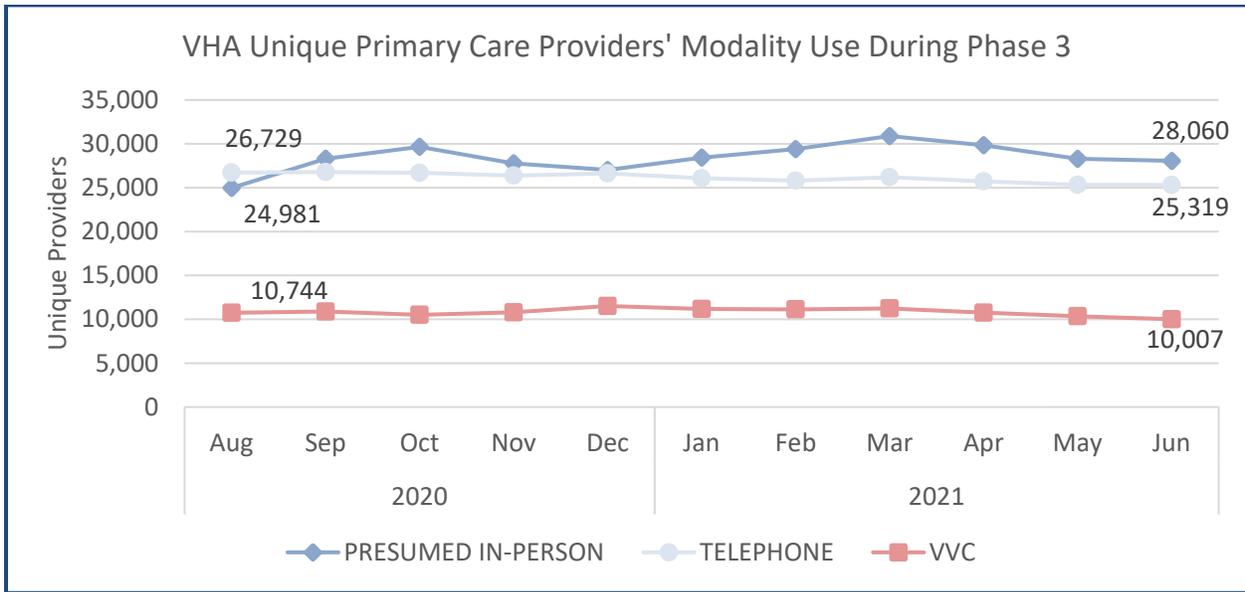


**Figure 10.** VHA unique providers' modality use during Phase 3, from August 2020 through June 2021; modalities limited to presumed in-person (in-person), telephone, and VVC encounters.

Source: VA OIG analysis of VHA CDW patient encounter data.

### Primary Care Providers

The OIG reviewed primary care provider use of VVC during Phase 3. The OIG found the number of providers using VVC decreased slightly from 10,744 to 10,007, almost 7 percent. Comparatively, the number of providers using in-person encounters increased from 24,981 in August to 28,060 in June, approximately 12 percent. The number of providers using telephone encounters decreased from 26,729 in August to 25,319 in June, 5 percent. (See figure 11.) The OIG determined that although primary care providers used VVC the least of all modalities, VVC use remained higher as compared to the beginning of the pandemic, indicating primary care providers have likely integrated VVC as a routine modality of care.



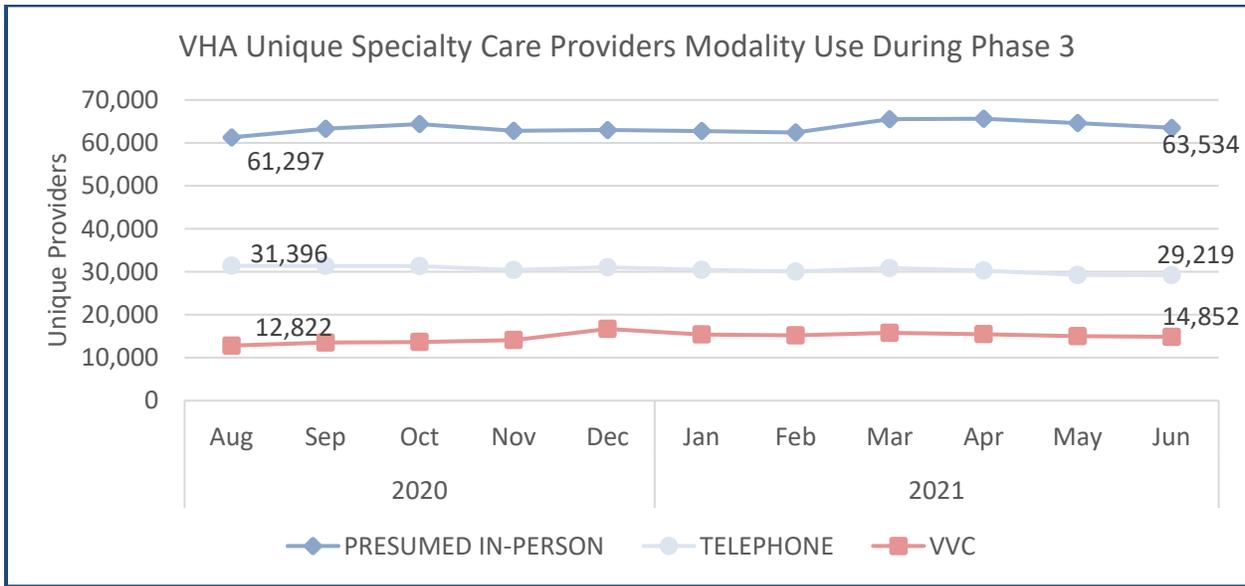
**Figure 11.** VHA unique primary care providers' modality use during Phase 3, from August 2020 through June 2021; modalities limited to presumed in-person (in-person), telephone, and VVC encounters.  
Source: VA OIG analysis of VHA CDW patient encounter data.

### Specialty Care Providers

The OIG reviewed specialty care provider use of VVC during Phase 3 and found the number of providers using VVC increased from 12,822 to 14,852, approximately 16 percent.

Comparatively, the number of providers using in-person encounters increased from 61,297 in August to 63,534 in June, almost 4 percent. The number of providers using telephone encounters decreased from 31,396 in August to 29,219 in June, approximately 7 percent. (See figure 12.)

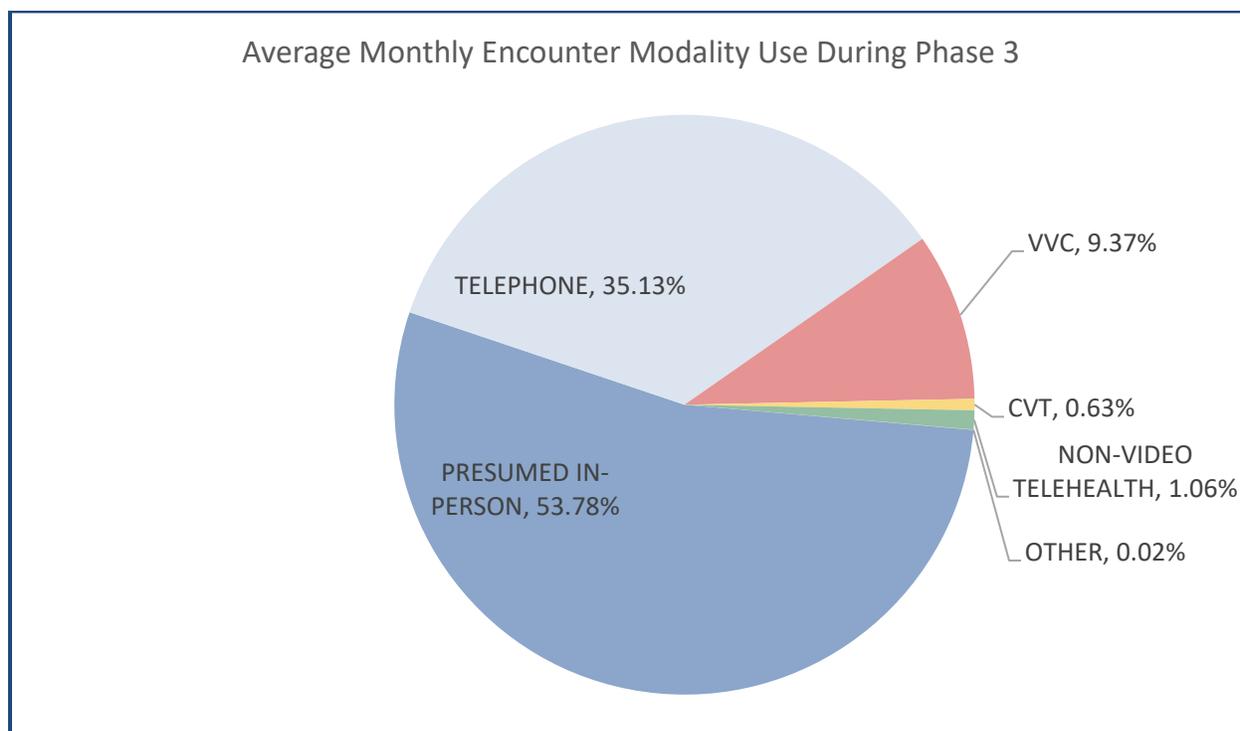
The OIG determined that although specialty care providers used VVC the least, VVC use remained higher as compared to the beginning of the pandemic, indicating specialty care providers have likely integrated VVC as a routine modality of care.



**Figure 12.** VHA unique specialty care providers' modality use during Phase 3, from August 2020 through June 2021; modalities limited to presumed in-person, telephone, and VVC encounters.

Source: VA OIG analysis of VHA CDW patient encounter data.

Although the growth in providers' use of VVC from the pandemic was sustained, it remained the least used modality of care as compared to in-person and telephone encounters. (See figure 13.)



**Figure 13.** Average monthly encounter modality use for all VHA providers, during Phase 3, August 2020 through June 2021.

Note: “All” includes Primary Care, Specialty Care, Mental Health, and other VHA Services. CVT in this graphic represents video telehealth between VA facilities and other than a patient’s home. Non-video telehealth, and other modalities, while included in this graph, were excluded from the primary data set used for analysis as the OIG does not consider these modalities to be direct patient care.

Source: VA OIG analysis of VHA CDW patient encounter data.

The OIG concluded that the growth in providers’ use of VVC that began in tandem with the pandemic was sustained during Phase 3, as providers appear to have integrated VVC as a routine modality in patient care. Provider utilization of VVC almost doubled, from 4.75 to 9.37 percent of all monthly encounters from August 2020 through June 2021.

## 2. VHA Provider Experience with VVC

In December 2018, former VA Secretary Robert Wilkie identified the expansion of telehealth services as transformational change, stating “[v]irtual care is the future of medicine” and “[w]e are on the cusp of the most trans-formative period in the history of the Department of Veteran Affairs.”<sup>67</sup> The American Medical Association describes transformational change as “a radical shift from one state of being to another state of being so significant that it requires a shift in

<sup>67</sup> VHA, “Telehealth: Adapting tech to improve VA health care,” *Vantage Point* (blog), December 20, 2018, <https://blogs.va.gov/Vantage/55049/va-telehealth/>.

mindset, behavior and culture to implement successfully and sustain over time.”<sup>68</sup> Further, Dr. John Kotter, a recognized expert in organizational change, highlights the generation of urgency as an “essential” step to execute successful change.<sup>69</sup>

The OIG recognized that VHA established VVC as an alternative to in-person care, and then responded to the urgency created by the pandemic through promotion and encouragement of VVC use, resulting in transformational change.<sup>70</sup> The OIG analyzed encounter data and found the number of providers using VVC substantially increased from October 2016 through June 2021, from 706 providers to 41,228 providers, approximately 5,740 percent.

To examine this transformational change through provider perspectives, the OIG interviewed 33 VHA primary and specialty care providers, across all VISNs, who used VVC prior to and during the pandemic.<sup>71</sup> The OIG categorized these perspectives into benefits and barriers related to VVC use.

## **VVC Benefits**

During interviews, providers stated the pandemic served as a turning point, pivoting VHA health care from in-person to telehealth modalities. Providers also commented on the benefits available through the use of VVC, such as convenience and increased patient engagement. The OIG determined that VVC use changed the way providers delivered patient care, particularly during the pandemic. Providers found VVC allowed continued visual contact with patients, increased access to care, and improved patient engagement.

### ***Pandemic as the Turning Point for VVC Use***

*“I think the pandemic was a watershed moment, I really think that. . . there was a cultural shift.”*

–VHA Physician

The OIG found that as a result of the pandemic, in-person encounters were limited due to infection control and public safety concerns. The VHA Office of Emergency Management’s March 2020 COVID-19 Response Plan indicated, “virtual care will be utilized as first line care

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<sup>68</sup> “3 steps to transformational change in your health organization,” American Medical Association, accessed July 27, 2022, <https://www.ama-assn.org/practice-management/sustainability/3-steps-transformational-change-your-health-organization>.

<sup>69</sup> John P. Kotter, “Leading Change: Why Transformational Efforts Fail,” Harvard Business Review, March-April 1995. “John P. Kotter - Faculty & Research,” Harvard Business School, accessed August 16, 2022, <https://www.hbs.edu/faculty/Pages/profile.aspx?facId=6495&view=featured-work>.

<sup>70</sup> VHA, COVID-19 Response Plan.

<sup>71</sup> The OIG interviewed providers from all the VISNs, and included physicians, physician assistants and nurse practitioners, nurses, social workers, speech language pathologists, pharmacists, and therapists such as physical and kinesiotherapy. The providers worked in primary and specialty care areas, such as cardiology, audiology, and rehabilitation.

whenever possible to minimize exposure of Veterans, visitors, and staff.”<sup>72</sup> Although VVC was an existing modality prior to the pandemic, the demand for its urgent and critical expansion to ensure continuity of care arose when the pandemic occurred. Providers told the OIG of their increased need to use VVC due to the pandemic:

- “I guess I just didn’t realize it [VVC] was an option. . . all I know is that all of the sudden it became very, very important with the pandemic.”
- “. . . [T]he pandemic hits, we had this experience. . . people don’t want to come [to the facility], and then it was like, hey this [VVC] is what we do.”
- “[The pandemic] kind of gave us a big boost as to how we could. . . finally utilize it [VVC], in a sense, more exclusively, because it force[s] you to do everything via telehealth.”
- “The pandemic. . . forced us to. . . use it [VVC] a little bit more. . . most of my patients are. . . geriatric patients and. . . did not want to use the. . . video visits. . . when the pandemic hit, we had to. . . use this [VVC].”
- “. . .[O]nce the pandemic happened. . . that was the push that some people needed to. . . jump in. And it’s [VVC] really. . . been helpful. . . it’s not like. . . this big scary beast that I think other people maybe thought that it was.”

Providers commented that the pandemic also drove the patients’ increased use of VVC:

- “[Patients have] become a bit more savvy [using VVC], since the pandemic began because, it. . . was really the only option to interact with health care providers or professionals.”
- “[B]ecause a lot of these patients did not use it [VVC] or they were skeptical about it before the pandemic. And then during the pandemic their. . . hands were tied, ‘Hey this is my only way to talk to the doc or the provider,’ and they tried it and they realized it works great.”
- “Pre-pandemic it was a learning curve. [Patients] didn’t really know what to do with [VVC]. . . Older patients didn’t understand it. . . After the pandemic. . . [VVC] was more popular, patients were getting the information. . . it was an easy sell because everyone was like. . . ‘This is great!’ And [patients] were asking for it. . . So, I think, the pandemic helped. . . in making it happen.”

The OIG learned that the interviewed providers viewed the pandemic as an implement of change that encouraged VVC use and offered alternatives to in-person health care delivery.

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<sup>72</sup> VHA, COVID-19 Response Plan.

## Convenience

*“I was pleasantly surprised at how. . . the world kind of transitioned with the pandemic. . . I think a lot of those things we’re still using because. . . it’s. . . easier and. . . you can share more things, quicker than if you’re doing things in-person.”*

–VHA Psychologist

VA telehealth strategic plans between 2018 and 2022 outlined a vision for enhanced accessibility to VA health care via telehealth, including care through VVC.<sup>73</sup> Provider experiences suggested that the convenience of VVC served as a motivating factor for continued use. One provider stated, “it’s so convenient, and I did not miss one appointment during the pandemic, from day one because I just said switch mine over to all VVC.” Providers also commented that VVC use removed barriers to in-person and telephone patient care encounter modalities, improving patient access to care, specifically

- “lots of veterans. . . with ALS [amyotrophic lateral sclerosis], who have difficulty accessing the session in-person. So, if they need an evaluation. . . we are able to do that.”<sup>74</sup>
- “[A] lot of them [patients] don’t want to do face-to-face right now and they find it more convenient anyway, they don’t have to drive somewhere.”
- “if it’s a telephone visit. . . I get more no shows. . . [VVC] makes it a lot easier for them.”
- “[e]very veteran I used VVC with, loved it. . . they got to talk to somebody that day. They. . . weren’t. . . put in a queue somewhere for the team to call them back whenever they had time to call them back.”

The OIG spoke with a provider who championed the convenience of VVC use by, “. . . helping my staff believe that this is really an amazing opportunity for the veterans. . . [s]o once the [staff] really embrace that, we can better help the veterans understand the benefit and usually once they try it. . . they too, love it.”

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<sup>73</sup> OCC, “VA Anywhere to Anywhere VA Telehealth Strategic Plan: FY 2018-2020 Update.” OCC, “VA Anywhere to Anywhere VA Connected Care Strategic Plan: FY 2020-2022 Update.” OCC, “Trusted Care: Anytime, Anywhere: VHA Connected Care Strategic Plan 2021-2025.”

<sup>74</sup> Mayo Clinic, “Amyotrophic lateral sclerosis (ALS),” accessed July 25, 2022, <https://www.mayoclinic.org/diseases-conditions/amyotrophic-lateral-sclerosis/symptoms-causes/syc-20354022>. Amyotrophic lateral sclerosis is a progressive nervous system disease affecting the body’s brain and spinal cord nerves.

The OIG learned that providers interviewed recognized the convenience in using VVC, such as increased access to care and ease of use for both patients and providers. Also, some providers noted fewer missed appointments.

### *Engaged Patient Care*

*“My preference is VVC over phone. I just think. . . it’s so much better. . . I can better engage with the patient. I can read their facial expressions, I can kind of follow if they’re understanding.”*

–VHA Geneticist

The October 2018 VHA telehealth strategic plan supported telehealth to “enhance the accessibility, capacity, and quality of VA health care for Veterans.”<sup>75</sup> The March 2021 update further stated that telehealth would be “integrated into the daily lives of both VA staff members and the Veterans they serve.”<sup>76</sup> Providers told the OIG that VVC allowed for a better way to engage with patients, different from that of in-person or telephone encounters. Providers said

- “[VVC is] giving a context into. . . where the patient actually lives and what their living arrangement is like. . . I think it’s really pretty helpful.”
- “. . . people tend to. . . be more comfortable in their own environment than. . . coming into the office to see me. . . [T]hey’re definitely happier at home. . . I think it makes people more relaxed. . . .”
- “[VVC] gives us an opportunity to actually be right there. . . and a lot more comes up. . . [a]nd it gives us a better way to help [patients].”
- “You kind of get to know a different perspective. . . [a]nd it improves the rapport.”

The OIG also learned of increased engagement with patient support systems such as family members or other caregivers through VVC use. A provider shared,

. . . if they have an aide that comes in, you can schedule the appointment the day the aide comes in. You can explain the meal plan to the aides. . . [the patient or family] show me if they are doing a smoothie. . . so they get out their ingredients. [Y]es, it is very good. . . to get the family connected.

Another provider stated

[b]eing able to see the patient. . . [y]ou can assess the way they look. . . you can see the environment and. . . with the phone call you just hear what the patient says. . . but with the video if you have a spouse in the background. . . they will chime in, so I think it keeps the patient a little bit more honest. . . It’s a good asset.

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<sup>75</sup> OCC, “VA Anywhere to Anywhere VA Telehealth, Strategic Plan: FY 2018-2020 Update.”

<sup>76</sup> OCC, “Trusted Care: Anytime, Anywhere: VHA Connected Care Strategic Plan 2021-2025.”

The OIG learned that interviewed providers appreciated patient and family engagement during VVC use. Additionally, providers were able to view patients in their home environment, gaining more information than would be obtained during an in-person or telephone visit.

## **Barriers**

Through provider interviews the OIG learned of barriers to VVC use such as, the patients' ability to navigate the VVC application on the phone or computer, internet connectivity issues, and provider difficulties with scheduling VVC appointments. Providers also commented that VVC appointments did not always mirror in-person appointments.

The OIG learned of improvements to assist patients with using the VVC application and with scheduling VVC appointments, including on-demand scheduling.<sup>77</sup> However, several providers interviewed were either unaware of, or lacked the support to carry out these improvements.

### *Patient Difficulties with VVC Technology*

*“The biggest rate limiting step is just the technology...and making sure the patient understands the technology.”*

—VHA Surgeon

The OIG learned of two challenges with VVC technology that providers experienced, a lack of patient training and issues with patients' connectivity to the internet or mobile device.

### *Training*

VHA's 2018 Telehealth Manual states it is important to orient and educate patients “who have never been exposed to telehealth.”<sup>78</sup> The VHA Telehealth Manuals of 2019 and 2020 both advised that facility telehealth organizational structure must support the delivery of high-quality health care through telehealth modalities, including support for individualized patient education about telehealth care.<sup>79</sup>

The OCC Chief Officer told the OIG that telehealth modalities training is more important for patients than providers. Additionally, per VHA policy, facility telehealth staff are required to do test calls “. . . with patients, to get them comfortable with the technology before. . . [the

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<sup>77</sup> “VVC Now,” VA Mobile, accessed June 28, 2022, <https://mobile.va.gov/app/vvc-now>. VVC Now is a version of the VVC application that allows a patient immediate video connection to a VVC encounter from an emailed or texted VVC link.

<sup>78</sup> VHA, “Connected Care/Telehealth Manual,” November 2018.

<sup>79</sup> VHA, “Telehealth Manual,” August 2019. VHA, “Office of Connected Care Telehealth Manual.”

encounter].”<sup>80</sup> The OIG learned from other OCC staff that the use of test calls is one aspect of the Digital Divide consult tool.<sup>81</sup> The former Synchronous Telehealth Lead who was responsible for conducting VVC test calls told the OIG that test calls “varied across facilities” and a number of facility staff could be conducting test calls, although the national helpdesk is “more than adequate for supporting test calls.” The OCC Virtual Care Program Manager shared that VHA is “working to simplify the [VVC] environment as much as we can.”

During interviews, providers told the OIG that the VVC application would benefit from being easier to use, and that patients sometimes were unable to use the technology.<sup>82</sup> One provider explained the facility sent electronic devices to patients without providing training on how to use them, stating “I kind of train them a little bit over the phone. . . and tell them how to [use VVC].” Further, the provider described a reduction in time spent performing patient care as the provider had to deliver the training,

getting them setup and. . . just being ready to come in and rock and roll. . . [I]n my program I see them weekly, so we might have a few hiccups the first few sessions, but, then we work it out. . . [I]f I was only seeing people sporadically. . . that would be frustrating if you’re spending half your visit just trying to get connected.

A second provider stated

nobody is really [identifying] whether or not the patient population has the wherewithal to do VVC. Not everyone has people in the home with them that can help them with it, and it just gets too complicated for them, and they find it much easier to just take a phone call.

The OCC National Technology Integration Lead, the National Connected Care Help Desk Manager, and the former Synchronous Telehealth Lead, told the OIG of a Connected Devices Support Program, formerly known as White Glove service, that went into effect in early 2021, that provides a patient with a VA electronic device capable of operating VVC. The OIG learned

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<sup>80</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Specialty Care Department of Veteran Affairs (VA) Video Connect (VVC) Expansion.” This memorandum required facility directors “attest to the development of a Test Call Program Standard Operating Procedure” by December 28, 2020.

<sup>81</sup> OCC staff include the OCC National Technology Integration Lead, the National Connected Care Help Desk Manager, and the former Synchronous Telehealth Lead. The OIG learned from OCC that the former Synchronous Telehealth Lead who, at the time of the inspection was the OCC Deputy Director for Clinical Services, serving as the Synchronous Telehealth Lead to November 21, 2021.

<sup>82</sup> *Merriam-Webster.com Dictionary*, “able,” accessed January 25, 2022, <https://www.merriam-webster.com/dictionary/able>. The term ability is used in reference to a patient having the skills or resources, such as a mobile device or tablet, necessary to use VVC technology. *Merriam-Webster.com Dictionary*, “capable,” accessed January 25, 2022, <https://www.merriam-webster.com/dictionary/capable>. The term capability is used in reference to a patient having the potential to use the VVC application, such as the ability to understand how to utilize VVC technology.

through interviews with OCC staff that while the Connected Devices Support Program was considered an extension of the test calls provided through the Digital Divide consult, the service was not articulated in VHA procedure until August 2022.<sup>83</sup> The Connected Devices Support Program uses national helpdesk employees to train patients on how to set up a VA-loaned device and operate the VVC application. Staff from the Connected Devices Support Program then perform a VVC test call with the patient.<sup>84</sup> The OIG discussed the Connected Devices Support Program with 14 of the providers interviewed and learned that 10 were unaware of the service and the remaining 4 had awareness of it but could not describe how it functioned.

The OIG discussed patient test calls with 20 providers and 14 of the providers indicated that their patients had received a test call in preparation for VVC use. However, during interviews the OIG identified that there was no standardized processes for conducting test calls and providers reported that a variety of staff were conducting the test calls.<sup>85</sup> Providers told the OIG of their frustrations with inconsistent processes for test calls and troubleshooting with patients:

- “There was a short period of time. . . within last year where we had an additional MSA [medical support assistant] that would do a trial video call to see if the patient was able to connect, and to also try to intervene if they were having difficulty. . . [t]hat lasted only for. . . a couple of months.”<sup>86</sup>
- “I’ve heard the patient[s] say that there is a practice portion of it [VVC], that they can practice themselves, but to have the staff do it with them, I have not been able to get that to happen.”
- “. . . [The patients] cannot troubleshoot by themselves. So, their spouse, their significant other, you know, sometimes, it’s a daughter, whatever, somebody is there, and does the actual connection.”

Another provider commented that test calls were performed but when issues arose, such as the VVC application not working properly, obtaining troubleshooting support was difficult.

Yes, they do the test call, but if the VVC is not working. . . [i]t takes way too long to get an answer on the hotline. . . [a]nd the people that are in the facility that are techs are also LPNs [licensed practical nurses]. . . taking care of patients. So, I, as

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<sup>83</sup> OCC, “Digital Divide Standard Operating Procedure,” August 2022.

<sup>84</sup> OCC, “Digital Divide Standard Operating Procedure.” OCC staff told the OIG that test calls could also be used for assistance to operate the VVC application for patients with personal access to a VVC-capable mobile device.

<sup>85</sup> Providers interviewed told the OIG that staff conducting test calls included medical support assistants, other department or service line staff, telehealth staff, or the provider themselves.

<sup>86</sup>VA Handbook 5005/117, *Staffing*, August 1, 2019. Medical support assistants are “administrative support positions that supervise, lead, or perform support work relating to the care and treatment given to patients in inpatient units, outpatient clinics, patient scheduling call centers, Care in the Community Support Staff (CitC), and ancillary support services.”

opposed to disrupting 15 minutes of our appointment. . . we'll try to go out, come back in. We'll do that twice and if that doesn't work and then. . . just do a telephone call.

Providers interviewed by the OIG reported encountering patients who did not receive VVC training, which if they had, would have likely prevented issues with the application.

### *Internet Connectivity*

On August 12, 2020, VHA released a memorandum alerting VISN directors about a new consult, called the Digital Divide, which aimed to remove “the gap that exists between individuals with access to a[n] [electronic] device and [internet or mobile] connectivity and those who do not have access to similar resources.”<sup>87</sup> The Digital Divide consult provides patients “without a video-capable device or sufficient connectivity” the equipment and services required to access telehealth.<sup>88</sup> Specifically, facility social work staff evaluate a patient’s ability to access telehealth technology and determine the need and eligibility for free mobile connectivity through community partners; internet and phone service discounts; or access to a space in the community where a patient can conduct a video appointment.<sup>89</sup>

Providers told the OIG of patients having deficient internet or mobile connectivity specifically related to the patients’ locations, which led to issues with VVC use. However, none of the providers interviewed mentioned entering a Digital Divide consult to assess patients’ locations for sufficient internet or mobile connectivity. Providers remarked

- “[be]cause sometimes [patients] live in the middle of nowhere. . . it really depends on connectivity. . . in some places it’s good, in some it’s not.”
- “their [patients’] internet wasn’t strong enough for us to get on. Or we could get on and we would just have video, no sound, or just sound, no video.”
- “it depended on reception because there were patients that were appropriate as far as they were willing. . . to do it [VVC] and they welcomed it, but the reception. . . [was] not as strong.”

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<sup>87</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Expanding Access to Telehealth for Veterans Through the Digital Divide Consult,” August 12, 2020.

<sup>88</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Expanding Access to Telehealth for Veterans Through the Digital Divide Consult.”

<sup>89</sup> VHA Assistant Under Secretary for Health for Operations memorandum, “Expanding Access to Telehealth for Veterans Through the Digital Divide Consult.” “Connecting Veterans to Telehealth Care,” OCC, September 2021, accessed January 25, 2022, <https://connectedcare.va.gov/sites/default/files/telehealth-digital-divide-fact-sheet.pdf>. Community partners include AT&T, T-Mobile, and Verizon; phone service discounts are through the Federal Communications Commission’s Lifeline program; and community spaces may be provided at the American Legion, Veterans of Foreign Wars, or Walmart.

The OIG found that despite OCC efforts to support patient engagement by introducing patient training tools for VVC use through the creation of the Connected Devices Support Program and the Digital Divide consult, several providers told the OIG of unfamiliarity with VHA initiatives and that many patients did not know how to use VVC which affected patients' access to care.

### ***VVC Emulating In-Person Encounters***

*"I really think. . . if we're going to keep this as a platform we deliver the care and...expand the care. . . we need to provide the support. . . [W]hen we have a patient come to the clinic, we have a nurse that does the vitals, that makes patients wait for me. In. . . VVC there's no support, there is a patient there's a provider. . . [I]f we can really build in that support for the patient and provider."*

– VHA Physician

VHA's telehealth strategic plans outlined that telehealth encounters must be similar to in-person encounters, in regard to scheduling and integrating virtual care "into routine operations."<sup>90</sup> In August 2020, VHA requested facility Chiefs of Staff to, "Establish processes for conducting Specialty Care VVC visits so they mirror in-person visit clinical workflows" by December 2020.<sup>91</sup> The September 2020 OCC Telehealth Manual stated that "[i]deally, a telehealth video visit mirrors an in-person visit," for any provider using telehealth care.<sup>92</sup>

Providers told the OIG that telehealth encounters did not mirror in-person encounters. One provider stated, VVC is not the same as clinic visits, which have nurses available to check-in the patient, take vitals, and schedule follow-up care upon the conclusion of the appointment. Another provider explained in-person, telephone, and VVC clinics were not set up to allow the provider to switch between the modalities of care to accommodate the patient's preference.

Providers shared that patients' perceptions of a virtual visit was not comparable to an in-person visit. One provider shared that the lack of facility staff support in preparation for the visit may have led to this perception. The provider stated

[s]ometimes patients don't get the importance of this being a medical appointment. . . They think it's "ah I'm just having a little chit chat with somebody." Sometimes they'll be driving. . . [T]hey don't consider it as seriously as they would a face-to-face appointment. . . It's just us. It's just the provider

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<sup>90</sup> OCC, "VA Anywhere to Anywhere VA Telehealth, Strategic Plan: FY 2018-2020 Update." OCC, "VA Anywhere to Anywhere VA Connected Care, Strategic Plan: FY 2020-2022 Update."

<sup>91</sup> VHA Assistant Under Secretary for Health for Operations memorandum, "Specialty Care Department of Veteran Affairs (VA) Video Connect (VVC) Expansion." "If a nurse triages a Veteran prior to a Specialist's in-person appointment, the same process should be replicated within virtual clinic rooms." was an example given within this memorandum.

<sup>92</sup> VHA, "Office of Connected Care Telehealth Manual."

themselves. The only contact the patient would have would be the clerk, at the time of scheduling the appointment and that's it.

Additionally, providers reported patients' frustration with the VVC experience while waiting for the provider to join the appointment, as there is no ability to communicate the provider's status. Two providers explained

[W]hen patients are sitting in the waiting room, they're not worried...if they are doing it correctly...but when you're sitting at home in front of the computer waiting for the doctor who might be 10 minutes late, which doesn't seem like that big of a deal when you're in the office—it really does at home.

On a VVC day. . . I have a patient at 8:00, 8:30, 9, 9:30, 10. . . it's back-to-back. . . [I]n a clinic, if one patient. . . has an issue, you're spending a little longer time, the nurse can always go into your next room and say, 'Hey [the doctor] is still up in emergency or. . . [is] behind.' So, they can wait. . . But on a VVC. . . my 8:00 patient I'm going a little more late because I have to address issues. . . My 8:30 patient, there's no way for me to. . . tell them.”

The OIG found that VVC encounters operate similarly to in-person appointments but do not always mirror the support for the provider, lacking elements such as the patient check-in process, scheduling of follow-up care, and communication to the patient when the provider is running late. The OIG concluded that these deficiencies could impede patient care.

### **VVC Scheduling**

*“During the pandemic, the scheduling is still the biggest hurdle I think. . . The patient is scheduled by the clerk, but then I have to go in for every single one of my patients and send the link.”*

— VHA Nurse Practitioner

The August 2019 OCC Telehealth Manual identified appointment scheduling as “the No. 1 failure point for telehealth.”<sup>93</sup> VHA policy requires standardization and management of the appointment scheduling to ensure timely and clinically appropriate patient care.<sup>94</sup>

The OIG reviewed VVC and in-person scheduling processes and determined that although similar, VVC scheduling requires staff to complete additional steps. These additional steps include

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<sup>93</sup> VHA, “Telehealth Manual.”

<sup>94</sup> VHA Directive 1232(4), *Consult Processes and Procedures*. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. VHA Directive 1230 was in place during the time of events discussed in this report. It was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. The directives contain the same or similar language regarding scheduling.

- creation of a VVC visit,
- generation of a VVC appointment link, and
- providing the link to the patient through the Virtual Care Manager.<sup>95</sup>

Scheduling staff were not offering VVC encounters to patients and elected to schedule telephone encounters. Providers told the OIG

- “[c]lerks would always give the patient the option of phone. . . I said please explain the video, ‘cause I would rather do a video appointment. But it’s much easier for the clerk to do a phone appointment rather than schedule a video appointment. . . I was telling them please don’t default to easier option.”
- “. . . you do have to get the scheduler to offer it to the patient. . . you can indicate it on the consult. . . The schedulers. . . [have to] take that extra step to explain it to the patient, and to do that video link, so. . . it was easier for them to just do the telephone. . . ”

Additionally, providers expressed that some scheduling staff made VVC appointments, but did not create the VVC link, which resulted in providers having to create them and send the link to the patient at the time of the appointment, “[T]he scheduling is still the biggest hurdle. . . the providers had to send all links. . . The patient would be scheduled by the clerk, but then I have to go in for every single one of my patients and send the link for the appointment.”

The OCC Chief Officer told the OIG that despite improvements, VVC scheduling remains a “rigid affair” and requires a lot of work and energy to overcome.<sup>96</sup> The OCC Chief Officer provided *VVC Now* as an example of such improvements. *VVC Now* launched on October 3, 2020, and allows providers to instantly invite patients to a VVC appointment.

Providers interviewed that were aware of *VVC Now*, described the application as easy, simpler, and a quicker way to access the VVC application. One provider commented, “This video connect on-demand where we can just send a text message, and they can just click on it, and without having to download an app, and just kind of reducing some steps. It’s made it really easy.” Another provider stated that sometimes it was easier to send patients a text message instead of an

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<sup>95</sup> “Virtual Care Manager,” VHA Telehealth Programs, accessed June 29, 2022, <http://vaww.telehealth.va.gov/pgm/vcm/index.asp#>. Virtual Care Manager is a scheduling tool used “to create, view, and join video visits with Veterans” through VVC, as well as send email notifications to patients, such as a link to VVC appointment. “VA Video Connect,” VA Mobile. VHA, “Telehealth Manual.” VHA, “Office of Connected Care Telehealth Manual.” (This is an internal website not publicly accessible.)

<sup>96</sup> The OCC Chief Officer explained to the OIG that *VVC Now* was the result of efforts to enhance the VVC application by meeting providers’ needs and provide the technology for impromptu video telehealth visits with patients.

email. An additional provider told the OIG, “The fact that the link can be text [*sic*] to a person versus just going through an email because it’s just quicker and I just love it.”

The OIG learned that other providers expressed the need for an on-demand video telehealth function and were unaware that one existed in the form of *VVC Now*.

The OIG found that despite OCC efforts to remove scheduling barriers to VVC use, providers described scenarios that suggested an unawareness of these improvements and continued to experience difficulty with scheduling VVC appointments. The OIG determined scheduling barriers may affect a provider’s ability to ensure timely and clinically appropriate patient care.

## Conclusion

The OIG found VVC use increased but was the least used modality of care prior to the pandemic. At the onset of the pandemic, telephone and VVC encounter use increased as presumed in-person decreased. Additionally, VHA was not able to support the increased demand of VVC use, leading providers to perform patient care through telephone encounters. To sustain the increased demand, VHA issued memorandums allowing for the use of non-public facing video chats, supplied resources such as workstations with the equipment necessary to perform VVC visits, and provided additional funding for bandwidth expansion. Following the initial months of the pandemic, telephone encounter use decreased and presumed in-person and VVC encounter use continued to increase.

The OIG identified and interviewed a subset of providers whose VVC utilization trends included an increase or decrease in VVC encounter use as compared to telephone encounter use. During interviews, providers stated the pandemic served as a turning point, pivoting VHA health care from in-person to telehealth modalities. Providers also commented on the benefits available using VVC, such as convenience and increased patient engagement. The OIG determined that VVC use changed the way providers delivered patient care, particularly during the pandemic, as providers found VVC allowed continued visual contact with patients, increased access to care, and improved patient engagement.

Through provider interviews, the OIG also learned of barriers to VVC use that may affect patient care, such as, patient obstacles with VVC technology, VVC appointments not emulating in-person appointments, and provider difficulty with scheduling VVC appointments.

## Recommendations 1–3

1. The Under Secretary for Health evaluates provider knowledge and utilization of VA Video Connect technology, including resources such as the Digital Divide Consult, Connected Devices Support Program, and *VVC Now* and takes action as indicated.
2. The Under Secretary for Health evaluates availability of clinical and administrative support to providers initiating and completing VA Video Connect encounters and clarifies expectations and requirements to ensure access to virtual care emulates in-person encounters.
3. The Under Secretary for Health ensures education of providers and support staff regarding VA Video Connect scheduling processes.

## Appendix A: Scope and Methodology Data Reference

**Table A.1. Stop Codes Utilized to Identify VVC Encounters\***

Stop Code	Stop Code Name	Definition
179	Real Time Clinical Video Telehealth to Home – Provider Site	Records workload at the provider site (distant site) using real-time clinical video telehealth as a means to replicate aspects of face-to-face assessment and care provided to Veteran patients in their home (e.g., private residence, vacation home, daughter’s home, etc.) or at a non-VA location/home (e.g., homeless shelter, university dormitory room, transitional housing, assisted living center, etc.) when the Veteran patient independently coordinates and conducts the Clinical Video Telehealth (CVT) encounter with their VA provider, without assistance from a non-VA site or 3 <sup>rd</sup> party organization’s staff or resources to coordinate, support or assist with the successful completion of the CVT encounter. Assessment and care may include: health/social evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain, etc. These CVT encounters must be electronically documented in CPRS [computerized patient record system] fully meeting criteria for a provider encounter. Use provider work-unit as the primary Stop Code, i.e., 171179 HBPC Nurse, 323179 Home Tele-Primary Care, 502179 Home TeleMental Health.
648	Real Time Clinical Video Telehealth with Non-VAMC Location – Provider Site	Records workload at the provider site (distant site) using real-time clinical video telehealth as a means to replicate aspects of face-to-face assessment and care provided to Veteran patients in a non-VA location (e.g., Vet Center, university student health clinic, Indian Health Service clinic, Department of Defense medical treatment facility, State Veterans Home, etc.) when the non-VA patient site staff have actively participated in the coordination and support of the Clinical Video Telehealth (CVT) encounter. This non-VA site coordination and support activity may include but is not limited to: providing assistance with scheduling; providing a suitable CVT space; management of VA CVT device and/or related equipment (either owned by the non-VA site or the VA); or accompanying the Veteran patient to or during the CVT encounter. Typically, this coordination and support is documented in a formal written document (e.g., memorandum of understanding (MOU) and/or Telehealth Service Agreement (TSA) between the non-VA site and the VA provider site, however, the 648 CVT encounter could be ‘ad hoc’ without such written agreement. Telehealth is the use the use of electronic communications and information technology to provide and support health care when distance separates the participants. Both the patient and provider must be present during the real-time video session.
679	National Center Real Time Clinical Video Telehealth to Home – Provider Site	Records workload at the provider site (distant site) using real-time Clinical Video Telehealth (CVT) by a provider from a National Telehealth Center as a means to replicate aspects of face-to-face assessment and care provided to Veterans in their home (e.g., private residence, vacation home, daughter’s home, etc.) or at a non-VA location/home (e.g., homeless shelter, university dormitory room, transitional housing, assisted living center, etc.) when the Veteran independently coordinates and conducts the CVT encounter with their

Stop Code	Stop Code Name	Definition
		VA provider, without assistance from a non-VA site or 3 <sup>rd</sup> party organization's staff or resources to coordinate, support or assist with the successful completion of the CVT encounter. Assessment and care may include: health/social evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain, etc. These CVT encounters must be electronically documented in CPRS fully meeting criteria for a provider encounter. Use provider work-unit as the primary Stop Code, i.e., 345679 Home Genomic Care 323679, Home Tele-Primary Care, 502679 Home Tele Mental Health.

*Source: VHA Support Service Center Encounters Workload Cube, August 2, 2021, and VHA Managerial Cost Accounting Office Fiscal Year 2021 mid-year active stop codes.*

*\*The above table stop code numbers, stop code names, and definitions are verbatim from the VHA Managerial Cost Accounting Office Fiscal Year 2021 mid-year active stop codes listing.*

**Table A.2. Clinical Groups Utilized for VHA Provider Experience Selections**

OIG's Clinical Grouping	Stop Code*	Stop Code Name*
<b>Primary Care</b>	322	Comprehensive Women's Primary Care Clinic
	323	Primary Care Medicine
	338	Telephone Primary Care
<b>Home Based Primary Care (HBPC)</b>	156	HBPC - Psychologist
	157	HBPC - Psychiatrist
	170	HBPC - Physician
	171	HBPC – Nursing (RN or LPN)
	172	HBPC – Physician Extender (NP, CNS, PA)
	173	HBPC – Social Worker
	174	HBPC - Therapist
	175	HBPC - Dietician
	176	HBPC – Clinical Pharmacist
	177	HBPC - Other
178	Telephone HBPC	
<b>Specialty Care</b>	118	Home Treatment Services (Non-HBPC, Non-HIH, Non-HCBC Services)
	136	Tele-Post Deployment Integrated Care – Patient Site
	137	Tele-Post Deployment Integrated Care – Provider Site
	181	Telephone/Dental
	199	Telephone Polytrauma/Traumatic Brain Injury (TBI)
	216	Telephone Rehabilitation (Rehab) and Support

OIG's Clinical Grouping	Stop Code*	Stop Code Name*
	221	Telephone Visual Impairment Services Team (VIST)
	224	Telephone Spinal Cord Injury (SCI)
	229	Telephone Blind Rehab Program
	325	Telephone Neurology
	326	Telephone Geriatrics
	424	Telephone/Surgery
	425	Telephone Prosthetics/Orthotics
	428	Telephone/Optomety
	440	Tele-Fittings and Adjustments – Provider Site
	441	Telephone Anesthesia
	490	TeleTransplant Service – Patient Site
	491	TeleTransplant Service – Provider Site
	611	Telephone/Dialysis
<b>Other</b>	103	Telephone Triage
	147	Telephone Ancillary
	148	Telephone/Diagnostic
	182	Telephone Case Management
	324	Telephone Medicine
	708	Tele-Smoking Cessation – Provider Site
	723	Tele-Opioid Safety Education – Patient Site
	724	Tele-Opioid Safety Education – Provider Site

*Source: VHA's Managerial Cost Accounting Office Fiscal Year 2021 mid-year active stop codes.*

*\*Stop code numbers and stop code names are verbatim from the VHA Managerial Cost Accounting Office Fiscal Year 2021 mid-year active stop codes listing.*

## Appendix B: Under Secretary for Health Memorandum

### Department of Veterans Affairs Memorandum

Date: March 20, 2023

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic. The Veterans Health Administration concurs with the recommendations and provides an action plan in the attachment.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [VHA10BGOALACTION@va.gov](mailto:VHA10BGOALACTION@va.gov).

*(Original signed by:)*

Shereef Elnahal, M.D., MBA

## Under Secretary for Health Response

### VETERANS HEALTH ADMINISTRATION (VHA)

#### Action Plan

Review of Access to Telehealth and Provider Experience in VHA Prior to and During the COVID-19 Pandemic, Project Number 2021-02805-HI-1187

**Recommendation 1. The Under Secretary for Health evaluates provider knowledge and utilization of VA Video Connect technology, including resources such as the Digital Divide Consult, Connected Devices Support Program, and VVC Now and takes action as indicated.**

**VHA Comments:** Concur. VHA Office of Connected Care (OCC) will evaluate provider knowledge by completing an assessment of the existing VA Video Connect (VVC) provider training and post-tests. If gaps are identified, VHA will address these gaps through updates to the training. VHA will integrate relevant content from the Digital Divide Consult training, that is currently in development, into the VVC provider course. This will also include new content about the White Glove service and *VVC Now*. To ensure that all providers working in clinical specialties where care may be delivered by video are knowledgeable about using the VVC platform, VHA will complete the necessary actions required for approval of the VVC training for providers as a mandatory, annual requirement beginning in fiscal year 2024.

**Status:** In progress

**Target Completion Date:** October 2023

**Recommendation 2. The Under Secretary for Health evaluates availability of clinical and administrative support to providers initiating and completing VA Video Connect encounters and clarifies expectations and requirements to ensure access to virtual care emulates in-person encounters.**

**VHA Comments:** Concur. VHA recognizes the importance of clinical and administrative staff in supporting VVC encounters. VHA will review existing guidance to the field and develop communication to the field that defines the required roles and responsibilities of clinical and administrative staff in supporting VVC encounters from the point of scheduling to completion. Additionally, the Office of Connected Care will collaborate with relevant program offices to establish a strategy to evaluate the availability of clinical and administrative staff supporting VVC encounters.

**Status:** In progress

**Target Completion Date:** December 2023

**Recommendation 3. The Under Secretary for Health ensures education of providers and support staff regarding VA Video Connect scheduling processes.**

**VHA Comments:** Concur. For providers and applicable support staff in clinical specialties where care may be appropriately delivered by video-to-home, OCC will assess the existing VVC

provider training and post-test to identify opportunities for inclusion of more specific content pertinent to the VVC scheduling process.

For scheduling support staff in clinical specialties where care may be appropriately delivered by video-to-home, Office of Integrated Veteran Care will ensure the coordination of relevant program offices in reviewing the existing content in “Scheduling VA Video Connect Appointments” given during VHA National Scheduler Onboarding, a required course for all incoming schedulers. Beyond the onboarding period, VHA will review existing efforts and outreach, as well as explore additional avenues to reinforce education on scheduling processes associated with VVC for schedulers.

**Status:** In progress

**Target Completion Date:** October 2023

## OIG Contact and Staff Acknowledgments

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