

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Audit of
VHA's Efforts To Improve
Veterans' Access to
Outpatient Psychiatrists*

August 25, 2015
13-03917-487

ACRONYMS

CPT	Current Procedure Terminology
FY	Fiscal Year
FTE	Full-Time Equivalent
OIG	Office of Inspector General
OMHO	Office of Mental Health Operations
OPES	Office of Productivity, Efficiency, and Staffing
RVU	Relative Value Unit
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Highlights: Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists

Why We Did This Audit

We evaluated the Veterans Health Administration's (VHA) efforts to improve veterans' access to outpatient psychiatrists. The Office of Inspector General's (OIG) 2012 *Review of Veterans' Access to Mental Health Care* identified a bottleneck in access to psychiatrists.

What We Found

VHA has not been fully effective in its use of hiring opportunities or its use of existing personnel to improve veterans' access to psychiatrists. From fiscal year (FY) 2012 through FY 2014, VHA increased outpatient psychiatrist full-time equivalents (FTEs) by almost 15 percent. During that time, the number of veterans' outpatient encounters with psychiatrists increased by about 10 percent, and the number of individual veterans who received outpatient care from a psychiatrist increased about 9 percent.

We found that VHA did not have an effective method for establishing psychiatrist staffing needs. Throughout recent hiring initiatives, VHA did not stress a specific need for psychiatrists; instead, facilities determined their own staffing needs. VHA did not ensure facilities used consistent and effective clinic management practices.

This resulted in 94 of 140 health care facilities that needed additional psychiatrist FTEs to meet demand, as of December 2014. We found VHA facilities could have better used about

25 percent of psychiatrist FTE clinical time to see veterans in FY 2014, which equated to nearly \$113.5 million in psychiatrists' pay. Over the next 5 years, this would equate to over \$567 million if clinic management is not strengthened now.

What We Recommended

We recommended the Under Secretary for Health ensure facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed, and attain appropriate staffing levels or identify alternative options. We recommended the Under Secretary develop clinic management business rules, reassess the appropriateness of VHA's productivity target for psychiatrists, and develop a mechanism to monitor the variance in which psychiatrists code encounters.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and provided an appropriate action plan. We will follow up on the implementation of the corrective actions.

A handwritten signature in black ink that reads "Linda A. Halliday".

LINDA A. HALLIDAY
Deputy Inspector General

TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations	3
Finding VHA Needs To Further Improve Veterans’ Access to Psychiatrists	3
Recommendations	14
Appendix A Scope and Methodology.....	16
Appendix B Potential Monetary Benefits in Accordance With Inspector General Act Amendments	19
Appendix C Under Secretary for Health Comments	20
Appendix D Office of Inspector General Contact and Staff Acknowledgments.....	25
Appendix E Report Distribution	26

INTRODUCTION

Objective Our objective was to evaluate the Veterans Health Administration's (VHA) efforts to improve veterans' access to outpatient psychiatrists.

Prior Reports The Office of Inspector General's (OIG) 2012 *Review of Veterans' Access to Mental Health Care* (Report No. 12-00900-168, April 23, 2012), identified a bottleneck in psychiatrists' appointments and reported that, at the four facilities visited, psychiatrists generally were not available for the next 41 days, on average. In addition, three of the four facilities had vacant psychiatrist positions.

OIG's 2012 *Audit of VHA's Physician Staffing Levels for Specialty Care Services* (Report No. 11-01827-36, December 27, 2012), identified that VHA did not establish productivity standards for 31 of 33 specialty care services, including psychiatrists, and VA medical facility management did not develop staffing plans. VHA responded to OIG recommendations by establishing productivity standards for psychiatrists and other specialty care services.

Program Size In fiscal year (FY) 2014, VHA spent nearly \$6.7 billion on mental health care services. Of that, nearly \$4 billion was used for VA outpatient mental health care, which included outpatient psychiatry services. The \$4 billion was over 24 percent more than VHA spent for outpatient mental health care in FY 2012. During FY 2014, VHA employed an average of about 2,800 psychiatrist full-time equivalents (FTEs) and paid them over \$733 million in salaries and benefits. Of those psychiatrists, VHA allocated nearly 1,800 psychiatrist FTEs to provide outpatient clinical care during FY 2014. Clinical outpatient FTE time excludes non-working time such as annual and sick leave. Those VHA psychiatrists treated nearly 870,000 individual veterans during FY 2014.

Importance of Psychiatrists to Mental Health Psychiatrists are more expensive than other mental health clinicians, and often difficult to recruit. In a May 2012 internal memo, VHA stated workload concerns about the average number of veterans treated by a psychiatrist in a year and the average number of visits veterans receive per year. Specifically, VHA stated a significant proportion of VA psychiatrists saw in excess of 800 to 900 veterans per year and some veterans were only seen once per year due to access demands.

VHA Hiring Initiatives On April 19, 2012, the former Secretary of Veterans Affairs announced VHA would hire approximately 1,600 additional mental health clinicians. On May 8, 2012, the former Secretary of Veterans Affairs testified to Congress that psychiatrists are the toughest to recruit, and that of the 1,600 additional clinicians, VHA planned to hire about 57 psychiatrists. On June 3, 2013, VHA announced it successfully hired over 1,600 new mental health clinicians and filled over 2,000 existing mental health clinician vacancies. In

August 2014, VA initiated plans to hire over 2,700 additional mental health clinicians as part of a VHA-wide hiring effort in response to Public Law 113-146, the Veterans Access, Choice, and Accountability Act of 2014.

*Nationwide Pay
Exception for
Psychiatrists*

In May 2012, the then-Under Secretary for Health approved a nationwide blanket pay exception for psychiatrists. The pay exception expanded the pay range maximum amount from \$195,000 to \$250,000. According to VHA, the pay exception allowed facility directors the ability to offer a more competitive salary to a recruited psychiatrist without an individual exception request to VHA, saving valuable time.

Effective November 30, 2014, VHA moved psychiatrists from Pay Table 1 to Pay Table 2, and increased the maximum annual pay amount for Pay Table 2, Tier 1 to \$240,000 (\$250,000 for Tier 2). As a result, VHA officials stated the nationwide pay exception for psychiatrists was no longer necessary and VHA rescinded the exception effective November 30, 2014.

*Office of
Mental Health
Operations
Staffing Model*

During 2014, VHA's Office of Mental Health Operations (OMHO) developed a ratio to determine a minimum psychiatrist staffing level for facilities. OMHO determined the minimum ratio to be 1.22 outpatient psychiatrist FTEs per 1,000 individual mental health patients. OMHO derived the 1.22 ratio based on the median level of psychiatrists at VA medical facilities nationwide. OMHO stated the model was used as guidance for hiring psychiatrists at facilities in which psychiatrists were underrepresented in mental health clinics.

*Other
Information*

- Appendix A provides details on our scope and methodology.
- Appendix B provides potential monetary benefits.

RESULTS AND RECOMMENDATIONS

Finding **VHA Needs To Further Improve Veterans' Access to Psychiatrists**

VHA has not been fully effective in its use of hiring opportunities or its use of existing personnel to improve veterans' access to psychiatrists. During FY 2014, VHA spent nearly \$4 billion in outpatient mental health care services—over 24 percent more funding than in FY 2012—and increased outpatient psychiatrist FTEs by almost 15 percent. During that time, from FY 2012 through FY 2014, veterans' encounters with outpatient psychiatrists increased by about 10 percent, and individual veterans who received outpatient care from a psychiatrist increased by about 9 percent. An encounter represents an appointment between a patient and a clinician responsible for diagnosing, evaluating, and treating the patient's condition. Some veterans have multiple encounters with an outpatient psychiatrist per year.

VHA did not have an effective method for establishing psychiatrist staffing needs at VA medical facilities. During a 2012 hiring initiative and throughout recent hiring efforts, VHA did not stress a specific need for psychiatrists; instead, it provided Veteran Integrated Service Networks (VISNs) and facilities the latitude to determine their own staffing needs using their own methods. In addition, VHA did not ensure facilities used consistent and effective clinic management practices, resulting in inefficiencies and a high rate of clinical time that was not used for patient care during FY 2014.

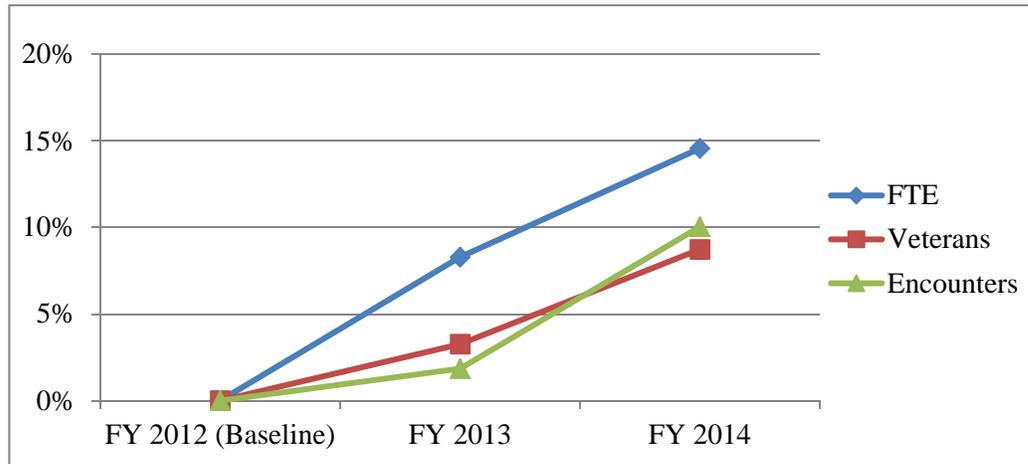
VHA's focus on meeting its hiring goals instead of focusing on hiring the appropriate number of mental health clinicians at the appropriate specific facility contributed to 94 of 140 facilities needing additional psychiatrist FTEs to meet veteran demand, as of December 2014. We also found that facilities had varying levels of clinical time that was not used for patient care, regardless of whether they needed additional psychiatrists. VHA facilities could have better used an estimated 25 percent of psychiatrist FTE clinical time to see veterans during FY 2014, which equated to nearly \$113.5 million in psychiatrists' pay. Over the next 5 years, this clinic time not used for patient care would equate to over \$567 million if clinic management is not strengthened now.

Veterans' Access Needs Improvement

VHA did not effectively use psychiatrists in its efforts to improve veterans' access to psychiatric care. VHA significantly increased the number of psychiatrists providing outpatient clinical care since FY 2012, but did not show a corresponding increase in veterans receiving care from psychiatrists.

From FY 2012 through FY 2014, VHA increased the number of psychiatrist FTEs by about 226 outpatient clinical FTEs (nearly 15 percent). During the same period, the total number of veterans' outpatient encounters with psychiatrists increased about 10 percent, and the number of individual veterans who received outpatient care from a psychiatrist increased about 9 percent. As shown in the following figure, the nationwide rates of increase of veterans obtaining care from psychiatrists and their total encounters with psychiatrists, were not commensurate with the increase in FTEs allocated to provide that care.

Figure 1. Percent Increase in Outpatient Psychiatrist FTEs, Individual Veterans, and Encounters From FY 2012 Through FY 2014



Source: OIG analysis of outpatient FTEs from VHA's Physician Productivity Cube and outpatient psychiatrist data obtained from VHA's Office of Productivity, Efficiency, and Staffing

Some individual facilities did not increase encounters from FY 2012 through FY 2014 even with their additional psychiatrist FTEs. For example, Minneapolis, MN, VA Medical Center (VAMC) increased FTEs by over 14 percent, but decreased encounters by over 21 percent. In contrast, Miami VAMC increased its psychiatrist clinical outpatient FTE by about 25 percent and increased encounters by just over 36 percent. Miami, FL, VAMC's Chief of Psychiatry and a lead program analyst actively monitored psychiatrists' workload and productivity data.

An OMHO official stated it was unknown what the appropriate increase in encounters should have been. He suggested that the addition of new staff might have curtailed psychiatrists' workload to a more manageable level.

As shown in Table 1, veterans nationwide received roughly the same frequency of encounters with psychiatrists in FY 2014 (3.56 encounters per veteran) as they did in FY 2012 (3.52 encounters per veteran), despite a nearly 15 percent increase in psychiatrist FTEs.

Table 1. Veterans Accessing Psychiatrists in VHA

Unit of Measure	FY 2012	FY 2014	Increase	Percent Change
Encounters	2,811,379	3,093,840	282,461	10.0%
Individual Veterans	799,181	869,018	69,837	8.7%
Frequency of Encounters	3.52	3.56	0.04	1.2%

Source: OIG analysis of outpatient psychiatrist data obtained from VHA's Office of Productivity, Efficiency, and Staffing

Note: Because of rounding, columns may not sum.

We determined that 59 of 129 facilities (over 45 percent) did not increase the average number of psychiatrist encounters per veteran from FY 2012 through FY 2014.¹ An OMHO official said that an improvement in the frequency of encounters would depend on several factors, including whether the facility gained additional patients. For example, if the number of individual patients at a facility increased by 10 percent, that facility may not be able to provide a corresponding increase in the veterans' frequency of encounters without an increase in psychiatrist FTEs. However, if VHA established a method for identifying staffing needs for psychiatrists at individual facilities, VHA would ensure that facilities with increased numbers of patients received additional FTEs.

No Uniform Staffing Approach

During a 2012 hiring initiative and throughout recent hiring efforts, VHA did not stress a specific need for psychiatrists and provided individual VISNs and facilities the latitude to determine their own staffing needs using their own methods. Two primary hiring efforts follow.

- During the 2012 hiring initiative, VHA did not implement a specific approach to distribute the 1,600 mental health clinicians, including psychiatrists. OMHO created a model that estimated the number of mental health staff each facility should add, but the model did not specify

¹ Although there are 140 VA medical facilities, the outpatient psychiatrist data obtained from VHA's Office of Productivity, Efficiency, and Staffing, combined certain medical facilities as Health Care Systems, resulting in 129 total facilities. A Health Care System is an integrated system under the direction of one administrative parent facility and comprising multiple health care facilities.

the type of clinicians those facilities needed. Thus, VHA did not define or plan for the number of psychiatrists that facilities needed.

- In 2014, despite established staffing goals for psychiatrists within mental health services, VHA continued to rely upon each VISN and its facilities to make staffing decisions because VHA believed the facilities were in the best position to address their unique veteran demand for mental health services.

2012 Hiring Initiative Did Not Focus on Psychiatrists

In 2012, at the request of several congressional leaders, OIG completed a review of veterans' access to mental health care. The 2012 report determined that one of VHA's greatest challenges in providing timely mental health care was its ability to hire and retain psychiatrists. On April 19, 2012, in response to congressional hearings over Congress's growing frustration to ensure veterans received timely access to mental health care, the former Secretary of Veterans Affairs announced VHA would hire approximately 1,600 mental health clinicians—including nurses, psychiatrists, psychologists, and social workers.

On April 25, 2012, the then-Chairman of the Senate Committee on Veterans' Affairs commended VA for the decision to hire additional mental health providers, but stated that VHA did not have a "reliable staffing model to determine where individuals were needed." In response, the former VHA Deputy Under Secretary for Health for Operations and Management stated that three VISNs were testing a staffing model. He testified that the model would provide a clear basis for assessing staffing for mental health services, and currently showed there were shortfalls at some sites nationally. In addition, he testified that psychiatrists were the most difficult mental health clinicians to recruit. He added during the hearing that:

Decisions concerning staffing and programs were determined historically at the facility level to allow flexibility based on local resources and needs. However, as evidence accumulates, it is clear that sites can benefit from more central guidance on best practices in determining needed mental health staff.

In May 2012, VHA provided each VISN with facility-specific recommendations for the distribution of the additional clinical mental health FTEs. The recommendation identified the number of staff each facility should receive, but did not specify which types of mental health clinicians that facilities should hire. VHA determined the recommended hiring distribution by identifying facilities with lower rates of mental health clinician FTEs. Specifically, OMHO determined that each facility should have at least 7.72 mental health clinicians per 1,000 mental health patients.

During VHA's 2012 hiring initiative, VHA provided VISNs the latitude to hire other types of mental health clinicians or to move FTE allocations to a different facility if their ability to hire a certain clinician, such as a

psychiatrist, within the period was difficult or unlikely. Then in June 2013, VA announced it had hired over 1,600 new mental health clinicians. However, based on information from VHA's Workforce Management and Consulting Office, VHA added only about 150 new outpatient psychiatrist FTEs through this initiative. This turned out to be an increase from the estimated 57 psychiatrists the former Secretary of Veterans Affairs testified to Congress in May 2012 that VHA planned to hire. The then-OMHO Director told us that VHA's goal was to ensure it hired 1,600 mental health clinicians and, in theory, would have approved hiring 1,600 social workers if that was what the VISNs stated they needed. She further stated that OMHO did not need to know how many psychiatrists VHA needed on a national level.

As of May 2013, after completion of the 2012 initiative to hire 1,600 additional mental health clinicians, OMHO determined that more than 60 facilities were still below what it determined to be a minimally acceptable mental health clinician staffing goal per facility—at least 7.72 mental health clinicians per 1,000 mental health patients. At that time, OMHO had not determined how many psychiatrists each facility needed. Thus, it did not know how many facilities still needed psychiatrists.

*VHA Not
Ensuring
Facilities Meet
Staffing Levels
in 2014–2015
Hiring Plans*

In 2014, despite established staffing ratios for psychiatrists within mental health services, VHA continued to rely upon each VISN and its facilities to make staffing decisions because VHA believed the facilities were in the best position to address their unique veteran demand for mental health services. On September 16, 2014, and again on December 29, 2014, VHA sent the VISNs a staffing model intended to drive the influx of hiring actions brought on in part by the Veterans Access, Choice, and Accountability Act of 2014. The staffing model established a minimum psychiatrist staffing level for facilities to be 1.22 outpatient psychiatrist FTEs per 1,000 individual mental health patients. OMHO derived the 1.22 model based on the median level of psychiatrists at facilities nationwide. According to OMHO, staff-to-veteran ratios directly correlate with access to care.

However, OMHO did not require facilities to follow the estimated staffing model it provided. OMHO stated the model was used as guidance for the VISNs. It also stated it established the ratio in an effort to prevent VISNs and facilities from hiring easy-to-recruit, or less expensive mental health clinicians, in order to achieve the targeted FTE allocation. OMHO believed facilities that fell below the 1.22 ratio tended to be less efficient, because facilities need psychiatrists to make a number of important decisions that non-psychiatrists cannot legally or medically make. In December 2014, VHA's staffing model showed that 94 facilities were below this ratio.

Instead of using the staffing model to drive hiring decisions, VHA requested that VISNs and facilities provide budget and hiring plans based on the facilities' identified needs. VHA again allowed VISNs to move FTEs among

their facilities, or to different care services, at the discretion of the VISN. According to OMHO, VISNs and facilities would make the decisions about actual numbers of hires, with input from VHA program offices.

VHA's estimate in December 2014 showed that 94 facilities needed nearly 335 psychiatrist FTEs to meet veteran demand. During January 2015, the VISNs revised VHA's December 2014 hiring plan. However, the VISNs requested only roughly 313 additional psychiatrist FTEs. While the VISNs' requested total was close to the total of what VHA estimated they needed, the VISNs' request reallocated psychiatrist FTEs to different facilities. For example, OMHO's model suggested that one facility needed 24 additional psychiatrist FTEs, but the VISN requested only 12 psychiatrists for that facility.

If facilities hire psychiatrist FTEs according to the VISNs' January 2015 estimated staffing plans, 62 facilities would remain understaffed with psychiatrists based on what OMHO determined they needed to meet veteran demand. This would result in a similar outcome to the 2012 hiring initiative, when OMHO determined that more than 60 facilities remained below minimum staffing level for mental health clinicians.

VHA lacked an effective method for establishing psychiatrist staffing needs at individual facilities. While VA has established staffing models within mental health services, it has not ensured facilities followed the staffing ratios. VHA should ensure VISNs and facilities incorporate OMHO's staffing model to determine the appropriate number of psychiatrists needed for outpatient care and work together to attain appropriate staffing levels or identify alternative options to meet veteran demand for psychiatrists. This would improve veterans' access to care through effective placement of resources.

**Clinic
Management
Practices
Allowed for
Unused
Capacity**

VHA clinic management practices resulted in unused capacity of its psychiatrists. We determined that the facilities we visited did not use consistent and effective standards for how many veterans their psychiatrists could care for or for their psychiatrists' time available for direct patient care. Facilities varied in their own expectations of such practices, which resulted in different levels of access. As a result of *OIG's Audit of VHA's Physician Staffing Levels for Specialty Care Services* and previous VHA studies, VHA recently implemented productivity measures. However, VHA should reassess its established productivity target.

**Veterans per
Psychiatrist**

VHA did not have standards for the appropriate number of veterans its psychiatrists could care for. During FY 2014, the average number of unique veterans that a psychiatrist FTE provided care to during the year ranged from 311 veterans at one facility to 906 veterans at another facility. Facilities with high veteran-to-psychiatrist ratios generally have less opportunity to provide

additional appointments to existing or new patients. As shown in Table 2, in FY 2014, the average number of psychiatrist patients per psychiatrist FTEs during a 1-year period was 502 unique veterans.

Table 2. Average Number of Psychiatrist Patients per Psychiatrist FTE

VA Facility	FY 2012	FY 2014
Lowest VA Facility	306	311
San Francisco	306	316
New York Harbor	420	400
Miami	489	449
National Average	529	502
Dublin	711	545
Chillicothe	648	634
Temple	729	669
Highest VA Facility	1,114	906

Source: OIG analysis of VHA's Physician Productivity Cube and outpatient psychiatrist data obtained from VHA's Office of Productivity, Efficiency, and Staffing

An OMHO official confirmed that VHA did not have an internal measure or benchmark for the number of patients per psychiatrist. Therefore, facilities determined their own expectations of how many veterans their psychiatrists could care for, which resulted in different ranges of access. Three examples follow.

Example 1

Temple, TX, VAMC's average was 669 patients per psychiatrist during FY 2014, and veterans received an average of just over 2.7 encounters with psychiatrists during the year. The Chief of Mental Health said on average an ideal maximum caseload for a psychiatrist would be approximately 800 veterans per psychiatrist.

Example 2

New York Harbor Healthcare System's average was 400 patients per psychiatrist during FY 2014, and veterans received an average of 5.3 encounters with psychiatrists during the year. The Chief of Mental Health said their ratios should be about 500 veterans per psychiatrist.

Example 3

VA Texas Valley Coastal Bend Health Care System had the nation's highest ratio of approximately 906 patients per psychiatrist, and veterans received only about 2 encounters per year with psychiatrists.

Use of Clinical Time for Patient Care

On average, a psychiatrist clinical FTE scheduled appointments with veterans only for an estimated 22.4 hours per week during FY 2014. The six facilities we visited had varied expectations on the number of hours each psychiatrist should spend on clinical time, ranging from 25 to 32.5 hours during a 40-hour week. In 2014, OMHO presented analysis to VHA leadership regarding the percentage of clinical time that is “bookable.” OMHO suggested that about 78 percent of clinicians’ worked clinical hours per year are bookable and should be spent in generating encounters. This equates to 31.2 hours in a 40-hour week for a clinical FTE. OMHO suggested clinicians would use their remaining working clinical time for other patient care-related activities, such as team meetings, documentation, and phone calls.

Table 3 depicts the average number of hours a psychiatrist FTE used to complete encounters with veterans during a week, assuming 31.2 hours per week should be spent in encounters with veterans. We considered missed opportunities, such as patient no-shows, as scheduled time, and counted that time as used even though a veteran did not receive an encounter.² On average, a psychiatrist clinical FTE scheduled only 22.4 out of 31.2 potential hours per week during FY 2014, leaving over 8.8 hours unscheduled.

Table 3. Psychiatrist FTEs’ Use of Patient Care Time per Week

VA Facility	Total Scheduled Hours— Out of 31.2 Potential Hours	Potential Hours Remaining To Schedule Veterans
New York Harbor	29.1	2.1
Miami	27.2	4.0
Temple	24.6	6.6
Chillicothe	24.3	6.9
National Average	22.4	8.8
Dublin	19.6	11.6
San Francisco	19.0	12.2

Source: OIG analysis of outpatient psychiatrists’ patient care time and completed encounters obtained from VHA’s Office of Productivity, Efficiency, and Staffing

² Our analysis reflected missed opportunities in the scheduled, or used, time. We applied the average missed opportunity rate for each facility during FY 2014 for all mental health clinics. Nationwide, VHA data indicated the mental health missed opportunity rate during FY 2014 was 18.5 percent.

VA facilities could have used the remaining clinical time to complete additional outpatient appointments for veterans. In total, we estimated VA facilities did not use about 706,000 hours of patient care time to generate encounters with veterans. VHA facilities could have better used an estimated 25 percent (706,000 hours / 2.88 million potential hours) of psychiatrist FTE clinical time to see veterans during FY 2014, which equated to nearly \$113.5 million in psychiatrists' pay. Over the next 5 years, that clinical time not used for patient care will equate to over \$567 million if clinic management is not strengthened.

Improving the use of patient care hours from 22.4 hours to 31.2 hours would provide more appointments to those veterans seeking mental health care. VHA should develop clinic management business rules to ensure facilities consistently monitor the use of clinical time and number of veterans per psychiatrist, in conjunction with monitoring psychiatrists' productivity. Improved clinic management practices across VHA would assist facilities in efficiently using psychiatrists in their outpatient mental health clinics.

Productivity

VHA should reassess its established productivity measure. During FY 2014, the average outpatient psychiatrist FTE exceeded the target by over 22 percent. VHA Directive 1161, *Productivity and Staffing In Outpatient Clinical Encounters for Mental Health Providers* (June 7, 2013), states psychiatrists should strive for a yearly productivity target above 2,574 Relative Value Units (RVUs), though VHA considers productivity between 2,317 and 2,831 RVUs as meeting the standard.

An RVU is a measure of the complexity and time required to perform a professional service. For purposes of the productivity measurement, only the work component of the RVU value is used. The 2,574 RVU target is adjusted based on the individual's leave during the period and time allotted for direct patient care. Managers can use this to evaluate a psychiatrist's productivity.

Although psychiatrists did not use all of their clinic time to schedule and complete encounters with veterans, VHA's productivity measure indicated generally high psychiatrist productivity. VHA's productivity target for psychiatrists is based on the median RVU rate during FY 2011.

As shown in Table 4, nationwide, the average outpatient psychiatrist FTE exceeded the 2,574 target by over 22 percent.

Table 4. Outpatient Psychiatrist Productivity During FY 2014

VA Facility	Average RVUs per FTE	Difference From VHA Target
Lowest VA Facility	1,017	(60.5%)
Chillicothe	3,112	20.9%
National Average	3,145	22.2%
New York Harbor	3,268	27.0%
Dublin	3,365	30.7%
San Francisco	3,409	32.4%
Temple	4,005	55.6%
Miami	4,268	65.8%
Highest VA Facility	5,417	110.4%

Source: OIG analysis of VHA's Physician Productivity Cube and outpatient psychiatrist data obtained from VHA's Office of Productivity, Efficiency, and Staffing

In total, 106 of 140 facilities (76 percent) exceeded VHA's psychiatrist productivity target in FY 2014. Of those, 90 facilities exceeded the target by more than 10 percent during FY 2014. VHA Directive 1161 states that significantly high productivity numbers might suggest a need to reassign staff. In addition, productivity numbers significantly higher or lower than the target might reflect improper coding, and service chiefs are encouraged to monitor for compliance with national coding guidelines.

Nearly two-thirds of VHA facilities exceeded the VHA psychiatrist productivity target by more than 10 percent during FY 2014. The national average exceeded the target by over 22 percent. VHA attributed some of the increase in RVUs to a 2013 change in current procedure terminology (CPT) code values, which included an increase in the value of some CPT codes that psychiatrists use. However, VHA did not make a corresponding increase to VHA's RVU target. VHA should reassess the appropriateness of its RVU target for psychiatrists.

Procedure Coding

Inconsistent and inappropriate procedure coding by psychiatrists lessened the reliability of their total RVUs. VHA's productivity measure is dependent on psychiatrists to accurately record workload using CPT codes. Psychiatrists record CPT codes for encounters they complete with veterans to record a work value for work performed. Each CPT code has a work value assigned

called an RVU, which makes up the productivity measure. However, we determined that:

- Psychiatrists inconsistently applied procedural coding.
- Psychiatrists inappropriately recorded duplicate procedure codes on single encounters.

Inconsistent Procedure Coding

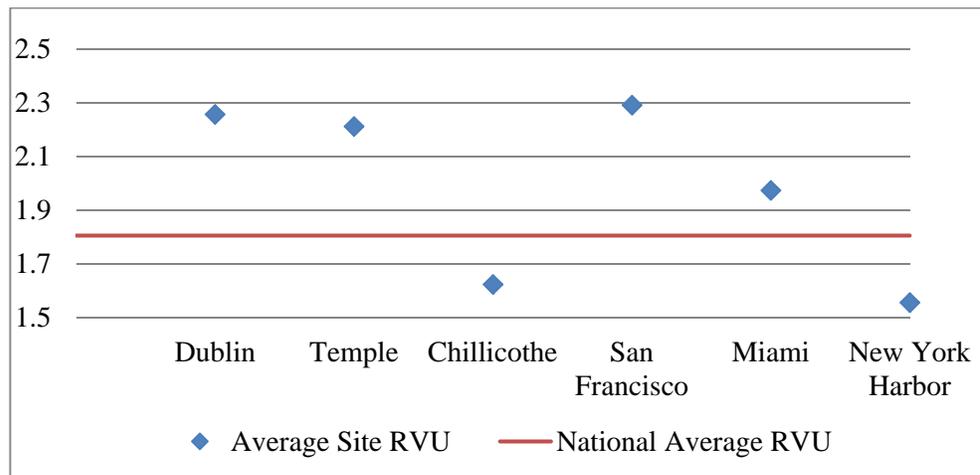
The six sampled facilities used different CPT codes for similar patient encounters. It was reasonable to expect variances based on each facility's veteran demographics and the complexity of care provided. However, the following is an example of psychiatrists of different facilities using different CPT codes for similar types of encounters.

Example 4

VHA psychiatrists used CPT codes 99211 and 99215 to record an outpatient encounter with an established patient. CPT code 99211 represents a less-complex encounter and has a value of 0.18 RVUs. CPT code 99215 represents a more complex encounter and has a value of 2.11 RVUs. Nationally, the more complex CPT code 99215 accounted for less than 2 percent of CPT codes used by outpatient psychiatrists during FY 2014. At the Dublin, GA, VAMC, CPT code 99215 accounted for about 27 percent of all CPT codes recorded by outpatient psychiatrists during FY 2014.

Figure 2 depicts the average RVUs per clinical outpatient psychiatrist FTE for the six sampled facilities, as well as the national average. As shown in the figure, the average RVU value recorded by psychiatrists at New York Harbor Healthcare System (1a complexity facility) was lower per encounter than the national average during FY 2014. In contrast, the Dublin, Temple, and San Francisco VAMCs (3, 1b, and 1a complexity, respectively) recorded higher RVU values than the national average.

Figure 2. Average Psychiatrist RVU per Encounter During FY 2014



Source: *OIG analysis of VHA's Physician Productivity Cube and outpatient psychiatrist data obtained from VHA's Office of Productivity, Efficiency, and Staffing*

OMHO acknowledged that there are inconsistencies in coding in VHA, and psychiatrists received minimal training for coding.

*Duplicate
Procedure
Coding*

Psychiatrists at Dublin VAMC and Chillicothe, OH, VAMC inappropriately recorded duplicate CPT codes on single encounters. Dublin VAMC inappropriately recorded 953 duplicate CPT codes on 941 outpatient encounters by applying the same CPT code multiple times to each encounter during FY 2013. Chillicothe VAMC inappropriately recorded 645 duplicate CPT codes on 215 encounters for psychiatric evaluations during FY 2012. This resulted in overstated RVUs by over 12 percent and nearly 9 percent, respectively, during that time.

According to OMHO and facility staff, psychiatrists did not have routine CPT training. In addition, OMHO officials said they generally only reviewed CPT codes for quality assurance in instances in which third party insurance was used for the encounter. To ensure accurate procedure coding and reliable productivity values, VHA should develop a mechanism to monitor the variance in which psychiatrists code encounters, and determine appropriate coding guidance and training to ensure consistency. This would improve VHA's ability to use RVU data to evaluate productivity and make informed staffing decisions.

Conclusion

VHA needs to take action to establish effective clinic management practices and to identify specific psychiatrist staffing needs at individual facilities. While VHA significantly increased the number of psychiatrists providing outpatient clinical care, veterans' access to those psychiatrists can still improve. VHA identified in December 2014 that 94 facilities needed 335 psychiatrist FTEs to meet known veteran demand. In addition, we determined that facilities nationwide had an estimated 25 percent of psychiatrist FTE clinical time during FY 2014 that they could have used to complete additional outpatient encounters with veterans. By identifying the appropriate number of psychiatrists that facilities need, and implementing effective clinic management business rules, VHA could optimally place and use psychiatrists. This would improve access for veterans currently receiving psychiatrists' care, as well as future, unmet veteran demand.

Recommendations

1. We recommended the Under Secretary for Health ensure Veteran Integrated Service Networks and medical facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed for outpatient care, and work with those facilities to attain appropriate staffing levels or identify alternative options to meet veteran demand for psychiatrists.
2. We recommended the Under Secretary for Health develop clinic management business rules to ensure facilities consistently monitor the

use of clinical time and number of veterans per psychiatrist, in conjunction with monitoring psychiatrists' productivity.

3. We recommended the Under Secretary for Health reassess the appropriateness of the Veterans Health Administration's productivity target for psychiatrists.
4. We recommended the Under Secretary for Health develop a mechanism to monitor the variance in which psychiatrists code encounters and determine appropriate coding guidance and training to ensure consistency.

**Agency
Comments**

The Under Secretary for Health concurred with our findings and recommendations and stated that VHA would implement Recommendations 1–3 by September 2016, and that VHA had already implemented Recommendation 4. The Under Secretary for Health's entire verbatim response is located in Appendix C.

OIG Response

The Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. We consider Recommendation 4 closed based on VHA's actions and planned ongoing guidance, training, and monitoring by VA Central Office and local supervisors.

Appendix A Scope and Methodology

Audit Scope

We conducted our audit work from December 2013 through July 2015. The audit focused on veterans' access to outpatient psychiatrists in mental health care. This audit was delayed for several months as a result of the OIG's efforts to address patient wait time allegations at the Phoenix VA Health Care System and at VA health care facilities nationwide.

VHA defines outpatient care as encounters between veterans and providers within the VA health care system that take place without an inpatient stay. We reviewed physicians that VHA's Office of Productivity, Efficiency, and Staffing (OPES) identified under the specialty care service of psychiatry. We also reviewed the encounters completed by those psychiatrists. An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. We did not include encounter data that OPES identified as duplicates, phantom encounters (appointments that were placeholders but no care was actually provided), or encounters for lab work. We also did not include non-VA paid physicians or their encounters.

We analyzed VHA data of outpatient psychiatrist clinical FTEs, psychiatrists' encounters, CPT codes, veteran demand, psychiatrist pay, and productivity during FYs 2012, 2013, and 2014. We also reviewed VHA's hiring efforts and clinic management practices over psychiatrists at six randomly sampled VA medical facilities.

This audit did not assess the quality of care psychiatrists or mental health clinics provided to veterans. Veterans receive VA mental health care from many different types of mental health clinicians other than psychiatrists, including psychologists, social workers, nurse practitioners, and others. According to VA testimony from November 2011, psychiatrists in VA typically provide medication management, and veterans see a psychologist, social worker, or other licensed mental health provider for psychotherapy. However, psychiatrists can also provide psychotherapy if it is determined that it is clinically indicated. VA further stated that there are no national VA policies in place that restrict psychiatrists from providing any service that they determine is clinically indicated, as long as it is within their scope of practice.

Methodology

The audit focused on VHA's hiring efforts and clinic management practices in regards to access to outpatient psychiatrists.

To address our audit objective, we performed the following actions.

- Conducted site visits to VA facilities in Chillicothe, OH; Dublin, GA; Miami, FL; New York Harbor, NY; San Francisco, CA; and Temple, TX
- Interviewed VHA's OMHO officials, VHA's Workforce Management and Consulting officials, facility chiefs of staff, facility mental health service chiefs, staff psychiatrists, human resources staff, administrative officers, and billing and coding staff
- Analyzed VHA mental health hiring initiative plans and estimated staffing needs
- Obtained and analyzed data from VHA's OPES, and VHA Support Service Center's Physician Productivity Cube and Mental Health Cube

Although VHA collects and reports mental health wait time data, we did not include wait time data in this audit. OIG and VHA have determined over recent years that VHA's wait time data are unreliable. The inaccuracies in the data hinder the usability of information; therefore, we did not rely on such data in this report.

*Psychiatrists'
Pay*

We identified the average annual cost for a psychiatrist FTE using the VHA Support Service Center Mental Health Cube. We determined the average pay and benefits of an outpatient psychiatrist FTE was \$260,752 during FY 2014. We verified the Mental Health Cube pay data with information identified in VA's Personnel and Accounting Integrated Data.

*Psychiatrists'
Time*

We analyzed psychiatrists' clinic time based on encounter data and individual veteran data obtained from OPES, and clinical outpatient psychiatrist FTE from the Physician Productivity Cube.

We compared the potential clinical time with scheduled and completed encounters, per clinical FTE, with the number of actual completed encounters. We determined that established patient encounters are generally 30 minutes, and new patient encounters are generally 1 hour. Based on the number of unique veterans who received care in FY 2014, but did not receive care in FY 2013, we estimated the total number of potential encounters a clinical outpatient psychiatrist FTE could have completed, and then we compared that with the number of actual completed encounters during FY 2014.

We evaluated clinic time by calculating the additional time clinical outpatient psychiatrist FTEs could have used to complete encounters, based on 31.2 potential hours per week. The average weekly rate was based on all outpatient encounters that psychiatrists completed during FY 2014, and reflected the average missed opportunity rate.

**Fraud
Assessment**

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators. We did not identify any instances of fraud during this audit.

Data Reliability

We relied on computer-processed data obtained from OPES, as well as data obtained from the VHA Support Service Center Physician Productivity Cube and Mental Health Cube. We assessed the reliability of the data obtained from OPES and the Physician Productivity Cube by comparing 30 randomly selected encounter records with those veterans' individual medical records. We tested these data to determine reliability of overall encounters, number of individual veterans, and number of outpatient FTEs. We also obtained information from the Physician Productivity Cube system owner, reviewed systems documentation, and reviewed the data to identify obvious errors in accuracy and completeness to ensure that the Physician Productivity Cube had the most complete data available regarding outpatient psychiatrist RVUs. Based on these tests, we concluded the data were sufficiently reliable to meet the objective of the audit.

We assessed the reliability of psychiatrist pay from the VHA Support Service Center Mental Health Cube by comparing it with data collected from VA's Personnel and Accounting Integrated Data. We determined that the average pay for a psychiatrist FTE identified in the two sources were different by just over 1 percent. We then compared the sums of facility specific gross pay for psychiatrists from VA's Personnel and Accounting Integrated Data with the facility-supplied data. We determined the average gross pay identified in the two sources were different by less than 3 percent. Based on these tests, we concluded the average psychiatrist pay identified in the Mental Health Cube was sufficiently reliable for the purposes of this audit.

**Government
Standards**

Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix B Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
2	VA facilities could have better used an estimated 25 percent of psychiatrist FTE clinic time to see veterans during FY 2014. This time equated to nearly \$113.5 million in psychiatrists' pay in FY 2014; it could equal \$567 million over the next 5 years.	\$567,000,000	\$0
Total		\$567,000,000	\$0

Potential Monetary Benefit Calculation

We determined the estimated potential monetary benefits using the following analysis and assumptions.

- According to OMHO, about 78 percent of clinicians' worked clinic hours are "bookable" and should be spent in generating encounters (2,080 total hours x 78 percent = 1,622 patient care hours per clinical FTE per year).
- We identified approximately 2.88 million total hours (1,776 clinical FTEs x 1,622 patient care hours per year = 2.88 million hours).
- We determined that psychiatrists did not use more than 706,000 hours to complete encounters, which equated to about 25 percent of patient care time (706,000 hours / 2.88 million hours = 24.5 percent).
- The clinical time not used for patient care during FY 2014 equated to 435 psychiatrist FTEs (1,776 clinical FTEs x 24.5 percent = 435.18 clinical FTEs not used for patient care).
- We determined the average pay and benefits of a psychiatrist FTE was \$260,752 during FY 2014, which equated to nearly \$113.5 million in clinical time not used for patient care (\$260,752 x 435.18 clinical FTEs = \$113.5 million).

This equates to better use of funds totaling over \$567 million over the next 5 years if clinic management is not strengthened.

Appendix C Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: July 28, 2015
From: Under Secretary for Health (10)
Subj: Office of Inspector General (OIG) Draft Report: Audit of VHA's Efforts to Improve Veterans' Access to Outpatient Psychiatrists (7620108)
To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the OIG draft report of the Audit of VHA's Efforts to Improve Veterans' Access to Outpatient Psychiatrists.
2. I concur with the findings and recommendations in the draft report and provide comments in response to recommendation 1-4.
3. Please direct questions or concerns regarding the content of this memorandum to Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.



David J. Shulkin, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

**Office of Inspector General's (OIG) Draft Report
Audit of VHA's Efforts to Improve Veterans' Access to Outpatient Psychiatrists**

Date of Draft Report: July 2, 2015

Recommendations/ Actions	Status	Target Completion Date Date
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Recommendation 1. We recommended the Under Secretary for Health ensure Veteran Integrated Service Networks and facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed for outpatient care, and work with those facilities to attain appropriate staffing levels or identify alternative options to meet veteran demand for psychiatrists.

Comments: Concur

Importantly, the psychiatry staffing benchmark is not a VHA policy requirement. VHA agrees that each Veterans Integrated Service Network (VISN) and facility should use the current benchmark: 1.22 psychiatrist full-time employee equivalent (FTEE) per 1,000 outpatient mental health (MH) service-using Veterans. Facilities should consider this when developing their staffing plans for MH services.

The Office of Mental Health Operations (OMHO) recently implemented a dashboard that displays the status of the psychiatry staffing benchmark for each facility and is scheduling recurring MH management conversations with VISN clinical leaders to review that information.

OMHO supports the responsibilities of VISNs and facilities for attaining and maintaining sufficient psychiatry staffing, including utilizing "alternative options" such as delivery of care via telemental health from other sites or the community, non-VA mechanisms such as CHOICE, contract, or fee basis, and/or delivery of care as appropriate via advanced practice nurses, physician assistants, and/or clinically-trained pharmacists. Alternative options are useful in sites where the available professional population in the area is very small and recruiting is difficult. Additionally, VISN and facility leaders are encouraged to fully utilize available incentive strategies such as the Education Debt Repayment Program (including the recently authorized education debt repayment provisions of the Clay Hunt Act), geographic pay and scarce specialty pay. Finally, because retention of psychiatrists is generally more effective and less costly than recruitment of new psychiatrists, it is important that VISN and facility leaders ensure that salaries for currently employed VA psychiatrists are commensurate to salaries offered to new recruits.

To complete this action, VHA will:

1. Provide documentation that each VISN has submitted a plan to OMHO for psychiatric staffing by the end of fiscal year (FY) 2016, quarter 1. The plan must include the targeted number of FTEE psychiatrists per 1,000 outpatient MH service-using Veterans; an explanation of negative variance from the benchmark; recruiting and retention approaches; barriers to achieving the target; and alternative approaches to provide the services required to meet Veteran demand.
2. Monitor progress on hiring and vacancies as well as the staffing ratio in conjunction with Workforce Management and review this regularly with VISN MH and clinical leadership.

Status	Target Completion Date
In process	September 30, 2016

Recommendation 2. We recommended the Under Secretary for Health develop clinic management business rules to ensure facilities consistently monitor the use of clinical time and number of veterans per psychiatrist, in conjunction with monitoring psychiatrists' productivity.

Comments: Concur

VHA supports a very critical process of setting individualized productivity targets for psychiatrists. VHA also specifies productivity benchmarks for the discipline as a whole. This process is aimed at optimizing access to and quality of care for Veterans in psychiatric care. However, VHA does not support the use of business rules for defining exact hours of face-to-face clinical care and numbers of patients served for all psychiatrists as this is counterproductive in an environment in which different psychiatrists with different patient populations work in very different, but appropriate, manners.

VHA has implemented a policy regarding productivity of MH providers, including psychiatrists, in VHA Directive 1161, Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers. That directive provides policy on outpatient provider productivity based on outpatient clinical encounters for all psychiatrists and psychologists, as well as for those advanced practice nurses, social workers, and physician assistants who work in mental health settings. OMHO has provided support for implementation of the directive in a variety of ways, including: Mental Health Business Operations monthly national calls, facilitation of productivity management training sessions for individual sites and VISNs, reviews of discipline productivity in quarterly MH management conversations between OMHO and VISN leadership, OMHO site visits, and through individual reviews with facility and VISN leaders.

Recently, each facility leadership team received a memo from VA Central Office (VACO) asking for verification that each MH provider (as required by the productivity directive) has an established individualized productivity target. While OMHO does not require a

fixed percentage of hours spent in direct patient contact (of hours mapped to clinical care), teaching on how to use the productivity tools suggests that 70-80 percent of that time be in direct contact with Veterans for those assigned to general mental health clinical settings full-time.

The benchmark of 1.22 FTEE psychiatrists per 1,000 outpatient MH service-using Veterans suggests that a site would have roughly 820 Veterans per psychiatrist FTEE. However, some of these Veterans engaged in MH care would not require care from a psychiatrist so the number of patients treated on a single psychiatrist's panel would almost always be less than 820. The number of Veterans a single psychiatrist can safely and effectively manage varies widely based on type of mental disorder. For example, Veterans with schizophrenia or dementia often require more time than those with depression. Veterans with more severe mental disorders, new diagnoses and those with chronic conditions may require more time than those with unstable, severe conditions. Similarly, the structure of the clinical team may affect psychiatrist work-load as some work alone and others work with additional therapists, case managers and nurses. Thus, the number of Veterans per psychiatrist is a local decision made by taking into account many variables. OMHO agrees that psychiatrist panel size should be monitored during the regular local review of productivity with each provider.

To complete this action plan, VHA will:

1. Verify that all facilities have implemented individual productivity targets for psychiatrists.
2. Monitor VISNs' and facilities' psychiatric productivity measures as well as work Relative Value Units (wRVU)/encounter metric through the OMHO dashboard.
3. Address outliers on these measures with VISN leadership regularly in the MH management conversations.
4. Issue guidance regarding appropriate percentages of time mapped for psychiatric clinical activity to be spent in face-to-face care of Veterans. This guidance will require a discussion of wRVUs, encounters, labor mapping of clinical hours, and unique Veterans served as well as the overall productivity measure during each productivity review with a psychiatrist.
5. Offer continued education, support and training provided to VISN and facility leadership as needed.

Status
In process

Target Completion Date
September 30, 2016

Recommendation 3. We recommended the Under Secretary for Health reassess the appropriateness of the Veterans Health Administration's productivity target for psychiatrists.

Comments: Concur

As noted in the productivity directive, VHA will review and readjust targets for productivity for each type of provider covered by the directive. Due to the large-scale change in current procedural codes (CPT) for psychiatrists that occurred during 2013, VHA deferred readjusting psychiatrists' productivity targets until there was a stable year of activity. OMHO analysts and leadership will examine the distribution of wRVUs by psychiatrist FTEE and the relationship of this metric to Veteran satisfaction with access to providers to determine an appropriate target that best serves cost-efficiency and access.

To complete this action, VHA will provide documentation of OMHO findings and/or decisions regarding changes to psychiatric productivity targets.

Status	Target Completion Date
In process	September 30, 2016

Recommendation 4. We recommended the Under Secretary for Health develop a mechanism to monitor the variance in which psychiatrists code encounters, and determine appropriate coding guidance and training to ensure consistency.

Comments: Concur

VHA agrees that a mechanism for coding psychiatric services that is reliable across psychiatrists and sites is important. To that end, on July 10, 2015, OMHO hosted a National business operations call devoted to this training on this task. OMHO and Mental Health Services staff from the Office of Patient Care Services combined to provide guidance on workload capture for mental health providers through its mental health coding guides.

This information is readily available to all VA psychiatrists and their leadership on National Sharepoints and has been presented on national training calls previously. OMHO will have ongoing calls regarding coding and workload capture throughout the year. OMHO analysts will shortly be able to identify differences in patterns of CPT code use across facilities and will be able to generate reports regarding outliers. Through use of the Office of Productivity, Efficiency, and Staffing physician productivity tool for psychiatrists, each facility MH chief or Associate Chief of Staff can review the array of CPT codes used by psychiatrists they supervise. This review may be used to intervene with psychiatrists to decrease variability and increase reliability of coding. Some variance is appropriate and expected as some psychiatrists have quite different practice patterns than others. For example, a psychiatrist involved in opiate agonist treatment might have large numbers of brief appointments whereas a psychiatrist providing geropsychiatric services might have longer appointments. Thus, guidance, training, and monitoring from VACO combined with investigations by local supervisors should improve consistency as recommended.

Status	Target Completion Date
Completed	July 2015

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Larry Reinkemeyer, Director Josh Belew Robin Frazier Brad Lewis Daniel Morris Carla Reid Erin Routh Nelvy Viguera Butler
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Appendix E Report Distribution

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