DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints

AUDIT | REPORT #21-00510-105 | MARCH 24, 2022

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Executive Summary

VA's top priority for fiscal years (FY) 2018 through 2024 is providing excellent customer service.[1] The Patient Advocacy Program, established in 1990, helps advance the Veterans Health Administration's (VHA) effort to improve customer service, supports veterans' access to quality care, and provides a mechanism to resolve healthcare delivery issues.[2] When a veteran submits a complaint at a VA medical facility, a patient advocate begins the process of documenting the concern, communicating a resolution, and providing follow-up and feedback. Patient advocates also are expected to identify trends to signal potential opportunities for medical facility improvements.

VHA's program management responsibilities are shared and involve personnel at every level: the local medical facility, its regional network office, and the national program office. Facility patient advocates enter complaints and communicate with complainants about the resolution of their concerns. Regional Veterans Integrated Service Network (VISN) patient advocate coordinators promote standardization for implementing program requirements and develop VISN-wide approaches to ensure timely and consistent documentation of complaints in the patient advocate tracking system. The national Office of Patient Advocacy (OPA) is responsible for overseeing the Patient Advocacy Program, including managing the patient advocate tracking system, developing national policy and procedures, and providing guidance to medical facilities on managing complaint resolution. OPA is also required to receive and assess local and regional trending reports on a quarterly basis to support organizational change.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA patient advocates resolved serious complaints on time and as required in FY 2020.[3] VHA defines complaint resolution as a process that includes documentation of the complaint, the steps taken to resolve the complaint, and the outcome in the patient advocate tracking system. A complaint is considered resolved when the outcome is communicated to the complainant and the record is closed in the tracking system. This process is required to be completed within seven business days. The OIG categorized serious complaints as those involving delays in accessing health care or services, problems with clinical care, and medication issues. The audit also assessed whether VHA Patient Advocacy Program leaders effectively used program data to identify and address pervasive healthcare issues for veterans.[4]

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[1] VA, *FY 2018-2024 Strategic Plan*, refreshed May 31, 2019.

[2] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020; VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018.

[3] The OIG did not, however, try to assess whether veterans were satisfied with how their complaints were resolved.

[4] Appendix A provides full details of the scope and methodology of the audit, and appendix B describes the statistical methods.

What the Audit Found

The OIG found that VHA lacked adequate governance of the Patient Advocacy Program. VA defines governance as the process of management or oversight by which VA leaders make informed decisions; provide strategic direction; and maintain accountability based on objectives, risks, and resources.[5] VHA did not effectively issue and implement adequate policy, monitor complaint practices, and provide guidance to medical facility directors responsible for local program management. This inadequate governance contributed to patient advocates and other program leaders not fully complying with requirements for managing complaints in FY 2020. Until VHA addresses these program weaknesses, it may not have the necessary data to drive improvements, and veterans may not receive the support they need.

Patient Advocates Did Not Always Enter Complaints in the System

According to responses to an OIG survey in March 2021, patient advocates and patient advocate supervisors at 24 of 138 medical facilities (17 percent) did not always enter complaints into a patient advocate tracking system as required.[6] This occurred, at least in part, because there was inadequate program policy to identify clear expectations and responsibilities. As a result, VHA lacks full visibility into related issues at VA medical facilities that could be addressed to advance healthcare improvements for veterans. The incomplete picture also makes it difficult to accurately assess the program workload for staffing decisions.

Even Though Complaint Records Generally Appeared to Be Closed on Time, Patient Advocates Did Not Always Document the Communication of the Outcomes to the Complainants

VHA policy requires that complaints be resolved and closed within seven business days. Complaint resolution is complete when both the outcome is communicated to the complainant who filed it and the complaint record is closed.[7] In FY 2020, VHA tracked about 162,000 serious complaints in its patient advocate tracking systems. Patient advocates closed an estimated 133,000 serious complaints (82 percent) within seven business days to indicate that complaints were resolved. Although the data indicated that patient advocates generally closed serious complaints on time, the OIG found that they did not always adhere to the documentation requirements to show full complaint resolution. The OIG estimated that about 44,600 of the 162,000 serious complaints (27 percent) had incomplete information to show that complainants received a response about their complaint outcome as required. This practice makes it difficult to determine whether resolution actions were completed, including whether veterans were informed

[5] VA Directive 0214, *Department of Veterans Affairs Enterprise Governance Structure and Process*, May 14, 2019.
[6] Respondents from 138 of 140 VA medical facilities participated in the OIG survey.
[7] VHA Directive 1003.04.

of the outcomes of their serious complaints. In addition, VHA lacks assurance that the timeliness of complaints resolved and closed in the patient advocate tracking system was reliable.

The OIG found there was inadequate monitoring at every program level. At the local level, some patient advocate supervisors told the audit team they only conducted limited quality reviews or occasional spot checks of complaint records. At the regional level, three of the four VISN patient advocate coordinators the audit team interviewed said they performed limited or no reviews of complaint records to ensure they contained the required information. At the national level, OPA did not review complaint records to assess whether the required resolution activities were documented. OPA also did not follow through to provide guidance to medical facility directors to ensure they fulfilled their responsibilities in managing local programs.

Responsible Personnel at the Local and VISN Levels Did Not Consistently Analyze Complaints in the Patient Advocate Tracking System for Trends

Based on interviews and survey responses, the OIG found some program personnel did not conduct required analyses of patterns of complaints to see if they occurred frequently or in specific situations. These analyses are known as complaint trending. At the local level, 76 patient advocate respondents at 64 medical facilities (46 percent) responded in an OIG survey that they did not look for trends in complaint data from the patient advocate tracking system. Moreover, patient advocate supervisors at 26 medical facilities (19 percent) who responded to the OIG's survey acknowledged not performing trending of complaint data. Three of four VISN patient advocate coordinators interviewed by the audit team also did not conduct complaint trending. These issues occurred, in part, because of inadequate policy and monitoring. Until VHA analyzes veterans' complaints, it cannot fully understand the scope of the problems veterans encounter at VA medical facilities and then drive improvements to veterans' experiences.

What the OIG Recommended

The OIG made three recommendations to the under secretary for health to review and update program policy to formally align with OPA's program expectations; implement controls to require that patient advocate supervisors and VISN patient advocate coordinators perform regular, documented reviews of records; and provide guidance to medical facility directors to ensure they fulfill their required program management duties.

VA Comments and OIG Response

The deputy under secretary for health concurred with all recommendations and submitted responsive corrective action plans. Appendix C provides the full text of the deputy under secretary's comments. The OIG will monitor implementation of planned actions and will close

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

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Contents

Abbreviations

FY	fiscal year
GAO	Government Accountability Office
OIG	Office of Inspector General
OIT	Office of Information and Technology
OPA	Office of Patient Advocacy
PATS	Patient Advocate Tracking System
PATS-R	Patient Advocate Tracking System-Replacement
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

VA's top priority for fiscal years (FYs) 2018 through 2024 is providing excellent customer service—seeking feedback and understanding the needs of veterans and their families to make care and services accessible.[8] The Patient Advocacy Program has an important function in supporting the Veterans Health Administration (VHA) customer service goal and plays a significant role in ensuring patients have access to quality care and a mechanism to resolve healthcare delivery issues. The VA Office of Inspector General (OIG) performed this audit to determine whether VHA patient advocates resolved serious complaints on time and as required in FY 2020. The audit also assessed whether VHA Patient Advocacy Program leaders effectively used program data to identify and address healthcare system issues for veterans.

Patient Advocacy Program

Since VHA established the Patient Advocacy Program in 1990, the program has evolved from performing a primarily administrative function to cultivating agents of change who solve patients' problems as part of VHA's efforts to improve customer service and ensure patient satisfaction.[9] Patient advocates coordinate "service recovery"—a process that involves acknowledging concerns, communicating a resolution, providing follow-up and feedback to veterans, and using program data to make improvements. Service recovery is a fundamental element of VA's commitment to fulfill its duty to veterans and their families. According to VHA, patient advocates can improve veterans' satisfaction with VA by making amends for customer service issues in the delivery of health care.[10] According to information provided by VHA's Office of Patient Advocacy (OPA) in February 2021, there were approximately 690 patient advocates, including supervisors, at 140 VA medical facilities nationwide.

Complaint Requirements

Veterans, patients, and their families can submit complaints to a patient advocate at a VA medical facility online or by phone, through Congress or a hotline, or in person. Employees within each service line of a medical facility may also assist patient advocates with taking complaints.

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[8] VA, *FY 2018-2024 Strategic Plan*, refreshed May 31, 2019.

[9] Linda S. Kinsinger, Joan Van Riper, and Kristy Straits-Tröster, "Advocacy for Veterans within the Veterans Health Administration," *North Carolina Medical Journal*, 70 (March/April 2009): 159–162. https://www.ncmedicaljournal.com/content/ncm/70/2/159.full.pdf.

[10] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020; VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018.

The Patient Advocacy Program requires actions in three general phases to manage complaints: (1) complaint entry; (2) complaint resolution, including communication of outcome to complainant and closing out the record within seven business days; and (3) complaint trending.

Figure 1 illustrates the general requirements for managing a complaint in the Patient Advocacy Program.

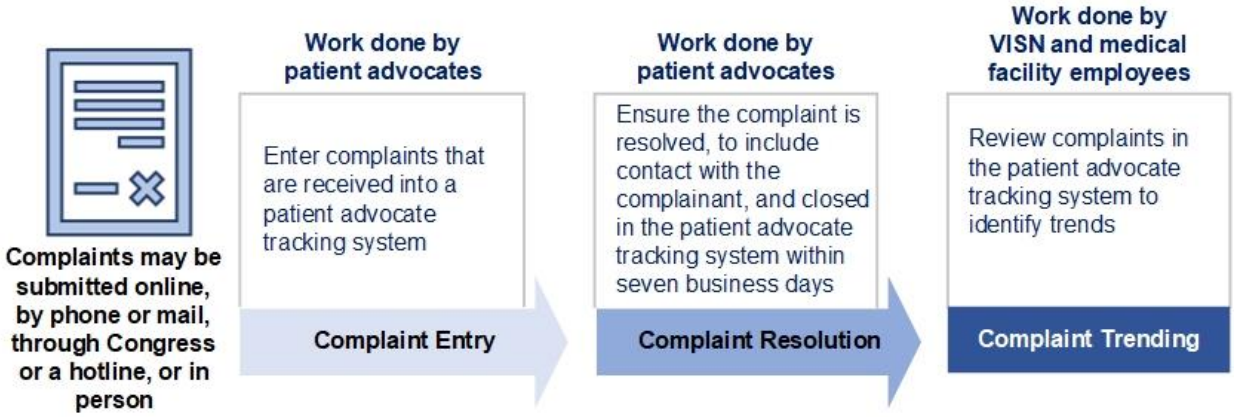

Figure 1. *Main requirements for managing complaints in a patient advocate tracking system.*
Source: OIG analysis of VHA Directive 1003.04.

Complaint Entry

Patient advocates must record complaints, as well as compliments and requests for information, into the patient advocate tracking system. Patient advocates assess the description of the complainant's concern and assign issue codes to the complaint. The issue codes organize complaints to help employees identify trending and emerging problems. The codes cover a diverse array of subjects ranging from general issues, such as unclear facility signage, to concerns involving delays accessing care. According to information provided by OPA, VHA had approximately 120 issue codes during FY 2020.

Before April 2018, VHA primarily used the Patient Advocate Tracking System (PATS) to capture relevant information on veterans' issues and concerns. PATS also gave VA facilities the ability to analyze and categorize complaint trends to identify the need for changes within the VA healthcare system. However, PATS had limited functionality. For example, PATS did not enable staff to upload correspondence or documentation of responses to veterans' complaints.

VHA and the VA Office of Information and Technology (OIT) worked together to develop a new patient advocate tracking system to replace PATS.[11] Beginning in April 2018, VHA piloted a web-based tool called Patient Advocate Tracking System-Replacement (PATS-R). PATS-R is

[11] VA Directive 6518, *Enterprise Information Management (EIM)*, February 20, 2015. OIT supports VA administrations, such as VHA, in designing, implementing, and maintaining VA's information technology systems environment.

integrated with other complaint systems and can be accessed by frontline employees. These features are designed to expand employee involvement in service recovery and enhance the efficiency of complaint resolution. OPA implemented PATS-R at medical facilities in two phases between 2018 and 2020. OPA employees first trained patient advocates to use PATS-R and then allowed them to enter complaints and other program data into the system. According to the OPA executive director, the rollout was completed in June 2020, and all new complaints must now be entered into PATS-R.

In FY 2020, VHA recorded about 475,000 contacts in PATS and PATS-R, as illustrated in Figure 2.[12]

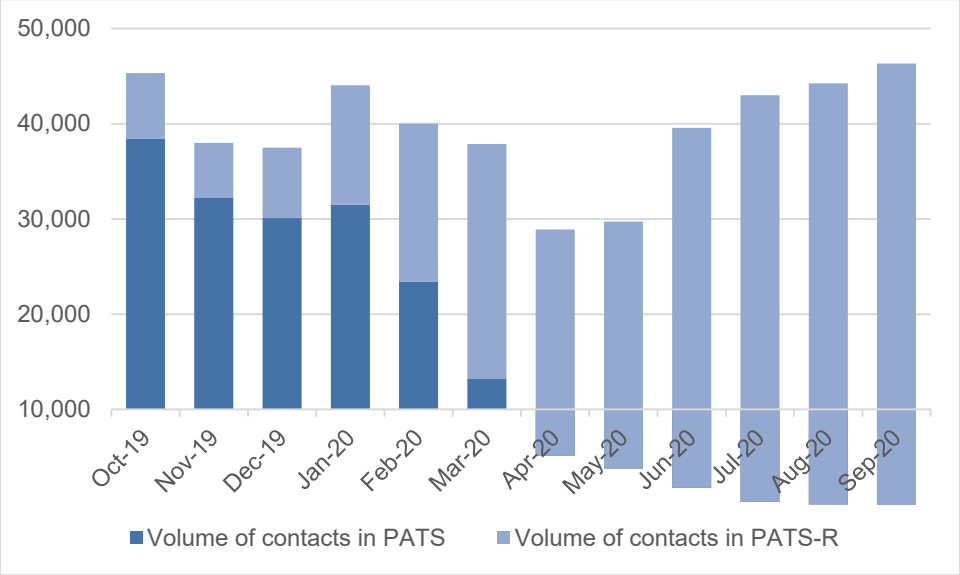

Figure 2. *Number of FY 2020 contacts of complaints, compliments, and information requests in PATS and PATS-R.*
Source: OIG analysis of PATS and PATS-R.

In consultation with OPA, the audit team analyzed issue codes in PATS and PATS-R and identified those that represented serious issues to the veteran. These issues included delays in accessing care or services, problems with clinical care, and medication issues. From the universe of FY 2020 contacts, the audit team determined that VHA had about 162,000 complaints assigned an issue code that represented serious concerns to the veteran.

[12] Sixty-nine percent (223 of 323) of patient advocate and supervisor respondents reported in the OIG survey that they felt their complaint workload was about the same as before the COVID-19 pandemic.

Complaint Resolution

VHA policy states that complaint resolution is complete when the outcome is communicated to the complainant and the complaint record is closed.[13] The complaint resolution process includes patient advocates (or other facility employees) taking steps to resolve the identified issues and patient advocates documenting the outcome in a tracking system. VHA policy requires this process to be completed within seven business days.[14] Status updates must be provided to the complainant if the issue takes longer than seven business days to resolve.

Complaint Trending

Documenting complaints and related information in the tracking systems, such as communications with complainants, is essential for program employees and leaders to properly identify trends. Complaint trending is used to understand veterans' experiences across the VA healthcare system and make improvements.[15] Complaint trending can include analyzing patterns in the main types and volume of complaints received at a medical facility over time. Patient advocates identify trends that can be used to determine potential opportunities for medical facility improvements. The patient advocates communicate the trended complaint data to leaders at their respective medical facilities. Veterans Integrated Service Network (VISN) patient advocate coordinators review complaints within their region and communicate trends to VISN leaders.[16]

Governance Structure and Responsibilities

VHA's program policy defines the governance structure and responsibilities for managing the Patient Advocacy Program.[17] Personnel at all levels share responsibility for achieving program goals: the national program office, regional VISNs, and local medical facilities.

[13] VHA Directive 1003.04.

[14] VHA Directive 1003.04.

[15] VHA Directive 1003.04.

[16] VHA delivers health care through 18 regional VISNs. Each VISN director coordinates and oversees administrative and clinical activities at the medical facilities in the network.

[17] VHA Directive 1003.04.

Figure 3 illustrates the VHA governance structure for the Patient Advocacy Program during the audit.

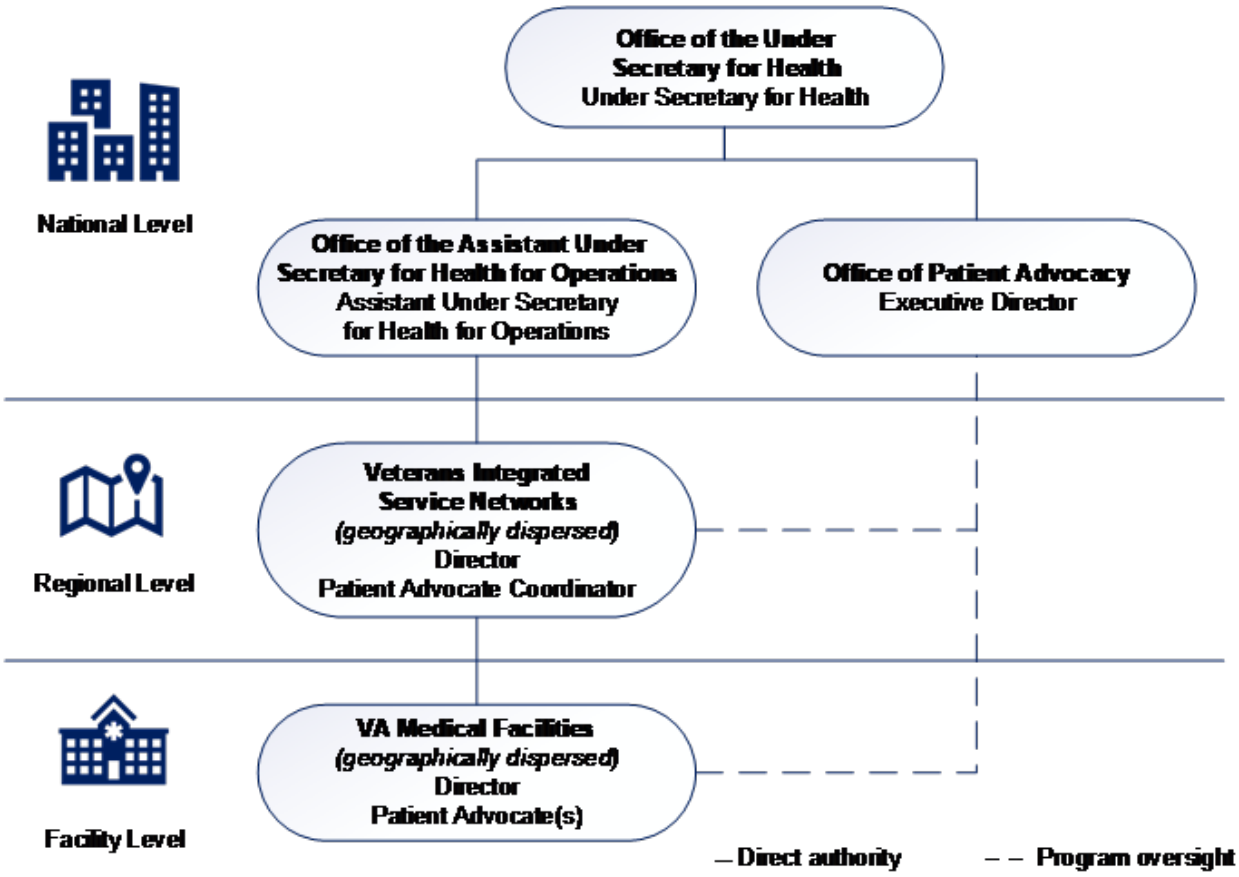

Figure 3. *VHA governance structure for the Patient Advocacy Program.*
Source: OIG analysis of VHA Directive 1003.04 and 2020 Functional Organization Manual.

National Program Office Responsibilities

In response to a legislative mandate, OPA was established in June 2017 as the national program office responsible for overseeing the Patient Advocacy Program.[18] Under the leadership of its executive director, OPA provides national program policy, system support, and training for patient advocates. It also coordinates with facilities to review, research, and respond to complaints received by senior VA leaders. OPA is responsible for ensuring VHA has a proactive approach to manage and resolve complaints, including establishing processes for the proper management, analysis, and use of the patient advocate tracking systems and associated program

[18] 38 United States Code (U.S.C.) § 7309A; VHA Directive 1003.04. Among other program requirements, the Comprehensive Addiction and Recovery Act of 2016 charged VA to establish a separate Office of Patient Advocacy. The VHA Office of Patient Centered Care and Cultural Transformation was previously responsible for managing the Patient Advocacy Program.

data. For example, VHA policy requires that OPA receive and assess local and regional trending reports on a quarterly basis to support organizational change. OPA is also responsible for providing guidance and consultation to program personnel at medical facilities about managing the complaint resolution process and executing service recovery activities.[19]

VISN Responsibilities

VISN directors, who report to the assistant under secretary for health for operations, ensure each facility in their region has a process to resolve complaints. VISN directors assign a VISN patient advocate coordinator to help their facility-level patient advocates (as a collateral duty). VISN patient advocate coordinators must develop consistent approaches for ensuring facility patient advocates are documenting complaints into the patient advocate tracking system. VISN patient advocate coordinators must also communicate complaint trends to VISN leaders.

Medical Facility Responsibilities

VA medical facility directors must implement and oversee their own Patient Advocacy Program. They should ensure patient advocates understand their responsibilities. They must also make certain that complaint data are analyzed to identify trends. Directors must have at least one patient advocate at the facility but may add more based on factors such as workload or number of veterans served. The local reporting structure of patient advocates can vary based on the programmatic setup at a particular facility. For example, the patient advocate at the Butler VA Health Care System in Pennsylvania was aligned under the local public affairs office, which reported directly to the facility director. In contrast, the patient advocates at the VA Eastern Kansas Health Care System in Topeka fell under the Veterans Experience Office, which reported directly to the facility assistant director.

Medical facility directors also have the discretion to select the appropriate program model. Directors can use a centralized model, with one office and one or more patient advocates managing all complaints, or a decentralized model in which line-level employees from different medical services are designated as "service-level advocates" to manage complaints.[20] Medical facilities can also implement characteristics of both models.[21]

VHA policy does not specify responsibilities for patient advocate supervisors located at medical facilities. The OPA executive director said that patient advocate supervisors were expected to perform program management functions, including reviewing complaint records for required information and compiling trends for their facilities.

[19] VHA Directive 1003; VHA Directive 1003.04; 2020 Functional Organization Manual.

[20] A service-level advocate is an employee designated at the point of service, such as the cardiology clinic, who assists in resolving issues.

[21] VHA Directive 1003.04.

Table 1 illustrates the responsibilities that may be assumed by a patient advocate and/or a service-level advocate.

Table 1. Comparison of Responsibilities Between Patient Advocates and Service-Level Advocates

Responsibility	Patient advocate	Service-level advocate
Enter complaints in a patient advocate tracking system	X	X
Facilitate action to address the complaint	X	X
Document actions to address the complaint in a patient advocate tracking system	X	X
Ensure communication with the complainant concerning the resolution of their concerns, which must be documented in the patient advocate tracking system	X	
Verify complaint resolution has been completed and the record is closed in the patient advocate tracking system	X	
Identify complaint trends	X	

Source: OIG analysis of program processes and responsibilities.

Prior Reports on Patient Advocacy

In March 2017, the OIG issued a report on VHA's Patient Advocacy Program that found VHA did not adequately capture FY 2015 patient complaint information and identify complaint trends.[22] The OIG also found that PATS did not have important security controls in place. As a result, the OIG made eight recommendations to strengthen the effectiveness of program operations at the time involving areas such as information technology and human resources. In response to the OIG's recommendations, VHA updated an expired policy, developed a training plan for patient advocates, and updated access controls for PATS. VHA also developed a staffing model and methodology for the Patient Advocacy Program that considered workload. Based on these corrective actions, the OIG closed the recommendations.[23]

In addition, in April 2018, the Government Accountability Office (GAO) issued a report on the guidance, training, and oversight of the Patient Advocacy Program that found VHA provided

[22] VA OIG, *Audit of the Patient Advocacy Program*, Report No. 15-05379-146, March 31, 2017.

[23] The OIG's 2017 report addressed material weaknesses at the time in areas such as staffing. VHA took sufficient action to address the recommendations and the main causes. The program has since evolved, however, including a different national program office and new strategies and expectations in achieving its mission that warranted fresh examination.

limited guidance on the governance and staffing of the Patient Advocacy Program.[24] The GAO report also found that VHA did not systemically review complaint data to assess program performance.

PATS-R Information Security

During the audit, the OIG found gaps in evidence that suggested the OIT may not have adequately managed information security for PATS-R when it was deployed. This included a lack of documentation clearly supporting that PATS-R had the authority to operate.[25] The OIG sought this information because several OIT officials told the audit team that PATS-R was a "major application" like the predecessor system PATS, which had its own authorization. PATS-R was included under the authority to operate for a broader cloud software.

However, after reviewing subsequent documentation and statements from other OIT sources, there was no basis to assess whether OIT's treatment of PATS-R was appropriate because the relevant security categorization was not submitted or reviewed. Specifically, both OIT's Office of Development, Security, and Operations and Office of Information Security showed that there was no documentation supporting a security categorization request or a Governance, Risk, and Compliance Oversight Board decision pertaining specifically to PATS-R.[26] In the absence of that decision and relevant documentation, the audit team did not draw a conclusion in this report related to information security for PATS-R. These matters will be addressed as part of the OIG's mandatory audit under the Federal Information Security Modernization Act.

[24] GAO, *VA Health Care: Improved Guidance and Oversight Needed for the Patient Advocacy Program*, GAO-18-356, April 12, 2018.

[25] The authority for a system to operate is gained through an assessment and authorization process to ensure system-related risks are adequately addressed, the system is operating as intended, and the information will be protected.

[26] The Governance, Risk, and Compliance Oversight Board maintains VA's information security posture and compliance under the Federal Information Security Modernization Act and identifies emerging threats and vulnerabilities to provide guidance on effective risk management decisions.

Results and Recommendations

Finding: Improved Governance Would Help Patient Advocates Manage Veterans' Healthcare Complaints

VHA's ability to manage healthcare complaints for veterans was hindered by governance weaknesses. Program officials did not issue and implement an adequate policy, monitor complaint practices, and provide guidance to medical facility directors. The audit team identified areas in which patient advocates and other program leaders did not fully comply with requirements to manage Patient Advocacy Program complaints in FY 2020:

- **Inconsistent complaint entry**. Patient advocates and supervisors from 24 of 138 medical facilities (17 percent) who responded to the OIG's March 2021 survey acknowledged not always entering complaints in PATS or PATS-R.
- **Incomplete complaint resolution**. VHA had about 162,000 complaints that were coded as serious issues in PATS and PATS-R during FY 2020. The audit team estimated that patient advocates generally closed 133,000 serious complaints (82 percent) within seven business days to indicate that complaints were resolved.[27]

  However, patient advocates did not always adhere to the documentation requirements to show full complaint resolution. This practice made it difficult to determine whether complainants were informed of the outcome. The audit team estimated that about 44,600 serious complaints (27 percent) had incomplete information to show that complainants received a response about their complaint outcome as required. The team also estimated that about 16,500 serious complaints (10 percent) lacked information to show that complainants were contacted with a required status update when the complaint took longer than seven business days to resolve.
- **Absence of complaint trending**. As previously mentioned, personnel at both the local and VISN levels are required to analyze complaints for trends. However, at the local level, 76 patient advocate respondents surveyed at 64 of 138 medical facilities (46 percent) said they did not look for trends in their tracking system complaint data. Moreover, despite OPA's expectations, patient advocate supervisors at 26 medical facilities (19 percent) acknowledged not ensuring that complaint data trends were identified. Three of four VISN patient advocate coordinators interviewed by the audit team did not perform complaint trending across the medical facilities in their region.

[27] The audit team did not review whether complainants were satisfied with how their complaints were resolved, as this was outside the scope of the audit. Appendix A contains information on the audit's scope.

As a result of these issues, VHA missed opportunities to assess the frequency of issues at VA medical facilities that could be addressed to improve the healthcare experience for veterans. VHA also lacked the documentation to ensure that all complainants with serious complaints received notification of VA's actions to resolve the problems. Moreover, the lack of PATS and PATS-R complaint trending limited VHA leaders' ability to understand the scope and nature of veterans' feedback concerning their healthcare experiences and to potentially make local or nationwide improvements.

What the OIG Did

The audit team identified a population of about 162,000 serious complaints entered in PATS and PATS-R at VA medical facilities during FY 2020. These had been assigned an issue code that represented serious concerns to the veteran (as determined by the audit team in consultation with OPA leaders), such as delays in accessing care or services, problems with clinical care, and medication issues. From this population, the team reviewed a stratified random sample of 220 complaints to determine whether VHA patient advocates resolved the complaints within prescribed time periods, including whether notifications to complainants were documented as required.[28] The team obtained relevant information from VHA program officials and employees in various offices, including OPA and select VISNs and VA medical facilities. The team also surveyed 418 patient advocates and patient advocate supervisors regarding FY 2020 program activities and analyzed the 326 responses (78 percent response rate) as of March 23, 2021.

Patient Advocates Did Not Always Enter Complaints in the System

Some patient advocates did not always record complaints into a patient advocate tracking system as required.[29] VHA policy directs medical facilities to enter complaints, regardless of seriousness, in a patient advocate tracking system to enable a comprehensive understanding of veteran issues and concerns.[30] In response to the OIG survey, patient advocates and supervisors at 24 of 138 medical facilities (17 percent) said they did not enter all complaints into a system.[31] They provided comments in response to the OIG survey to explain why some complaints were not recorded:

- "I was trained from the start to enter only bigger problems."

[28] Appendix A provides information on the audit's scope and methodology. Appendix B provides information on the statistical sampling methodology.

[29] As discussed later in this finding, there were inconsistencies between VHA policy and the expectations communicated by the OPA executive director.

[30] VHA Directive 1003.04.

[31] Respondents from 138 of 140 VA medical facilities participated in the OIG survey.

- "We only enter them from calls, WHH [White House Hotline], Secure Messages currently."
- "If a complaint can be addressed on the spot, then we do that, as this is the best possible outcome for the Veteran."

As another example, a patient advocate at the VA North Texas Health Care System told the audit team that she did not enter approximately 75 percent of all contacts received with various complaints into PATS-R due to challenges with coordination with facility employees who did not have access to the system.

Because some complaints were not entered into a patient advocate tracking system, VHA lacks full visibility into issues at those VA medical facilities, which in turn limits VA's ability to identify potential improvements for veterans across the healthcare system. Moreover, VHA is limited in establishing an accurate depiction of program workload for staffing resource decisions. For example, OPA needs reliable workload information to provide guidance on patient advocate staffing levels for consideration at medical facilities.[32]

Even Though Complaint Records Generally Appeared to Be Closed on Time, Patient Advocates Did Not Always Document the Communication of the Outcomes to the Complainants

In FY 2020, VHA generally closed serious complaints within seven business days to indicate that issues were resolved. VHA policy requires that complaints be resolved and closed within seven business days in a patient advocate tracking system.[33] The OPA executive director explained that this timeframe is based on when the complaint is received and when the record is closed in the patient advocate tracking system. Based on PATS and PATS-R data from October 2019 through September 2020, the audit team estimated VHA closed 133,000 of the serious complaints (82 percent) within seven business days to indicate that they were resolved.

The audit team could not independently verify timeliness in all instances reviewed. Specifically, the team requested and evaluated information about complaint actions, including asking each patient advocate to verify whether the dates of contact and closure in PATS or PATS-R were correct. Some patient advocates indicated that one or both dates should have been different than what was recorded. The patient advocates explained that the errors were due to challenges using PATS-R or forgetting to close the complaint record sooner. Based on the sample records reviewed, the team estimated that 14,900 serious complaints (9 percent) could have incorrect

[32] In July 2021, OPA developed a staffing model and methodology for the Patient Advocacy Program that considers workload in response to a recommendation from the OIG's 2017 report.

[33] VHA Directive 1003.04.

date information in the patient advocate tracking systems. Incorrect dates impede VHA's ability to assess whether those complaints were closed within the prescribed timelines.

Patient Advocates Closed Serious Complaints Without Consistently Documenting Information on Notification Actions

Although patient advocate tracking systems reflected that VHA closed most serious complaints on time in FY 2020, the audit team found that some patient advocates closed records in PATS and PATS-R without documenting that the complainants were contacted with the results. As mentioned earlier, VHA policy states that complaint resolution is complete when the outcome is communicated to the complainant and the record is closed.[34] Figure 4 shows an example of how a patient advocate at a VA medical facility ensured a complaint was resolved when the veteran was contacted with the outcome and documented as required in PATS-R before closing the record.

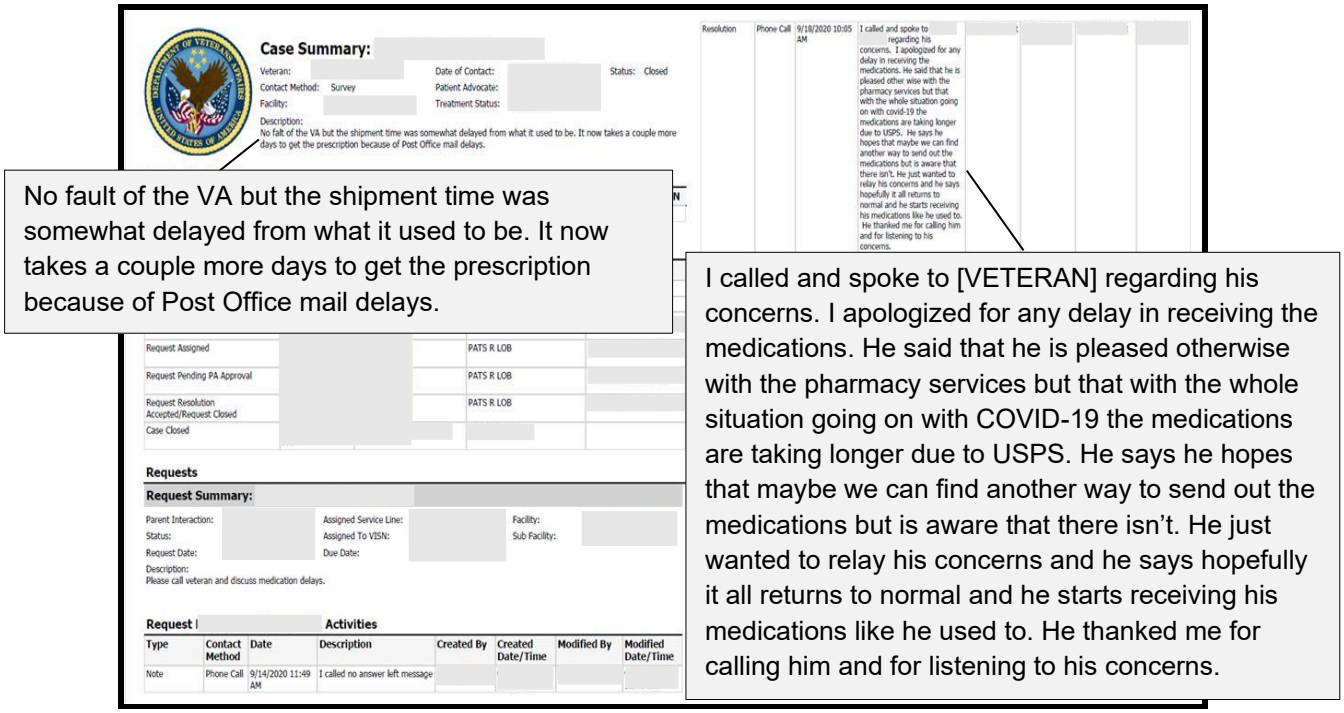

Figure 4. *Screenshot of a complaint record from PATS-R.*
Source: OIG developed this figure using a complaint record from VHA.
Note: Typographical errors in the screenshot were corrected for readability.

The audit team estimated that for FY 2020, about 44,600 of the 162,000 serious complaint records (27 percent) from PATS and PATS-R lacked information to show that complainants received the required response about their complaint outcomes.

[34] VHA Directive 1003.04.

Examples 1 and 2 illustrate how patient advocates provided incomplete information in PATS or PATS-R for complaints received before and during the COVID-19 pandemic.

Example 1

According to information from PATS and the patient advocate, a veteran submitted a complaint to the Marion VA Medical Center in Illinois in November 2019 concerning an excessive wait for a urology referral. The patient advocate closed the record in PATS and only indicated "concern noted" in the resolution section. The record did not include required information to show that the complaint outcome was communicated to the veteran. The patient advocate told the audit team that the veteran's complaint was sent to the specialty care supervisor for review but acknowledged that this information was not in PATS.

Example 2

According to PATS-R, a family member submitted a complaint in June 2020 to the patient advocate office at the VA Long Beach Healthcare System in California concerning her veteran father. She reported that her father was experiencing pain after a hip surgery was canceled due to the COVID-19 pandemic. She requested assistance to reschedule the surgery. The patient advocate recorded in PATS-R that the case manager would contact the veteran with a new surgery date and subsequently closed the record. The patient advocate told the audit team that the case manager called the veteran to reschedule the surgery, and this call was confirmed based on a copy of a progress note from the veteran's medical record. However, the record in PATS-R was closed without documenting that the complaint was fully resolved when the complainant was contacted with the outcome.

Patient advocates also did not consistently document updates in the systems as required. Status updates must be provided to the complainant if a complaint takes longer than seven business days to resolve. The audit team estimated that 16,500 serious complaint records (10 percent) from PATS and PATS-R lacked documentation that complainants were contacted with a status update when appropriate.

Incomplete records in PATS and PATS-R limited VHA's ability to know that veterans with serious complaints received customer service—a top priority within VA—and that patient advocates engaged in effective complaint resolution, as shown in example 3.

Example 3

According to PATS-R, a veteran contacted the patient advocate office at the VA Ann Arbor Healthcare System in Michigan in April 2020 with a complaint that his sleep clinic appointment was canceled without his knowledge when he was attempting to schedule a telephone appointment instead. The patient advocate recorded in PATS-R that a medical support assistant from the sleep clinic would contact the veteran to schedule an appointment. The complaint record was closed without information in PATS-R to verify that the veteran had been contacted in April with a response on the resolution to his complaint. The patient advocate said the veteran contacted the patient advocate office again in May 2020, alleging that no one in the sleep clinic had contacted him.

As seen in these examples, some patient advocates prematurely closed complaint records without documenting all required information. The lack of information makes it difficult for medical facilities and VISNs to ascertain whether all resolution actions were completed, including whether complainants were informed of the status or outcome of their serious complaints. Further, it impedes OPA's ability to conduct effective oversight of program performance. Finally, VHA cannot be certain that the timeliness data in the tracking systems are reliable, hindering its ability to assess whether complaints are actually resolved within the required timeframe.

Responsible Personnel at the Local and VISN Levels Did Not Consistently Analyze Complaints in the Patient Advocate Tracking System for Trends

Patient advocates within medical facilities are responsible for identifying trends in the types and frequency of complaints they receive. Patient advocates then communicate the trends to leaders at their respective medical facilities.[35] This information can identify opportunities for medical facility improvements such as changing processes and practices. Similarly, VISN patient advocate coordinators are responsible for preparing complaint trends based on aggregated data within their region from the patient advocate tracking system and communicating them to VISN leaders. Example 4 demonstrates how a facility patient advocate might identify actionable

[35] VHA Directive 1003.04.

information based on complaint trends, and example 5 shows how complaint trending was performed by a VISN patient advocate coordinator.

Example 4

In FY 2020, the patient advocate supervisor at the VA Providence Healthcare System in Rhode Island informed facility leaders about a trend in the number of complaints related to billing for community care services. Based on an analysis of the matter, the medical center determined that veterans were not aware of whom they should contact about their billing issues. As a result, the facility's patient advocate office created a flyer for patients with the needed information.

Example 5

The VISN 6 patient advocate coordinator presented to VISN leaders an analysis of complaints received at their medical facilities from June 1 through August 14, 2020. The coordinator determined that more than 8,000 complaints were received among its medical facilities. By analyzing the complaints, the coordinator was able to identify a trend in the number of complaints related to communication delays with care providers.

As previously mentioned, VHA policy assigns facility patient advocates the responsibility to analyze complaints for trends at the facility level. However, 76 patient advocate respondents to the OIG survey from 64 medical facilities (46 percent) said they did not trend complaint data from a patient advocate tracking system.[36] Although the OPA executive director said that facility patient advocate supervisors were expected to perform formal trending of complaints for local facility leaders, 27 patient advocate supervisors at 26 medical facilities (19 percent) who responded to the OIG's survey stated they did not perform complaint trending that could identify the need for corrective actions at the facility. At the VISN level, despite VHA policy requirements, three of the four VISN patient advocate coordinators interviewed said they did not analyze the data in the patient advocate tracking systems during FY 2020 to identify trends across medical facilities.

Lapses in trending complaints in FY 2020 limited VHA leaders' ability to fully know what feedback was received within the program to potentially improve veterans' experiences with VHA, as shown in example 6.

[36] Respondents from 138 of 140 VA medical facilities participated in the OIG survey.

Example 6

According to data from PATS and PATS-R, the VA North Texas Health Care System accumulated approximately 7,200 contacts in FY 2020 reflecting various issues. However, the patient advocate supervisor told the audit team that trending of complaints within the program did not happen in FY 2020. Instead, this facility used survey tools to monitor veteran satisfaction. However, survey tools are supposed to be used in conjunction with, not instead of, data from the patient advocate tracking system.[37]

Opportunities Exist to Improve Program Governance

Governance is the process of management and oversight by which VA leaders make informed decisions; provide strategic direction; and maintain accountability based on objectives, risks, and resources.[38] VHA did not fully comply with requirements to manage Patient Advocacy Program complaints in FY 2020 because it did not effectively issue and implement adequate policy, monitor complaint practices, and provide guidance to medical facility directors. By improving governance of the Patient Advocacy Program, VHA can ensure complaint requirements are consistently followed.

VHA Had Deficiencies in Policy to Govern the Program

VHA established a national policy for the Patient Advocacy Program that defines procedures and responsibilities. The policy requires that veteran feedback, such as complaints, be entered without exception into a patient advocate tracking system.[39] The OPA executive director's program modernization plan identified that it was a priority for program personnel to enter all complaints into the tracking system. Further, the OPA executive director told the audit team that every complaint is important and that she trusted patient advocates to enter complaints into the systems appropriately. She referred to this as an honor system.

However, contrary to these statements, she acknowledged that she verbally communicated to patient advocates the expectation that not all complaints must be entered into the tracking system. The expectation was not formalized in the program policy. The OPA executive director added that she did not expect a veteran's concern to be documented if the patient advocate was able to address the concern at the time it was received, such as a complaint about facility signage. She said that alone may not need to be entered into the system, but if three different veterans express the same concern, then those concerns would need to be in the system because it indicates a trend. The audit team recognizes that complaints can be addressed at the time

[37] VHA Directive 1003.

[38] VA Directive 0214, Department of Veterans Affairs Enterprise Governance Structure and Process, May 14, 2019.

[39] VHA Directive 1003.04. OPA is accountable for the program responsibilities and other contents of this directive.

depending on the matter. However, VHA policy requires that complaints must be entered in the patient advocate tracking system to be able to identify a trend.[40]

VHA policy notes that it is essential for program leaders to have a process to comprehensively analyze, track, and trend complaints.[41] The policy lists the responsibilities of program employees such as the facility medical director and patient advocates. However, the policy does not identify specific responsibilities for patient advocate supervisors at their facilities. For instance, the OPA executive director said she expected patient advocate supervisors to conduct reviews of patient advocates' work to ensure records contain the required complaint resolution documentation and primarily perform complaint trending for their respective facility leaders. These expectations for supervisors were not formally outlined in policy. The mixed messaging and failure to formalize expectations from the OPA executive director regarding VHA policy may have contributed to program issues and irregularities.

According to the OPA executive director, as of August 2021, OPA's efforts to update the policy were put on hold until after this audit.[42]

VHA Did Not Adequately Monitor Complaint Practices

Incomplete complaint records and the lack of complaint trending persisted, in part, because of inadequate monitoring at the local, regional, and national levels. The OPA executive director expressed that she relies on facility patient advocate supervisors to review their patient advocates' work to ensure the system contains the required information. However, as previously discussed, this expectation is not outlined in program policy. VHA policy charges VISN patient advocate coordinators to promote standardization with program requirements and develop VISN-wide approaches to ensure timely and consistent documentation of complaints in the patient advocate tracking system.[43] Moreover, OPA is responsible for overseeing the Patient Advocacy Program, including the proper management and use of the patient advocate tracking system. VHA policy also requires that local and regional data from the patient advocate tracking systems be submitted to OPA on a quarterly basis. Reports should include top complaints, total number of complaints, and the average length of time to close complaint records.[44]

[40] VHA Directive 1003.04.

[41] VHA Directive 1003.04.

[42] The deputy under secretary for health indicated in VA's official response to the draft report on February 17, 2022, that OPA was in the process of revising the policy during the course of the audit. Appendix C provides the full text of the deputy under secretary's comments.

[43] VHA Directive 1003.04.

[44] VHA Directive 1003.04.

Local-Level Monitoring

Some patient advocate supervisors told the audit team they only conducted limited quality reviews or occasional spot checks of complaint records. For example, a patient advocate supervisor at the VA St. Louis Health Care System in Missouri responded in the OIG survey that while she reviews complaint records to ensure complainants are informed of the resolution outcome, she does this review only as needed.

Additionally, 16 patient advocate supervisors at 16 medical facilities said they did not review complaint records to ensure that the complainants were contacted with a response. Further, 42 respondents said they did not review complaint records for information that complainants were kept informed on the status of complaints that took longer than seven business days to resolve. Other supervisors who reported performing regular reviews also indicated that they did not document their reviews.

Regional-Level Monitoring

Three of the four VISN patient advocate coordinators the audit team interviewed revealed that they performed limited or no reviews of complaint records to ensure they contained the required information.

National-Level Monitoring

Before this audit, OPA did not have a formal process to verify whether facility patient advocate supervisors and VISN patient advocate coordinators monitored complaint records. The OPA executive director told the audit team that OPA did not monitor or review complaint records in the patient advocate tracking systems to assess whether the required resolution activities were documented.[45] OPA primarily gets involved if there is a noticeable timeliness concern with a complaint. The executive director added that OPA does not have enough resources to conduct quality reviews but hoped to do them in the future. She further acknowledged that there has not been a formal assessment of staffing needs within OPA. OPA had 13 authorized nonsupervisory employees to perform program office functions such as special projects and training. OPA also undertakes client relation activities such as resolving complaints received by senior VA leaders.

During this audit, OPA implemented a new process that allows staff to review data in the tracking systems. In May 2021, the assistant under secretary for health for operations informed medical facility and VISN directors that OPA will implement a national monitoring and compliance process for records in PATS-R for quality assurance and reporting purposes. OPA employees will coordinate monthly with VISN patient advocate coordinators and facility patient

[45] GAO, *High-Risk Series: An Update*, GAO-15-290, February 11, 2015. GAO identified inadequate oversight and accountability—VA's oversight activities were not always sufficiently focused on facilities' compliance with applicable requirements—as an area of concern in managing risks and improving health care in the VA.

advocate supervisors to review randomly selected PATS-R records for information, such as documentation supporting whether the complainant was notified of the resolution. The OPA executive director said the process began in July 2021. The OPA associate director acknowledged that the process allows OPA to work around its limited staffing resources to support national reviews of complaint records in PATS-R.

OPA also did not monitor facility complaint trending reports during the review period to understand how well medical facilities were analyzing veteran concerns. The OPA executive director said while medical facilities and VISNs are responsible for preparing the trending data reports, her office was not collecting them because of the difficulty of reviewing reports from over 140 VHA facilities at the same time. The OPA national program manager for policy told the audit team that there will be an update to the VHA policy that will no longer require facilities and VISNs to submit reports to OPA.[46] OPA can identify complaint trends from the tracking system.

OPA Guidance to Facility Directors Was Lacking to Support Complaint Management

Although VHA policy designates directors of medical facilities with local program management responsibilities, OPA—which oversees the Patient Advocacy Program—did not follow through to provide guidance to directors to ensure they fulfilled their responsibilities. Medical facility directors are responsible for ensuring timely complaint resolution and collecting and trending complaint data. They must also ensure patient advocates understand their roles and responsibilities, which includes communicating with complainants about the outcome and using the patient advocate tracking system.[47] However, in addition to developing national program policy, the OPA executive director must provide guidance to medical facilities about managing the complaint resolution process and executing service recovery activities.[48]

Directors at four medical facilities told the audit team they were not aware of, or could not definitively say they directly received, guidance and instructions from OPA about what needed to be done to accomplish program objectives. The team determined that this lack of guidance contributed to uncertainty about duties among some patient advocates. For instance, in response to the team's review of the sampled complaints, patient advocates attributed errors in the complaint records, in part, to factors such as an unclear understanding of the requirements to document complaint resolution.

[46] As previously mentioned, OPA was in the process of updating the policy. As such, the audit team did not assess any proposed changes.

[47] VHA Directive 1003.04.

[48] VHA Directive 1003.

The OPA executive director acknowledged that she did not follow up directly with medical facility directors concerning their local program management responsibilities. She felt that matters on how local programs were managed were best left to the medical facility directors. Regardless, OPA is charged with overall Patient Advocacy Program management, which includes properly managing the tracking systems, coordinating program activities for VHA, and ensuring that patient advocates are completing their responsibilities.[49]

Conclusion

OPA needs to improve the governance of the Patient Advocacy Program to ensure patient advocates and program leaders carry out required activities and quality checks. These responsibilities include consistently entering complaints into the tracking system; documenting complaint resolution, including complainant notification; and identifying trends to drive improvements in facilities, regions, and nationwide. By strengthening program governance, VHA can support its customer service goal of better serving veterans and their families.

Recommendations 1–3

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

1. Review and update, as appropriate, program policy to formally align with the Office of Patient Advocacy's program expectations, including when complaints must be entered into a patient advocate tracking system and the responsibilities of patient advocate supervisors.
2. Implement controls that require facility patient advocate supervisors and Veterans Integrated Service Network patient advocate coordinators to perform regular, documented reviews of records in the patient advocate tracking system to monitor that the required information is entered properly.
3. Provide guidance to medical facility directors to ensure they fulfill their required Patient Advocacy Program management duties, including timely complaint resolution and trending complaint data.

VA Management Comments

The deputy under secretary for health concurred with the three recommendations and provided corrective action plans. For recommendation 1, the deputy under secretary stated that OPA had been in the process of revising VHA Directive 1003.04 during the OIG review. OPA will incorporate revisions such as clearer expectations of when complaints must be entered into the tracking system and the responsibilities of patient advocate supervisors to ensure formal

[49] 38 U.S.C. § 7309A (2016); VHA Directive 1003; VHA Directive 1003.04.

alignment with program expectations. The response to recommendation 2 stated that in January 2021, VHA implemented a compliance and monitoring program to establish processes to continuously monitor and review patient advocate tracking system documentation. Further, the nationally coordinated process launched July 1, 2021, establishing internal controls requiring facility patient advocate supervisors and VISN patient advocate coordinators to perform regular, documented reviews of relevant records to monitor that required information is entered properly. The baseline monitoring year will conclude in July 2022 and will be followed by an annual report.

For recommendation 3, the deputy under secretary stated that OPA began communicating program management duties and expectations to VISN and facility leadership in August 2021 via VISN Executive Leadership Conferences. These meetings provide an opportunity for OPA to communicate program management duties and for VISN and facility executive leaders to directly request guidance and provide feedback to the national program office. Additionally, the VHA Directive 1003.04 revision will include required duties for facility directors and patient advocate supervisors to ensure program management and timely complaint resolution and data trending occurs. Appendix C provides the full text of the deputy under secretary's comments.

OIG Response

The deputy under secretary for health's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the issues identified.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from November 2020 through December 2021. The audit scope focused on assessing the effectiveness of the Patient Advocacy Program at 140 VA medical facilities to address complaints on time and as required from October 1, 2019, through September 30, 2020. The audit team judgmentally selected four VA medical facilities for review in Topeka, Kansas; Butler, Pennsylvania; Dallas, Texas; and Richmond, Virginia. The audit included the VISNs that oversee those medical facilities.

The audit team used multiple sources of information, including applicable federal regulations and standards, VA policies and procedures, and complaint records from both PATS and PATS-R. The team obtained information from program officials and employees in various offices, including the OPA, OIT, and various VA medical facilities.

Methodology

To accomplish its objective, the audit team reviewed a stratified random sample of 220 complaints from PATS and PATS-R at 97 VA medical facilities. The selected complaints were assigned an issue code that the audit team determined represented serious concerns to the veteran, such as delays in accessing care or services, problems with clinical care, and medication issues. The team did not review less serious matters such as the codes related to availability of parking, staff courtesy, compliments, or general requests for information. The team requested information from patient advocates at the medical facilities involved in managing each of the sampled complaints. The team also provided the patient advocates with the results of its complaint analysis and identified issues for feedback and explanation.

The audit team obtained information from more than 50 VHA and OIT employees about audit objective topics, as well as their roles and responsibilities. The team also conducted an online survey of 418 patient advocates, including supervisors, to gather information and perspectives about local program practices during FY 2020. The team reviewed and analyzed all 326 responses received (a 78 percent response rate) as of March 23, 2021.

Internal Controls

The audit team assessed the internal controls of the Patient Advocacy Program significant to the audit objective. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.[50] In addition, the team reviewed the principles of internal controls as associated with

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

the objective. The team identified three components and four principles as significant to the audit objective. The team identified internal control weaknesses and proposed recommendations to address the following control deficiencies:

- Component 1: Control Environment
    - Principle 5—Management should evaluate performance and hold individuals accountable for their internal control responsibilities.
- Component 3: Control Activities
    - Principle 11—Management should design the entity's information system and related control activities to achieve objectives and respond to risks.
    - Principle 12—Management should implement control activities through policies.
- Component 5: Monitoring
    - Principle 16—Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.

Fraud Assessment

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

Data Reliability

The audit team used computer-processed data obtained from PATS and PATS-R. To assess the reliability of these data, the team performed testing on a statistically selected sample of complaints that were prepared in PATS and PATS-R from October 2019 through September 2020. The team requested information from VHA employees involved in managing the sampled complaints to corroborate complaint activities recorded in the applicable system and validate relevant fields such as dates of contact and closure. Except for the lack of complete complaint resolution information that the team found in sampled complaint records, for which the OIG made recommendations to address, the team believes that the data obtained from PATS and PATS-R were appropriate and sufficient for the purposes of this audit based on this approach and the results of the testing.

Through the course of the audit, the team found that patient advocates did not always enter complaints in the patient advocate tracking systems. As a result, some complaints were not available for selection by the team's sampling design. However, this did not prevent the team from assessing program performance regarding complaints that were entered into the systems.

Despite the issues identified, the audit team concluded that the data obtained from PATS and PATS-R were sufficiently reliable to support the audit objectives, conclusions, and recommendations.

Government Standards

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

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the audit objective, the audit team reviewed a stratified random sample of complaints that had a date of contact from October 1, 2019, through September 30, 2020. The complaints were extracted from two separate systems—PATS and PATS-R. During the scope of the OIG audit, PATS-R was not fully implemented at all medical facilities. Therefore, the team had to obtain complaint data from two systems to develop the audit population.

Patient advocates assess the description of the veteran's concern and assign issue codes to the complaint. The team used the issue codes in PATS and PATS-R to identify complaints that represented serious concerns to the veteran. These concerns included delays in accessing care or services, problems with clinical care, and medication issues. The team selected the issue codes deemed serious after consulting with OPA leaders. The OPA executive director agreed with the OIG's selection methodology. The team used statistical sampling to quantify the extent of complaint records that were resolved in a timely manner and contained the required information to illustrate that complaint resolution was completed.

Population

VHA had 474,528 contacts in PATS and PATS-R from October 2019 through September 2020.[51] For the purposes of the audit, the team focused on contacts that represented serious complaint issues. The team excluded contacts that were coded only with issues such as parking availability, staff courtesy, compliments, or general information requests. As a result, the audit population consisted of 162,332 unique complaints that matched serious issues coded in PATS and PATS-R.

Sampling Design

The audit team selected a random statistical sample of 220 of 162,332 complaints from PATS and PATS-R. The population was stratified by the 18 VISNs and the population by timeframe. Specifically, the team stratified the population into two time periods within FY 2020—before the COVID-19 pandemic (October 1, 2019, through March 31, 2020) and during the pandemic (April 1, 2020, through September 30, 2020).

[51] The audit team identified 36,505 contacts from PATS-R that appeared to not have a corresponding issue code assigned at the time the data were extracted in January 2021. These records were not included in the audit sampling frame. The audit team initially reviewed a judgmental sample of 10 of these contacts at two medical facilities and determined that they did have an issue code assigned. Subsequently, the team reevaluated whether all 36,505 contacts had either a request or issue code. The team determined that less than one percent of them had a serious issue code.

Table B.1 identifies each VISN, the number of complaints that were coded as serious issues by time periods in FY 2020, and the number of complaints selected.

Table B.1. Summary of Sampled Complaints by VISN and Time Periods

VISN	Serious complaints from October 2019 to March 2020	Serious complaints from April 2020 to September 2020	Sampled complaints
1	2,451	2,288	6
2	3,184	4,284	10
4	2,110	2,127	6
5	3,187	3,157	8
6	8,982	6,991	22
7	4,839	8,296	18
8	8,246	7,808	22
9	3,138	3,005	8
10	6,130	5,616	16
12	4,735	3,804	11
15	1,731	2,158	5
16	5,970	6,796	17
17	5,292	5,210	14
19	3,441	3,446	10
20	3,150	3,169	8
21	4,883	5,509	15
22	5,679	5,122	15
23	3,403	2,995	9
Total	**80,551**	**81,781**	**220**

Source: OIG analysis of stratified populations and sampled complaints.

Weights

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

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

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

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

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

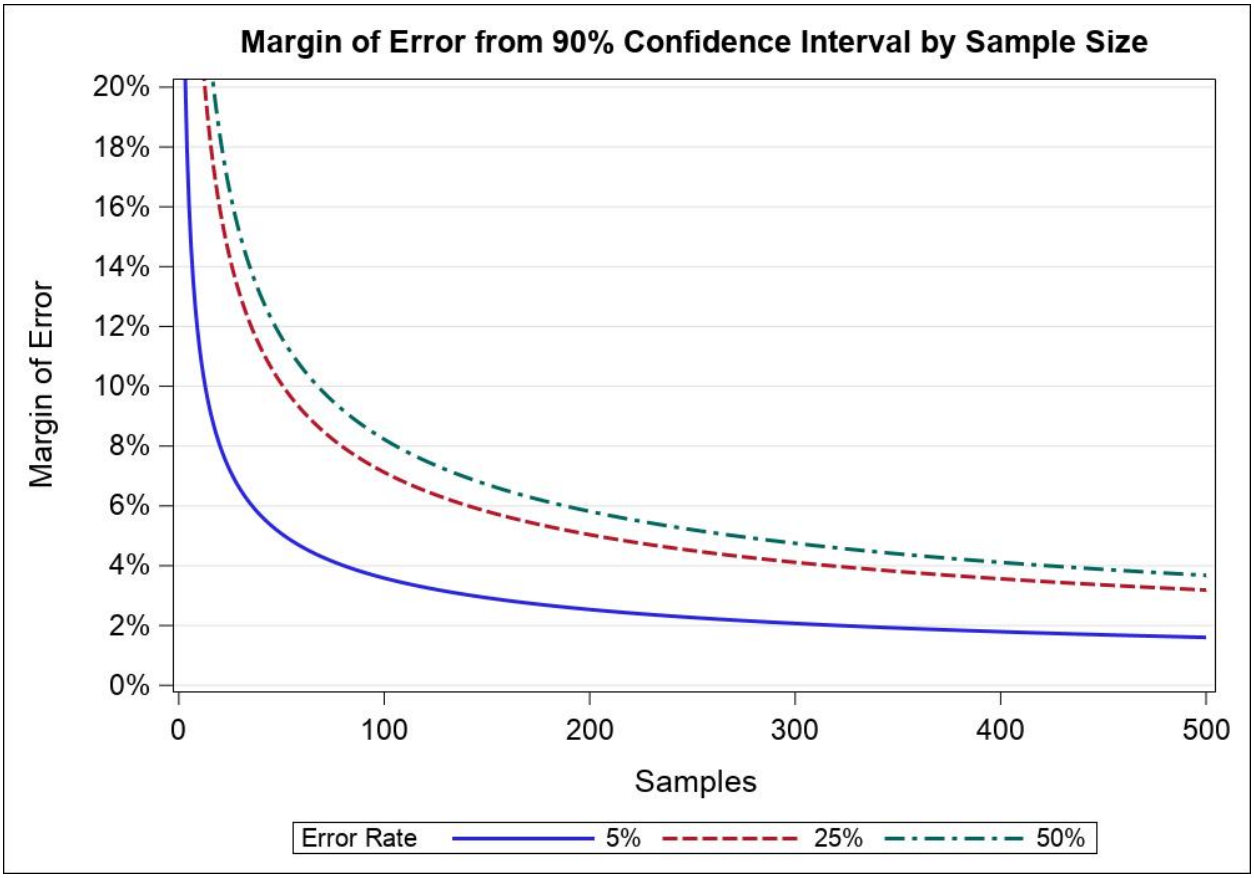

Figure B.1. *Effect of sample size on margin of error.*

Source: OIG analysis.

Projections

Table B.2 provides the projections for the number of serious complaints that were closed within seven business days to indicate they were resolved.

Table B.2. Statistical Projections Summary for Serious Complaints Closed in the Patient Advocate Tracking Systems within Seven Business Days

Category	Estimate number	Margin of error	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
Closed within seven business days to indicate they were resolved	132,614 (81.7%)	7,058 (4.3%)	125,556 (77.3%)	139,672 (86%)	180
Not closed within seven business days to indicate they were resolved	29,718 (18.3%)	7,058 (4.3%)	22,660 (14%)	36,776 (22.7%)	40

Source: OIG analysis of sampled results projected over the audit population.

Table B.3 shows the projection for the number of serious complaints that VHA confirmed were either correct contact and/or closure dates or should have been different.

Table B.3. Statistical Projections Summary for Serious Complaints in the Patient Advocate Tracking Systems that Showed Correct Dates of Contact and/or Closure

Category	Estimate number	Margin of error	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
Dates of contact and closures verified as correct by VHA	147,431 (90.8%)	5,246 (3.2%)	142,185 (87.6%)	152,676 (94.1%)	200
Dates of contact and/or closure that should have been different than what was recorded, according to VHA	14,901 (9.2%)	5,246 (3.2%)	9,656 (5.9%)	20,147 (12.4%)	20

Source: OIG analysis of sampled results projected over the audit population.

Table B.4 details the projection for the number of serious complaints that contained or lacked information to show that veterans received the required response about their complaint outcomes.

Table B.4. Statistical Projections Summary for Serious Complaints in the Patient Advocate Tracking Systems that Showed a Required Response About Complaint Outcomes

Category	Estimate number	Margin of error	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
Showed veterans received the required response	117,755 (72.5%)	7,712 (4.8%)	110,044 (67.8%)	125,467 (77.3%)	159
Lacked information to show that veterans received the required response	44,577 (27.5%)	7,712 (4.8%)	36,865 (22.7%)	52,288 (32.2%)	61

Source: OIG analysis of sampled results projected over the audit population.

Table B.5 projects the number of serious complaints that contained or lacked information to demonstrate that veterans were contacted with a status update when the issue took longer than seven business days to resolve.

Table B.5. Statistical Projections Summary for Serious Complaints in the Patient Advocate Tracking Systems that Showed a Status Update

Category	Estimate number	Margin of error	90 percent confidence interval lower limit	90 percent confidence interval upper limit	Sample size
Showed veterans were contacted with a status update or were not applicable	145,807 (89.8%)	5,374 (3.3%)	140,433 (86.5%)	151,181 (93.1%)	198
Lacked information to show veterans were contacted with a status update	16,525 (10.2%)	5,374 (3.3%)	11,151 (6.9%)	21,899 (13.5%)	22

Source: OIG analysis of sampled results projected over the audit population.

Appendix C: VA Management Comments

Department of Veterans Affairs Memorandum

Date: February 17, 2022

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

Subj: OIG Draft Report, Veterans Health Administration: Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints (Project Number 2021-00510-AE-0015) (VIEWS # 06951050)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on patient advocacy. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.

2. The Office of Patient Advocacy (OPA) appreciates the opportunity to work with OIG as we continuously strive to improve the quality and delivery of health care for America's Veterans. OPA is committed to ensuring Veterans' feedback about their health care is heard, documented, and resolved appropriately. OPA will continue to work on program policy and guidance and align it with expectations and appropriately delineated roles and responsibilities. Continued national coordination of the Patient Advocate Tracking System monitoring process will ensure regular, documented reviews of records and ensure required information is entered properly. Regular, consistent, and multifaceted communication with Veterans Integrated Service Network and Facility Directors will be critical to provide guidance and support as they fulfill their required program management duties.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report: Veterans Health Administration: Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints
(OIG Project 2021-00510-AE-0015)

Date of Draft Report: February 4, 2022

Recommendation 1. The OIG recommended that the Under Secretary for Health review and update, as appropriate, program policy to formally align with the Office of Patient Advocacy's program expectations, including when complaints must be entered into a patient advocate tracking system and the responsibilities of patient advocate supervisors.

VHA Comments: Concur. During the course of this review, the Office of Patient Advocacy (OPA) was in the process of revising VHA Directive 1003.04, *VHA Patient Advocacy*. OPA will incorporate revisions such as clearer expectations of when complaints must be entered into the Patient Advocate Tracking System (PATS) and the responsibilities of patient advocate supervisors to ensure formal alignment with program expectations.

Status: In Progress Target Completion Date: April 2023

Recommendation 2. The OIG recommended that the Under Secretary for Health implement controls that require facility Patient Advocate Supervisors and Veterans Integrated Service Network Patient Advocate Coordinators to perform regular, documented reviews of records in the Patient Advocate Tracking System to monitor that the required information is entered properly.

VHA Comments: Concur. In January 2021, VHA implemented a Compliance and Monitoring (CAM) program to establish processes to continuously monitor and review PATS documentation in alignment with VHA Directive 1003.04, *VHA Patient Advocacy*. The nationally coordinated monitoring process launched July 1, 2021, establishing internal controls requiring facility Patient Advocate Supervisors and Veterans Integrated Service Network (VISN) Patient Advocate Coordinators to perform regular, documented reviews of records in PATS to monitor that required information is entered properly. The baseline year of the monitoring process will conclude in July 2022 followed by the submission of an annual report.

Status: In Progress Target Completion Date: September 2022

Recommendation 3. The OIG recommended that the Under Secretary for Health provide guidance to medical facility directors to ensure they fulfill their required patient advocacy program management duties, including timely complaint resolution and trending complaint data.

VHA Comments: Concur. Beginning in August 2021, OPA began communicating advocacy program management duties and expectations to VISN and Facility leadership utilizing VISN Executive Leadership Conferences. These meetings provide an opportunity for OPA to communicate program management duties, in addition to providing VISN and facility executive leadership an opportunity to directly request

guidance and provide feedback to the national program office. In addition, OPA is revising VHA Directive 1003.04, *VHA Patient Advocacy*, to include the required duties for facility Directors and the addition of the Patient Advocate Supervisor role to ensure facility advocacy program management, timely complaint resolution and trending complaint data occurs.

Status: In Progress Target Completion Date: April 2023

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

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