

**STATEMENT OF  
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BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
FIELD HEARING ON  
VA HOME TELEHEALTH: LOOKING BEHIND THE NUMBERS  
TRAVERSE CITY, MICHIGAN  
AUGUST 30, 2017**

Mr. Chairman and Ranking Member Kuster, thank you for the opportunity to discuss the Office of Inspector General's (OIG) work regarding VA's Home Telehealth (HT) program. My statement today focuses on the results of our healthcare inspection reviewing allegations related to the documentation of patient enrollment in HT at the John D. Dingell VA Medical Center, Detroit, Michigan.

**VA HOME TELEHEALTH**

In July 2003, the Veterans Health Administration (VHA) established Telehealth Services within the Office of Patient Care Services to support the development of new models of care in VA using health information technologies to address patient needs. The goal was to improve quality, convenience, and access to care for patients via health informatics, telehealth, and disease management technologies that enhance and extend care and case management while reducing treatment costs, complications, hospitalizations, and clinic or emergency room visits, for veterans in post-acute care settings and patients with chronic diseases.<sup>1</sup> The Office of Connected Care is responsible for implementing telehealth throughout VA.<sup>2</sup>

According to the Office of Connected Care's Home Telehealth Operations Manual (HT Operations Manual), the term *Home Telehealth* "applies to the use of telecommunication technologies to provide clinical care and promote patient self-management as an adjunct to traditional face-to-face health care."<sup>3</sup> The exchange of health information between the veteran's home or other location to the VA care setting alleviates the constraints of time and distance.<sup>4</sup>

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<sup>1</sup> VHA Office of Connected Care Home Telehealth Operations Manual, April 2017.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

Since its inception, use of HT services has grown exponentially from approximately 2,000 to more than 96,000 enrolled patients at the conclusion of fiscal year (FY) 2015.<sup>5</sup> On August 3, 2017, the President and the VA Secretary announced three new initiatives—one regulatory and two technological—designed to expand the use of telehealth nationwide.<sup>6</sup> As the use of telehealth services expand, the need to provide proper surveillance and oversight is required so that telehealth can be delivered effectively to those patients who are enrolled in this program.

### **HEALTHCARE INSPECTION—DOCUMENTATION OF PATIENT ENROLLMENT CONCERNS IN HOME TELEHEALTH, JOHN D. DINGELL VA MEDICAL CENTER, DETROIT, MICHIGAN<sup>7</sup>**

#### **Allegations**

In October 2013, the OIG received allegations regarding inappropriate documentation of patient enrollment in the HT program at the facility. Specifically, the concerns were:

- Documentation of enrollment in HT monitoring services was entered in the electronic health records (EHRs) of over 900 patients without their knowledge or consent from September 14, 2013 until October 1, 2013. Specifically, notes were written in patients' EHRs stating they were enrolled in and monitored by HT when they were not.
- "In order to make her numbers for the end of the FY," the Associate Chief of Nursing Service (ACNS) required staff to work overtime (OT) for several weeks to produce documentation on the enrollment of patients in HT, regardless of whether these patients wanted to be enrolled or even contacted.

We conducted our review from January 2014 through March 2016. We made an initial site visit June 25–26, 2014 and conducted a follow-up visit with facility leadership and HT coordinators on March 23, 2016. We conducted more than 20 interviews with the complainant, facility leadership, and others with knowledge of the allegations. We reviewed numerous VA records, policies, and procedures relevant to the allegations.

#### **HT Enrollment Process**

HT enrollment involves a six-step sequential process delineated by the HT Operations Manual involving: 1) a referral or consult to the HT program; 2) screening for eligibility and suitability; 3) an initial assessment and treatment plan; 4) patient or caregiver education; 5) activation in VA and vendor computer systems; and 6) the initial monthly

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<sup>5</sup> VHA Office of Connected Care Home Telehealth Operations Manual (April 2017).

<sup>6</sup> The Anywhere to Anywhere VA Health Care initiative will create a regulation allowing VA providers to administer telehealth care to veterans anywhere in the Nation using VA Video Connect, a video conferencing service to connect patients and providers virtually, and the Veteran Appointment Request application, which will allow veterans to schedule or modify appointments using their mobile devices. See: *President Trump and Secretary Shulkin Announce Veteran Telehealth Initiatives*. The White House. <https://www.whitehouse.gov/blog/2017/08/03/president-trump-and-secretary-shulkin-announce-veteran-telehealth-initiatives>. Published August 3, 2017. Accessed August 21, 2017.

<sup>7</sup> Our report is available online at: <https://www.va.gov/oig/pubs/VAOIG-14-00750-143.pdf>.

monitor note (MMN). An MMN is a progress note written by HT program staff to document a patient's progress in the HT program that occurred in the 30 days prior to the entering of the note. An initial MMN should be the last note written in the HT steps of enrollment. It is not intended to function as a clinical note, but rather is a workload capture of the activity of daily monitoring by the HT Care Coordinator. We understood the HT Operations Manual to indicate, and VHA officials agreed, that enrollment of a patient into the HT program does not occur until after completion of all steps outlined in the Operations Manual.

### **Performance Goals**

Each FY, VHA establishes performance goals and measures and tracks achievement of each performance goal by facility. For FY 2013, one of the performance goals for the facility was to enroll a total of 6,778 or more unique patients into telehealth-based services. Another performance goal for this facility was to increase the total number of telehealth encounters to 11,724 or more. These HT performance goals were also part of the ACNS' individual performance goals.

The facility's telehealth programs provided telehealth services to 3,317 unique patients during FY 2013 and therefore did not meet the performance goal for enrollment of unique patients. However, the facility managers documented 12,295 telehealth encounters during FY 2013, exceeding the performance goal for encounters by 571. For FY 2013, the ACNS received an award of \$5,000 for her performance rating. The rating was based, in part, on achieving the number of HT patient care encounters, in addition to over 30 other objectives.

### **Findings**

We substantiated that from September 14, 2013 until October 1, 2013, HT program staff entered MMN documentation for the purpose of initiating the enrollment process for 836 new HT patients and worked OT in order to do so. We found that 828 of the 836 new patients were not properly enrolled in HT according to the sequence outlined in the HT Operations Manual. An initial MMN should be the *last* step of HT enrollment; however, the data showed that initial MMNs were entered in patients' EHRs regardless of proper enrollment sequence, missing consults, screening notes, and assessment notes. The 828 patients had not been issued HT monitoring equipment and had not received HT monitoring in the 30 days prior to the entering of the MMN.<sup>8</sup>

Further, we substantiated that the entry of the MMNs in the new patients' EHRs by HT staff during OT met the criteria for patient care encounters that contributed to the facility's and ACNS' ability to meet one of two FY 2013 performance measures for telehealth services. Without the use of OT during the last 2 days of FY 2013, which allowed the entry and completion of 634 MMNs, the facility and ACNS would not have reached or surpassed the performance goal of 11,724 HT encounters. However, we did

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<sup>8</sup> We did not specifically address whether patients' consents were obtained. We noted that since the MMNs were entered as the initial documentation, any consent post MMN would not be relevant to the inspection as the procedures delineated in the HT Operations Manual require that consent be obtained prior to HT services.

not find that HT staff were *required* to work OT as alleged. Rather, HT staff informed us that they voluntarily worked OT to complete patient enrollment and clean up missing notes during this timeframe.

The ACNS denied that staff worked OT in order to meet the HT performance goal. She stated she approved OT for HT staff near the end of FY 2013 to start HT patients' enrollment process. HT staff informed us that their practice was to enter the MMN first to capture workload and that Veterans Integrated Service Network (VISN) managers had directed them to use the MMN as the first note. However, the ACNS and HT staff were unable to provide written documentation from the VISN with instructions to enter the MMN first. VISN managers we interviewed did not indicate that a MMN could be used as the first note for HT enrollment. The VISN managers stated that they did not direct facility HT staff to use the MMN as the first note in order to capture workload.

The ACNS also described a documentation "clean-up" process during which staff would enter missing MMNs prior to the end of the FY 2013. We requested that the ACNS clarify this clean-up process in the context of entering 828 new MMNs for patients who had no previous HT care during the year. The ACNS reported that the entry of missing MMNs at the end of the FY was for enrolled patients; however, the data showed that the majority of notes written from September 14, 2013 until October 1, 2013 were MMNs for new HT patients.

### **Recommendations**

Based on our findings, we recommended that the Facility Director:

- Ensure that HT staff be retrained and follow the Veterans Health Administration HT process of care and documentation requirements.
- Ensure that documentation accurately reflects patients' HT enrollment status as described in this report.
- Review the circumstances surrounding the entry of HT Program monthly monitor notes in electronic health records of patients as discussed in this report with the Office of Human Resources and the Office of General Counsel and take appropriate action as necessary.

The VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. We consider Recommendation 1 closed based on information we received from the facility prior to the publication of our report. However, we consider Recommendations 2 and 3 open pending receipt of evidence from the facility that they have completed all activities outlined in their corrective action plan, which is detailed in Appendix B of our report. We will continue to follow up with the facility until all actions are complete.

## **OPPORTUNITIES TO EXPAND THE APPLICATION OF TELEHEALTH**

In addition to HT, there are many other opportunities to exploit the benefits of telehealth. One use of telehealth that has not been vigorously applied by VA is the use of telehealth to inform providers, often in emergency room (ER) settings, who diagnose a patient with a very recent cerebral stroke. Veterans who present to a VA or non-VA ER with this condition may not have the good fortune to be evaluated immediately by a stroke neurologist. In this scenario, telehealth is a modality that can be used by the ER provider to convey imaging of the brain, lab data, and physical exam results to the stroke neurologist and, if appropriate, receive expertise in the use of time sensitive “clot busting” agents. If time sensitive therapy is appropriate, then it can be administered in the ER and the patient may then be stabilized at the facility or transported to a hospital with more capability to treat a cerebral intravascular event.

In a recent report, the OIG recommended and the Under Secretary for Health agreed, that VHA would review current acute stroke treatment policies and assess the use of telehealth evaluation and more aggressive local treatment in patients presenting to rural and/or low complexity VHA facilities with signs and symptoms of acute stroke.<sup>9</sup> VA completed the assessment and provided evidence of a plan to establish a variety of stroke-related support services including a network linking expertise in acute stroke management at high complexity medical centers to rural and/or low complexity medical centers. We consider this recommendation closed.

This technology can be used not only to advise VA providers in VA facilities on the use of time sensitive stroke treatments but could also be made available to non-VA providers presented with a veteran with a presumed very recent cerebral stroke.

## **CONCLUSION**

HT is an innovative care model that leverages advancements in modern technology to improve the quality, access, and convenience of health care delivery to veterans across the nation, particularly those located in geographically remote areas. We anticipate that the need for and use of HT will continue to grow in parallel to both the demand for VA health care and the incorporation of digital technologies in our daily lives. In addition to the application of telehealth to the home environment, there are numerous opportunities to exploit this technology to improve the delivery of health care, as with the example of acute stroke, to veterans who live a great distance from tertiary medical centers.

As with any information system, poor data integrity can generate significant consequences and poor decision making. VA relies upon workload capture to evaluate programs for clinical outcomes, achievement of performance targets, and funding decisions.<sup>10</sup> For example, resource allocations for two of the four categories of care within the HT program are tied directly to the workload capture generated by the MMNs.<sup>11</sup> As the HT Operating Manual points out, “This can provide a significant source

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<sup>9</sup> [Healthcare Inspection, Care of an Urgent Care Clinic Patient, Tomah VA Medical Center, Tomah, Wisconsin](#) (June 18, 2015).

<sup>10</sup> VHA Office of Connected Care Home Telehealth Operations Manual (April 2017).

<sup>11</sup> Ibid.

of revenue for VISNs enabling them not only to sustain [HT] programs but to expand and grow these with additional staffing resources.”<sup>12</sup> Without data integrity, there is limited assurance that the resultant decisions represent the best interests of our Nation’s veterans.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Ranking Member Kuster may have.

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<sup>12</sup> VHA Office of Connected Care Home Telehealth Operations Manual (April 2017).

**OIG OVERSIGHT REPORTS REGARDING HOME TELEHEALTH*****Review of Alleged Wasted Funds at Consolidated Patient Account Centers  
for Windows Enterprise Licenses*****Report Number 16-00790-417, Issued December 16, 2016**Summary:

In November 2015, the OIG received an allegation that employees at Consolidated Patient Account Centers (CPACs) were required to use two Windows enterprise licenses when thin clients<sup>13</sup> were converted to computers. We conducted our review of CPACs' utilization of Windows enterprise licenses from December 2015 through March 2016.

According to the complaint, CPACs operated within a virtual desktop infrastructure (VDI) environment that required CPAC employees to log onto a virtual machine that had its own Windows enterprise license to perform their work-related functions. Allegedly, employees were using computers that required Windows enterprise licenses only as a gateway to access a virtual machine that also required a license. The complaint further alleged that the Windows enterprise licenses on the computers were not necessary because the computers were being underutilized.

We substantiated the allegation that VA's Office of Information and Technology (OI&T) wasted VA funds at CPACs to purchase underutilized computers that also required Windows enterprise licenses to operate. Specifically, CPAC employees used these computers only as gateways to access virtual machines on the network server that had individual Windows enterprise licenses. This occurred because OI&T mandated that CPACs replace thin clients which depend on networked resources to operate with computers.

However, OI&T did not consider the CPACs' operating framework before purchasing the computers or mandating the replacement. Because CPACs did not change their operating framework when they converted from thin clients and only used computers as gateways, OI&T paid for underutilized computers and avoidable licenses. As a result, OI&T wasted about \$7.2 million in VA funds converting CPACs from thin clients to computers.

Recommendation:

We recommended the Assistant Secretary for Information and Technology implement a policy to ensure cost-effective utilization of information technology equipment, installed software, and services and ensure coordination of acquisitions with affected VA

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<sup>13</sup> A device with only a few locally stored programs that depends on networked resources and typically does not have auxiliary drives or most software applications. Thin clients discussed in this report did not require local Windows enterprise licenses.

organizations. This will help ensure VA's operating framework and organizational needs are considered prior to acquisitions.

Status: Open. We anticipate receiving VA's next status update on/about October 1, 2017.

***Audit of the Home Telehealth Program***  
**Report Number 13-00716-101, Issued March 9, 2015**

Summary:

We conducted this audit to determine whether VHA managed effectively its HT Program. Specifically, the audit focused on VHA's effective management of the Home Telehealth Program and its mission to improve access to care and to reduce patient treatment costs. We conducted our audit work from February 2013 through December 2014. The audit included a review of home telehealth funds and management controls over the program during FY 2012 at six randomly sampled VISNs. We used FY 2012 data because it was the most current data available at the time.

We found that VHA can expand HT Program enrollment opportunities for Non-Institutional Care (NIC) patients. NIC telehealth patients showed the best outcomes, in terms of reduced inpatient admissions and bed days of care (BDOC). However, in FY 2012, the number of NIC patients-served grew by only about 13 percent. In FY 2013, the number of NIC patients-served declined by 4 percent, while the number of Chronic Care Management (CCM) and Health Promotion/Disease Prevention (HPDP) patients-served grew 51 and 37 percent, respectively.

The significant change in the mix of patients receiving care in this program occurred due to a change in the performance methodology. VHA began to measure program performance by the total number of patients-enrolled, rather than focusing on the increase in enrollment for NIC patients. This change in performance metrics encouraged VHA to enroll more HPDP participants. These participants would likely need less intervention from Primary Care physicians, because their health care needs would be less complex. VHA was successful in reaching its new performance metric. However, obtaining this goal did not result in more patients with the greatest medical needs receiving care under the program.

As a result, VA missed opportunities to serve additional NIC patients that could have benefited from the Home Telehealth Program. VA could have potentially delayed the need for long-term institutional care for approximately 59,000 additional veterans in FY 2013.

VHA needs to expand the Home Telehealth Program to better meet the projected health care needs for an aging veteran population and reduce the need to place veterans in more costly, long-term institutional care.

Recommendations:

1. We recommended that the Interim Under Secretary for Health implement mechanisms that effectively identify demand for Non-Institutional Care services to ensure that veterans who need these services are provided the opportunity to participate in the Home Telehealth Program.

Status: Closed effective November 18, 2016

2. We recommended that the Interim Under Secretary for Health develop specific performance measures to promote enrollment of Non-Institutional Care patients into the Home Telehealth Program.

Status: Closed effective November 18, 2016

***Audit of Mobile Medical Units***  
**Report Number 13-03213-152, Issued May 14, 2014**

Summary:

The House Committee on Appropriations requested the Office of Inspector General to conduct a review of VA's use of Mobile Medical Units (MMUs) to assess whether the Veterans Health Administration (VHA) is fully utilizing MMUs to provide health care access to veterans in rural areas. We conducted our audit from July 2013 through March 2014. The scope of our audit included the estimated 47 MMUs that operated in FY 2013.

We found that VHA lacks information about the operations of its MMUs and has not collected sufficient data to determine whether MMUs improved rural veterans' health care access. VHA lacks information on the number, locations, purpose, patient workloads, and MMU operating costs.

We determined VHA operated at least 47 MMUs in fiscal year 2013. Of these, 19 were funded by the Office of Rural Health (ORH) and the remaining 28 were funded by either a Veterans Integrated Service Network or medical facility. Medical facilities captured utilization and cost data in VHA's Decision Support System (DSS) for only 6 of the estimated 47 MMUs. If VHA consistently captured these data, it could compare MMU utilization and costs with other health care delivery approaches to ensure MMUs are providing efficient health care access to veterans in rural areas.

These weaknesses occurred because VHA did not designate specific program responsibility for MMU management, define a clear purpose for its MMUs, or establish policies and guidance for effective and efficient MMU operations.

As a result of limited MMU data, we were unable to fully address the Committee's concerns. However, it is apparent that VHA cannot demonstrate whether the almost

\$29 million ORH spent, as well as unknown medical facility funding for MMUs, increased rural veterans' health care access and the extent to which MMUs can be mobilized to support its emergency preparedness mission.

Recommendations:

1. We recommended the Under Secretary for Health withhold funding for new mobile medical units until a comprehensive assessment is conducted to assess factors, such as the current composition of the mobile medical unit fleet, services provided, operational days and costs, and the effect on rural veterans' access to health care.

Status: Closed effective July 13, 2015

2. We recommended the Under Secretary for Health assign responsibility for developing mobile medical unit policies, objectives, and strategy, and for providing program oversight.

Status: Closed effective July 13, 2015

3. We recommended the Under Secretary for Health assign responsibility for maintaining operational data on mobile medical units to ensure mobile medical unit resources can be used as part of VHA's emergency preparedness plan.

Status: Closed effective July 13, 2015

4. We recommended the Under Secretary for Health publish necessary policy and guidance to provide for effective and efficient mobile medical unit operations.

Status: Closed effective December 22, 2015

5. We recommended the Under Secretary for Health implement a mechanism to ensure that mobile medical unit-specific operations and financial data, such as patient workload, services provided, and costs, are collected in the Veterans Health Administration's Decision Support System.

Status: Closed effective July 13, 2015