

# VA HOME TELEHEALTH: LOOKING BEHIND THE NUMBERS

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## FIELD HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, AUGUST 30, 2017

TRAVERSE CITY, MICHIGAN

**Serial No. 115-27**

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.fdsys.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

WASHINGTON : 2018

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## **VA HOME TELEHEALTH: LOOKING BEHIND THE NUMBERS**

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**Wednesday, August 30, 2017**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON DISABILITY ASSISTANCE  
AND MEMORIAL AFFAIRS,  
*Washington, D.C.*

The Subcommittee met, pursuant to notice, at 9:02 a.m., in the Garfield Charter Township Board Room, 3848 Veterans Drive, Traverse City, MI, Hon. Jack Bergman [Chairman of the Subcommittee] presiding.

Present: Representatives Bergman and Kuster.

### **OPENING STATEMENT OF JACK BERGMAN, CHAIRMAN**

Mr. BERGMAN. Good morning, everyone. This hearing will come to order.

I really want to thank everybody and welcome you to today's field hearing on VA telehealth. I especially want to thank Ranking Member Kuster for joining us here in this beautiful part of the world that we call home here in northern Lower Michigan. Again, I am so glad you are with us.

Prior to getting started, I would like to ask unanimous consent that a statement to be provided by the Manistee County Veterans Council be entered into the hearing record.

Hearing no objection, so ordered.

Mr. BERGMAN. The VA has been using telemedicine for decades, and it is an increasingly important part of VA health care. I am proud that here in Michigan we have a concentration on some of the most tech savvy VA hospitals in the country. Hospitals and Health Networks Magazine recently released its annual "Most Wired" list. That used to mean different things at different times.

[Laughter.]

Mr. BERGMAN. This is a good thing.

Five VA medical centers around the country made the cut, and three of them are in the State of Michigan—Saginaw, Battle Creek, and Detroit.

Now, as the President and Secretary Shulkin announced at the White House earlier this month, VA telehealth is poised for another expansion. There are actually several distinct telehealth programs, each with its own purpose and needs. Today we will examine home telehealth, which is when VA puts technology into a veteran's home to help him or her manage a chronic health condition and remotely consult with a physician. The Anywhere-to-Anywhere

initiative, which will increase VA doctors' abilities to practice beyond state licensing boundaries, and a VA Connect app, which enables video conferencing with doctors on a smart phone, should boost home telehealth.

Of all the telehealth programs, home telehealth perhaps has the most impact on improving health outcomes, generating savings, and keeping thousands of elderly veterans out of nursing homes. Home telehealth is especially helpful in highly rural areas such as we have here in the 1st District, especially as you get into the Upper Peninsula.

VA's clinic network is impressive, but they cannot be everywhere. In many cases, like the UP, it is just not practical to drive an hour each way for a routine consultation.

Home telehealth also seems to be the most challenging for the VA. The complexity of care can be high, and managing IT equipment and medical devices in a veteran's home is necessarily more difficult than doing so in clinics. There is also an elaborate supply chain to distribute the equipment and extensive IT infrastructure in which any glitch may cause cascading disruptions.

VA also has a rocky history, which we all hope is behind us now and going forward, with home telehealth enrollment. The Office of Inspector General audited enrollment nationally and found a pattern of less vulnerable, less challenging patients being targeted for enrollment, to the detriment of more vulnerable, more challenged patients.

OIG also examined complaints about the Detroit Medical Center and substantiated that employees recorded hundreds of veterans as enrolled in home telehealth when they had, in fact, received no equipment for telehealth services. The employees even entered telehealth monitoring notes in these people's health records when no monitoring had happened. In both instances, the employees were attempting to hit targets in their performance evaluations in the easiest possible way. That is wrong.

While other telehealth programs are growing, home telehealth enrollment has declined over the last few years. There is no indication that wrongdoing is to blame, but I am concerned about this trend. I hope our witnesses today can explain that.

Another important service for rural veterans is VA's mobile medical units. They are trucks, tractor trailers, RVs and other vehicles outfitted as traveling clinics. In 2014, OIG found pervasive problems with their management. VA did not know how many mobile units it had, where they were located, what they were used for, and how many patients they served. Some were permanently parked, meaning in reality they were not mobile at all.

In the Choice Act, Congress mandated reforms and better reporting, and today there are nearly twice as many mobile medical units, but too many of them are inactive. They are not providing services often enough to meet the Congress' goal, and only a few provide telehealth. There is still quite a long way to go until the mobile medical units are being utilized to their full potential.

There are over 700,000 unique veterans served by VA telehealth every year, and that is impressive, and it is growing fast. Most of them are in clinics using video conferencing and imaging to communicate with specialists at other locations. VA seems well

equipped to handle these telehealth programs, and the track record is good. I want to make sure that home telehealth is working properly for the roughly 150,000 veterans now enrolled.

I also want to be confident that the program will grow to serve more people, and the supply chain and IT can keep up with that growth.

Mr. BERGMAN. I now yield to Ranking Member Kuster for her opening statement.

#### **OPENING STATEMENT OF ANN KUSTER, RANKING MEMBER**

Ms. KUSTER. Thank you, Chairman Bergman, and thank you for hosting here in Michigan. My husband and I have had a wonderful time in your beautiful district, and we are delighted to be here.

I really do enjoy working so closely with General Bergman to address many of the issues that our veterans face, and I hope your constituents understand your leadership role and the fact that our Subcommittee and our Full Committee are among the most bipartisan and productive in the whole Congress.

So, like Chairman Bergman, I represent a mostly rural district in New Hampshire, the western side of New Hampshire, from the Massachusetts border up to Canada, and by holding this field hearing here in Traverse City we have the unique opportunity to learn about the concerns of veterans in rural Michigan and how we share their concerns with rural veterans in New Hampshire.

When Chairman Bergman and I learned about common issues that our veterans faced, we worked together, and our goal is to solve these issues. So that is why we are so thankful to have the VSO's with us, as well as advocates, families, and caregivers to spend their morning with us and learn about how we can do an even better job with telehealth.

In New Hampshire and Michigan our veterans face significant geographical barriers to VA health care, sometimes traveling long distances, and I can say sometimes not in the best weather, and waiting too long to receive care due to a shortage of doctors or lack of hospitals or clinics in some communities. Treating veterans via telehealth has the potential to help veterans get the care they need in rural areas by saving veterans the time and often the expense of traveling to a VA facility, and we support the VA's decision and the current administration and Secretary Shulkin in their decision to expand telehealth.

However, infrastructure is a very real barrier for expansion of telehealth initiatives in rural areas. In both rural New Hampshire and rural Michigan, the IT infrastructure, the high-speed broadband and cellular service that is necessary, just simply might not exist or may be inadequate. Without this basic infrastructure to support the use of telehealth, rural veterans are still going to face barriers to accessing care.

That is why I am eager to learn more about the plan to expand home telehealth programming and whether the VA has plans to address the rural infrastructure barriers or is aware of other challenges that could slow or stop expansion of the program.

I want to know if other successful programs designed to provide care to rural veterans face barriers that could prevent their expansion in rural communities all across the country, and I want to un-

derstand what the VHA is doing on the local and national level to overcome these barriers.

We also want to ensure that the proper processes are followed so that veterans receive quality care. Telehealth is not appropriate in many care settings, and some veterans do not want to receive telehealth treatment. Veterans should always have the ability to say yes or no to treatment via telehealth.

That is why I was alarmed to learn of the actions taken by the Associate Chief of Nursing Services at the John Dingell Medical Center in Detroit. It is a violation of VA policy and unacceptable to add patients to the home telehealth program without their consent.

I am very concerned about performance goals being tied to home telehealth enrollment and worried that this created a perverse incentive for employees to care only about enrollment numbers so that they could receive a bonus and not about what was best for our veterans. We want to know what VA has done to ensure that employees are not incentivized to repeat this behavior under the new telehealth expansion initiative.

The veterans in Michigan, New Hampshire, and all across our country deserve high-quality, accessible care, and I believe that the VA should be using technology to achieve these goals. However, the VA must ensure it is using telehealth and technology to best serve our veterans, which is why it is important for the VA to follow policies and why we must continue to hold oversight hearings on these issues.

I thank you, Chairman Bergman, and I yield back the balance of my time.

Mr. BERGMAN. You know, you can tell I have been back in the district for about a month. I just realized there was a microphone in front of me, because up here we don't have a whole lot of electronics. The point is when we get out to talk, I have gotten in the habit of using my Marine command voice. So if I cause anybody to put earplugs in, I apologize for that.

[Laughter.]

Mr. BERGMAN. By the way, Representative Kuster and I have been talking about this trip for a long time.

Ms. KUSTER. I have been bugging him.

[Laughter.]

Mr. BERGMAN. It is great that we have been able to finally make this happen, and just know that we are headed to New Hampshire in about three weeks.

Ms. KUSTER. Thank you very much.

Mr. BERGMAN. To go up there to do it, because the more you know about what is going on outside of your own backyard and how it compared, the better we become in actually delivering the services that our veterans so—I mean, they earned them, they deserve them, and, by golly, we need to get them to them.

Now I would like to welcome our panel seated here in front of us at the—I hate to say the witness table. The bottom line is we are going to call it the presentation table today.

On the panel we have Dr. Kevin Galpin, who is the Executive Director of VHA Telehealth. Welcome.



He is accompanied by Dr. Pamela Reeves, Director of the Detroit VA Medical Center; Dr. Alan Constantian, Deputy Chief Information Officer and VHA Account Manager for Clinical Functions of VA's Office of Information and Technology; and we also have Dr. Thomas Wong, who is the Senior Physician with the VA Office of the Inspector General.

Dr. Galpin, you are now recognized for 5 minutes.

**STATEMENT OF KEVIN GALPIN, M.D.**

Dr. GALPIN. Good morning, Chairman Bergman, Ranking Member Kuster. Thank you for the opportunity to discuss VA telehealth, telehealth information technology, and our home telehealth program. I am accompanied today by Dr. Pam Reeves, Medical Center Director of the John D. Dingell VA Medical Center in Detroit, Michigan; and Dr. Alan Constantian, Deputy Chief Information Officer for the Office of Information and Technology.

VA Telehealth is a modern veteran- and family-centered health care delivery model. It leverages information and telecommunication technologies to connect veterans with their clinicians and allied or ancillary health care professionals, irrespective of the location of the provider or the veteran. It bridges enhanced access and expertise across the geographic distance that would otherwise separate some veterans, including those in rural areas, from the providers best able to serve them.

VA is recognized as a world leader in the development and use of advanced telehealth technology. In Fiscal Year 2016, of the more than 5.8 million veterans that used VA care, approximately 12 percent received an element of their care through telehealth. This represented more than 702,000 veterans and over 2.17 million telehealth episodes of care.

VA's telehealth portfolio allows for advanced clinical care delivery in over 50 clinical specialties. Services are delivered primarily through one of VA's three broad categories of telehealth.

The first, clinical video telehealth, is the use of real-time interactive video conferencing to assess, treat, and provide care to veterans remotely. As an example, this can be used to provide mental health counseling to veterans closer to their home, or even in their home.

The second category of telehealth is store-and-forward. This is the use of technology to asynchronously acquire and store clinical information such as a picture, a sound, or a video, which is then sent and assessed by a provider at another location for clinical evaluation. This can deliver services such as dermatology and retinal screening.

The third broad category is home telehealth. This is a technology-enabled remote monitoring program where clinical data and information is collected through a VA-provided home-based device or through the patient's own mobile device or home computer. This allows a VA provider to monitor the veteran's health status, provide clinical advice, and facilitate patient self-management as an adjunct to the veteran's traditional in-person health care. This service can help veterans continue to live independently, reduce hospitalization, and spend less time and money for medical visits.

Between 2013 and 2014, the VA Office of the Inspector General audited VA's home telehealth program, providing their final report to us in 2015. The OIG analyzed outcomes for over 15,000 veterans in the home telehealth program and concluded that the program was successful in reducing in-patient admissions for all three main patient categories of care, inclusive of the non-institutional category of care, what we call the NIC category, chronic care management category, and health promotion and disease prevention category.

The OIG described the program as a transformational modality for delivering quality health care that is convenient and accessible to veterans who cannot travel or live hours away from the medical facility.

While the OIG found the overall program to be successful, they also concluded that the VA missed opportunities to expand enrollment for the non-institutional, or NIC, category, the category of enrollment with the best outcomes based on their analysis methodology. In response they recommended, and the VHA agreed, to system enhancements that would help identify demand for NIC enrollments and establish new performance measures to promote enrollment of NIC patients into the home telehealth program.

In response, VHA has revised its care assessment needs score report so it automatically flags patients at risk for institutional care who might benefit from the home telehealth program as a NIC patient.

VHA also created and implemented national home telehealth templates and revised their dialogues that remind home telehealth staff to reassess patients' category of care at specified intervals.

Finally, VHA has proposed a NIC enrollment metric for the home telehealth program. The proposal has been presented to the Performance Accountability Work Group and National Telehealth Advisory Board, with the expectation of enacting the new targets in 2018.

VA has plans to dramatically enhance the telehealth program going forward. Related to the announcement on August 3rd by the President and VA Secretary Dr. David Shulkin, VA has sent a proposal to the Office of Management and Budget to address barriers that are adversely impacting our ability to deliver telehealth services to our Nation's veterans. Once OMB is done reviewing the proposal, VA will make it public so it can be commented upon.

Also noted at the White House announcement and part of VHA's new Anywhere-to-Anywhere telehealth initiative, VA is initiating the rollout of a new telehealth application called VA Video Connect. It provides a secure and web-enabled video service and makes it easy for veterans and providers to connect over video from any location with sufficient Internet services and any capable video device.

In conclusion, VA is a leader in providing telehealth services, which remains a critical strategy in ensuring veterans connect with health care when and where they need it. With the support of Congress, we have an opportunity to shape the future and ensure that VA remains a leader in leveraging cutting-edge technology to provide convenient, accessible, high-quality care to veterans through telehealth.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to testify before the Committee today. We do appreciate your support and look forward to responding to any questions either of you may have.

[THE PREPARED STATEMENT OF KEVIN GALPIN, M.D. APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you.

Dr. Wong, you are recognized for 5 minutes.

#### **STATEMENT OF THOMAS WONG, D.O.**

Dr. WONG. Good morning. Mr. Chairman and Ranking Member Kuster, thank you for the opportunity to discuss the OIG's work regarding home telehealth and documentation concerns at the John D. Dingell VA in Detroit, Michigan. My written statement has been submitted.

Home telehealth technology and its implementation answers a fundamental question asked by many, if not all, primary care providers and their staff: How is my patient doing in-between office visits? Home telehealth can answer that question, but can also make care better for our patients.

Telehealth technology can also bridge the barrier of distance that prevents patients from accessing specialists. A video link paired with telehealth equipment can provide necessary information for a specialist to help a patient that can be hundreds of miles away. This program must have proper oversight for these important functions to occur.

We received allegations that in the last two weeks of Fiscal Year 2013 there was improper patient enrollment of over 900 patients in home telehealth. There was use of overtime to produce end-of-year enrollment numbers regardless of whether patients wanted to be enrolled, or even contacted.

What we found is that in that period alleged, the home telehealth program enrolled 836 new patients, and the majority of those patients were enrolled in the last two days of Fiscal Year 2013. For those 836 patients, we expected to see 836 consults, 836 screening notes, 836 assessment notes, 836 monthly monitoring notes, all in this sequence, to properly enroll a patient for telehealth care.

What we found was 828 patients who did not have the proper enrollment sequence, and many monthly monitoring notes were written without the required previous steps of enrollment. Monthly monitoring notes capture and generate workload for a facility. The monthly monitoring note should be the last note entered for a patient to be enrolled in a home telehealth program. In the Detroit facility, monthly monitoring notes were entered into patients' electronic health records regardless of proper enrollment sequence, missing consults, missing screening notes, and missing assessment notes.

We also determined that without the use of overtime for the last two days of Fiscal Year 2013, the facility could not have surpassed their workload encounters.

We made several recommendations to the facility based on re-education of home telehealth staff on enrollment procedures and

better oversight of home telehealth documentation. We asked VA to evaluate administrative action to the individual and allowing these notes to be entered in this manner.

In summary, telehealth technology is an innovative way to care for patients. For those front-line staff caring for patients, telehealth allows for the processing of information to affect the lives of patients for the better, and no doubt can save lives in the long run. But to be effective, the program must be administered responsibly so that we can affect as many lives as possible.

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

[THE PREPARED STATEMENT OF THOMAS WONG, M.D. APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Dr. Wong.

The written statements of those who have just provided oral testimony will be entered into the hearing record.

We will now proceed to questioning, and we are going to start—Ranking Member Kuster is going to start with her first question.

Ms. KUSTER. Thank you. Thank you very much.

I am going to just go to our witness here from Detroit to give you an opportunity to respond, Dr. Reeves, on what steps have been taken both with regard to retraining and oversight to overcome the incident that was discovered, or apparently there were allegations that were investigated by the Inspector General.

Dr. REEVES. Sure. We retrained staff in 2015. We had the Office of Telehealth come and give training to all of our staff. They have ongoing training that they have to do. When any new staff join, there are some critical things that they need to know. Again, this is from the Office of Telehealth in terms of training that is done before they can see any patient, and then some other training that is done within 30 or 60 days of the start of their training.

Ms. KUSTER. And does part of that training include the concept of informed consent for a patient to enter into a telehealth program?

Dr. REEVES. Kevin?

Dr. GALPIN. I can address that. Any time a veteran is being considered for telehealth, they have to provide at least verbal consent to participate in the program. That is one of our program requirements, not just for home telehealth but all telehealth.

Ms. KUSTER. And is there some record of that?

Dr. GALPIN. It should be documented with a note by the provider doing the referral or by the care coordinator or the provider who is receiving the referral.

Ms. KUSTER. Okay. Were there any disciplinary proceedings?

Dr. REEVES. Yes. The Associate Chief Nurse received a 21-day suspension, unpaid suspension.

Ms. KUSTER. Okay. So moving on, I think I would like to go to Dr. Galpin just in terms of what the opportunities are with this technology. Could you just expound upon what some of the new initiatives will be under this Anywhere-to-Anywhere? If you could expand upon that and whether or not there is action needed by Congress to effectuate the goals of this policy.

Dr. GALPIN. Thank you. Actually, we may need to spend about 10 minutes on that because I think this is—

Ms. KUSTER. I have two-and-a-half. I have a good relationship with the General.

Mr. BERGMAN. We have some flexibility.

Ms. KUSTER. I am feeling good about the flexibility.

Dr. GALPIN. So let me just start by talking about the direction we are going, because I think it is an incredibly exciting direction. It is hard to kind of talk about everything we are doing unless I can kind of break it up into categories.

So the way I think of it—and there are all different ways to think of it—is the things we are doing at the facility level, the things we are doing at the regional level, the things we are doing at the national level.

So, first of all at the facility level, our expectation is that telehealth is just going to be integrated into all the services we provide to make it more accessible. So when you look across the broad spectrum of clinical services that we provide in the VA, or any health care provides, every specialty can add telehealth as a component of their care. Some can do pretty much all their care through telehealth. Some can do a portion of their care through telehealth.

So we want to make it so easy to do telehealth that it is like picking up the phone, and that is where our VA Video Connect application comes in. We want to make it easy. I want to be able to send a link to a veteran and say, hey, let's jump on a video call because you called in, said you have a rash, and I would like to look at it; or I got your x-ray back today, and I want to show it to you, not just describe it to you.

We also want providers to be able to say, instead of coming back to see me in two weeks for your follow-up, would you rather have a video appointment so you do not have to leave your home? So that integration of just the day-to-day operations is key, and that is going to happen at the facility level.

We also think, for some of our very large medical centers that have maybe 10 community-based outpatient clinics, they have challenges with meeting surge demand. So any given day you can have a provider out at a remote CBOC or community-based outpatient clinic. They may be two hours away from the main facility. You cannot figure out a way to staff up for that surge or contingency. But with telehealth you can have some centralized providers who, at a moment's notice, can be directed to that CBOC saying we have a provider out, let's have them work there and take care of refills, anything that they can do through telehealth through the day to cover for that out provider.

We can also have, if we have a bunch of same-day sick patients coming to that clinic, we can say we have 20 patients waiting here and it is two hours away from anywhere else, let's focus our resources there today to decrease that wait time for same-day sick.

We also think, because it is really, really important, and I am sure anyone who has ever taken care of a family member realizes, when you have someone who has a lot of medical comorbidities, it is really important to have family members or caregivers attend appointments, hear what the doctors are saying, help with the medications.

And so with telehealth, not just getting care more accessible for the veterans and patients but actually saying if you want to attend this appointment remotely because you have a full-time job and it is hard to leave for the whole day, or you have sick children at home, we want to give you an opportunity to attend virtually so you can participate in the conversation.

So at the facility level it is a lot about accessibility. It is about making that care more convenient, bringing it into the home, bringing the family members of caregivers, and helping to share clinical resources in the local area.

At the regional level we start looking at capacity. So there are parts of the country, rural communities, where it is very challenging to hire a provider. A provider leaves, maybe it is a year-and-a-half, two years before we can really replace them in person.

Through telehealth what we can do is we can say, all right, that rural community is close to a major metropolitan city, we are going to hire contingency staff in that location. When you lose your provider locally, we are going to fill in by telehealth so we have consistency in our access. When you can hire a provider, we will pull out. But in the meantime, the veterans' care is not going to be impacted. We are going to have a regular provider filling in for that person.

So on the regional level, it is really important that we be able to share clinical resources, and that is where the Anywhere-to-Anywhere authority comes in, because we are not aligned where every rural community has a metropolitan city right next to them in their state that has authority to provide telehealth. Sometimes we have to go across state lines.

At the regional level we also want to work on our telephone systems and add telehealth into what we are doing with call centers. So in the middle of the night, or anytime, 24 hours a day, we would like to see it, if a veteran calls in and they have a concern or a complaint that can be addressed with a provider, we would like to have a provider available who can get on a video call or an audio call with them and say let me take care of this so we are not sending you to the emergency room if we don't need to, or we are sending you to a clinic where you would have to wait because there are 10 other people who showed up on the same day.

At the national level, it is a lot about quality. So what we can do with telehealth is I can take the expert provider who is maybe one of the top researchers on a rare condition who works in VA Connecticut, and I can make their services available to the small number of veterans anywhere in the country that has that rare condition. That is another place where we need Anywhere-to-Anywhere authority. We can't license, maintain licenses in every state. So to be able to provide that level of service and be able to do it in the home or the places that are most convenient for veterans, we need to have the authority to be able to say we should not have barriers. If I have a provider who can deliver a service, if I have a veteran who needs a service, we should be able to connect them simply, no questions asked.

That is why that initiative is so important for us.

Ms. KUSTER. And just a last question. Is there legislation that is required for that initiative to do this Federal licensing or cross-border licensing?

Dr. GALPIN. We have the authority in the VA to get us most of the way there, and that is what the Secretary and the President were talking about at their event. The VA has the authority if we put out regulations. We have always preferred a legislative approach to this. It is the best solution. Legislation can take us farther than regulations can. We can develop new authorities through that. There are veterans that we will not be able to reach because they live across the border in Canada. They drive in for service to a VA, but then they go back home. They are now in another country. Our regulations would not allow us to treat those veterans through Anywhere-to-Anywhere.

There are also other things with controlled substances that are Federal laws that we can't impact with our VA regulations. We can get to a 90 percent solution. We can do certainly a lot more with regulations than our existing authority. Legislation would be, by far, the preferred choice.

Ms. KUSTER. I yield back.

Mr. BERGMAN. Thank you.

Dr. Galpin, you seem to be the first name on here. By the way, I would like to tell Ranking Member Kuster that that question and your response was probably the most relevant and motivating interaction that I have heard in all of our hearing testimonies to date, since we have been together as a Committee for the last six-plus months, because what I heard you say, Dr. Galpin, is that you had the ability to redirect assets out of the CBOCs whatever happens to be. The provider is out for the day, something is wrong, connect someone via telehealth and still provide the capability. In previous hearings I have talked about using the military method of the surge. This is a different form of that, but it is a redistribution of assets to get the job done. I commend you for that type of attitude and proactive response.

So let me ask you a slightly different question here, Dr. Galpin. VA provided figures that indicate that the telehealth enrollment overall is growing, but home telehealth is shrinking. Can you explain, give me some whys on that?

Dr. GALPIN. Yes. Let me provide a little bit of context of what we describe as home telehealth, because I think there are two different programs that need to be considered here.

One is our monitoring program, and that is what we traditionally call home telehealth. Then we have video into the home, which is the VA Video Connect.

Mr. BERGMAN. Can you describe the monitoring? How are we monitoring in the home telehealth?

Dr. GALPIN. So what we do is we enroll veterans in a program, and in most cases, about two-thirds of cases we will provide them a device in their home, and that device can connect by Internet, but it can also connect by telephone line.

We enroll them in what we call a Disease Management Protocol. So let's say they have diabetes and hypertension. The equipment has protocols in it that asks them questions: How are you feeling today? Did you take your medications? They can put in their blood

pressure. They can put in their blood sugar records. And then there is a nurse on the other end or some care coordinator—it doesn't have to be a nurse, but in most cases it is—who is monitoring that data and the parameters. If the blood pressure gets up to this high, the system gives you a red flag.

So that care coordinator works with the veteran, essentially a conduit between them and the organization. If they see parameters going outside the control, they see something happening with the veteran that is concerning, they call them up. They can educate them, they can connect them with a provider.

So it is a group of nurses essentially that have dashboards, and they have regular information that is coming in from veterans who are in their home to make sure that they are staying on a good pathway in their disease management. That is the monitoring program. So it is daily monitoring.

The video into the home program is more episodic care. This is when someone calls in and says, oh, I would like to have an appointment for this rash, and I say, great, let's get on a video. It is a one-time event. Maybe it is a scheduled event. Maybe it is an ad hoc event. We connect by video. We are seeing each other, we are hearing each other. That is video into the home.

The video into the home, when we looked at the end of quarter 3 data, that program has grown by over 70 percent over the last year's growth. That is the program that we are seeing expanded.

The remote monitoring program, as you say, those numbers have declined over the last several years. That is a resource-constrained program. Nurses can only manage so many patients and monitor them successfully and safely. Unless we add nurses to the program, those numbers will stay static, and that has been the situation that we have been in for several years.

On top of that, I think it was in 2014, our community got together and wanted to put standards for the amount of veterans that could be safely monitored through that program. Previously there were about 90 to 150 veterans that could be monitored. When that group got together and they said, well, we can do that; however, when we cross-cover, when someone is out, suddenly we are monitoring 200 to 300 veterans, that is not a safe practice.

So they created a panel-sized calculator that, based on the complexity of the panels and what you anticipate to be your panel make-up of complex versus non-complex patients, it produces recommendations on what your panel size should be, and that produced an average panel size of, I think, 80 to 85 veterans per nurse. So it kind of decreased the total number of veterans that we can enroll based on the existing staff. So we are not seeing heavy growth in that program at this point.

Mr. BERGMAN. Okay. You know, I think since it is just the two of us, we can go back and forth with questions if we decided we have asked enough questions. Is that okay?

Ms. KUSTER. That is perfect.

Mr. BERGMAN. Okay. Do you want to go again?

Ms. KUSTER. I am happy to, yes.

So, just to pick up on that before we leave it, more resources, more personnel resources would be needed.



What about the equipment in the home? What are the constraints on that, and are there recommendations about equipment in the home for participation?

I mean, I just want to say I have been surprised and very, very impressed, for example, that mental health treatment can be provided very effectively by telehealth. I did not anticipate that. Up north in my district, not far from the Canadian border we have a CBOC, but we also have veterans centers that are just for mental health, and they were able to provide care as long as a veteran was sitting comfortably in a chair in a room with privacy, on the television with their mental health provider.

But how do we address the equipment in order to bring that kind of treatment into the home?

Dr. GALPIN. I am going to separate again. Again, we have the remote monitoring program, and that is something that we can supply. So we have a central distribution mechanism where the veteran gets enrolled in the program. They can be distributed out equipment for home monitoring. We also have an option where they can use their own phones or their own Internet, though it is a much smaller percentage of veterans that actually use their own devices for home monitoring.

For the video into the home—I think that is the category you are focusing on most—I break it down into three categories of accessibility for the veteran in the home in that case. So we have veterans that live in areas where they can get broadband or high-speed Internet, they subscribe to it, and they have devices that are video capable. In that case, we can use that VA Video Connect application, send them a link, and we can connect them, we can do video conferencing.

What you are saying about mental health is true. It is also true for many other specialties. I mean, imagine the amount of specialties that don't require any physical examinations, or the amount of appointments that don't require physical examination other than visual. So mental health, social work, pharmacy, speech therapy—there is a long list where a very complete appointment can be provided through video conferencing.

The second category of veteran is veterans who live in an area that maybe has broadband 4G connectivity, but they may not have their own device or they may not subscribe to that bandwidth. So VA in this case has a program where we can distribute out a connected tablet. It has 4G connectivity. We ship it to the veteran. They can use it. We have distributed about 6,000 of those, or over 6,000 of those. That is certainly an area where we could get assistance. I don't know if the right answer is a public-private partnership, but that is a resource limit. There is a point where we do run out, we have to buy more.

Ms. KUSTER. Are the VSOs involved in that program at all? Do you know?

Dr. GALPIN. In the distribution—

Ms. KUSTER. The Veteran Service Organizations in the distribution or the purchase?

Dr. GALPIN. Not that I am aware of.

Ms. KUSTER. Maybe that is something we could look into.

Dr. GALPIN. I could look into that, but I am not aware of that.

Ms. KUSTER. Okay.

Dr. GALPIN. So we do have a way to get the veterans the connectivity and the device for that service, and we think that is certainly a great opportunity. We would like to be able to do more of that where it is needed.

The third category is the most challenging. We looked at this, and these are not official numbers, but we asked rural health at the beginning of the year to give us a list of where veterans are located, how many veterans do we have in communities that have no broadband, no 4G connectivity.

Ms. KUSTER. That would be my district.

[Laughter.]

Ms. KUSTER. This is why we have come together on this issue.

Dr. GALPIN. These are approximate numbers. But nationally, at least in that initial data query, we have about 40,000 veterans living in those areas, and in Michigan it's about 1,500, in New Hampshire it was like 300.

Ms. KUSTER. Forty thousand nationally?

Dr. GALPIN. Yes.

Ms. KUSTER. Oh, we should be able to correct this.

Dr. GALPIN. Yes. So these are preliminary numbers, again. I wasn't asking for—

Ms. KUSTER. No, but it is not like 4 million.

Dr. GALPIN. Yes. So those are the most challenging because we can't ship them a connected tablet and have it work, and this is where I think local community and the VA need to be working together—public-public partnerships, public-private partnerships—to say, okay, here is a veteran community or a community that has 11,000 veterans in it that don't have connectivity. We can't provide the services we want to provide into the home or close to their home. Let's find a building like this, maybe a rural community that has satellite connectivity. Let's see if we can reserve rooms. We can then send them a tablet and they can schedule a time in a room at a library, at an academic site, at a town center, just so they can connect to their local VA port or their distant VA provider.

That is a real opportunity. In the meantime—well, that is probably the thing we need to do first. But where Congress can help with this—I heard you ask that question earlier. I really didn't address it. I would certainly like some more time to talk about where we could get help from Congress, but making bandwidth, making Internet more of a utility. I know that is a bad word to some people, a utility, but more like a utility in that it is available everywhere.

Maybe there is a combination where there are different levels. I know, again, it is a touchy area, a utility versus a commodity, but we really should have that service everywhere, and we have got to figure out ways and support companies that want to do that. VA can't set up Internet connectivity all over the country, but there are people who can, and that is a big area, and that will help us tremendously.

Ms. KUSTER. Well, a lot of veterans—and I am sure General Bergman has seen this—in my district, they are choosing to live a rural life, and many of our Vietnam-era veterans came back and chose to live in a more rural area, and mental health-wise that is

probably healthy for them. They get out, they go hunting and fishing and snowmobiling, and it works well for them. But it is not just their health that would benefit from the connectivity; it is their economic opportunities, it is their personal opportunity for staying connected to family and friends. So I think it is definitely something worth looking into.

I will yield back.

Mr. BERGMAN. Thank you.

Dr. Wong, in your home telehealth enrollment audit, you found that less sick and younger veterans were being targeted for enrollment, and the sicker and more elderly vets were being deemphasized. Can you put some more meat on that bone, give further explanation and what effect it had on the home telehealth enrollment overall?

Dr. WONG. So, the meat on those bones was done by audit, and that is why I can't speak to that. I am from the health care division, and so I can speak to the Detroit issue with the home telehealth. But as far as that number and that report goes, that goes to the audit division of IG, which I was not involved with.

Mr. BERGMAN. So I need to go find the audit division of IG to answer that?

Dr. WONG. I can get that.

Mr. BERGMAN. You can direct me—

Dr. WONG. Absolutely.

Mr. BERGMAN. Are they in D.C.?

Dr. WONG. And I will. They are in D.C., yes.

Mr. BERGMAN. Oh, good. Then when we get back there, I will have a little direct meeting.

Dr. WONG. I will get that question to them, actually.

Mr. BERGMAN. Good. So then let me go to an extra one. In your Detroit report, you made recommendations to ensure that no one manipulates any more enrollment records, okay? The recommendations were to retain everyone, make sure policy is followed, correct the veterans' telehealth records, and to consider taking personnel action.

Have those recommendations been resolved?

Dr. WONG. The education has been resolved. We are still waiting for the facility to give us data on the surveillance of notes that confirm or do not confirm that telehealth has been delivered appropriately and documented.

The administrative action is still in process. We know that action has been taken, but we need VA to provide official documentation of that.

Mr. BERGMAN. Okay. And I am going to ask one more question and then yield back.

Ms. KUSTER. That is fine.

Mr. BERGMAN. Dr. Reeves, the Associate Chief of Nursing received a 21-day suspension?

Dr. REEVES. Yes.

Mr. BERGMAN. Was that with or without pay?

Dr. REEVES. Without pay.

Mr. BERGMAN. Without pay. In your opinion or that of those you have consulted with, was that appropriate, or did that send a

strong enough message throughout the system that that kind of behavior would not be tolerated?

Dr. REEVES. I think it sent a strong message. We have never—I have never given anyone a 21-day suspension, a manager a 21-day suspension without pay. And so we thought it was appropriate.

Mr. BERGMAN. Okay. I yield back.

Ms. KUSTER. I just want to follow up before we leave here on one issue that we haven't covered, and I will start with Dr. Wong, but if anyone wants to follow up on that.

This is with regard to the mobile medical units, another way of servicing rural communities. Two questions. Are you aware that the VA has a better accounting system at this time to locate these mobile medical units and keep track of them? And secondly, I would just ask you, given the situation down south in Texas and Louisiana, are they able to bring these units in in an emergency to provide care for both veteran and non-veteran populations?

Dr. WONG. The mobile medical unit, again, was a different audit report.

Ms. KUSTER. Oh, okay.

Dr. WONG. It was an audit report. It wasn't an inspection report, so I cannot speak for that.

Ms. KUSTER. Okay. Is anyone else on the panel able to speak to that, the mobile units?

Dr. GALPIN. I will qualify by saying I am not the subject-matter expert for mobile medical units.

Ms. KUSTER. Sure.

Dr. GALPIN. I can help with some of the responses, and I will have to take some of it back for the record.

Ms. KUSTER. Okay.

Dr. GALPIN. The mobile medical units are under emergency management. Basically, new recommendations, a new policy was developed that was just actually published in July that gives criteria for managing the mobile medical units, and I understand that a report is going to Congress yearly on the number, connectivity, use of those mobile medical units.

I know last year, for instance, we had 27 reported clinical workload. They produced approximately 27,000 encounters, did about 4,000 telehealth encounters. So they are being tracked much more closely under a program under policy now. But it is emergency management.

Regarding the question, I think it is a great question as far as how can we help Texas right now, how can we help the Houston area. There has been a tremendous amount of conversation over the last couple of days about what can telehealth do, and we had providers jumping out of their seats saying I want to help, how can I help, how can I get involved.

I know we have mobile vet centers. I think we have one mobile medical unit and vet center in the area. The manager for the mobile vet center said they have, I think, nine mobile vet centers within a one-day drive, if needed, to bring into the area. So at this point we are working with our central command trying to figure out exactly what needs to happen.

So there will be a lot more to come on this, and we can certainly give you an after-action.

Ms. KUSTER. Like I said, we had a flood in our Manchester, New Hampshire facility last month, and a number of mobile units were brought in from surrounding areas and have been very, very helpful for all different types. I think it would be useful, actually, for our Committee to tour and get a handle on how these are useful for all different types of—again, it was mental health, it was primary care, it was different clinics that were able to continue even after this flood. So it was good.

I am just going to go to Dr. Constantian, who came all the way out here. Is there anything that you would like to add from your area of expertise, anything that we should know or anything that Congress can be doing with regard to IT? I guess my biggest question has to do with the change in the electronic health record and how that would impact telehealth, and is there an off-the-shelf option here where we would be able to move forward quickly, or are we going to have a—I won't use the technical term in terms of what is going to happen next with the new electronic health record and our intent to expand telehealth.

Mr. CONSTANTIAN. Thank you, Ranking Member Kuster. I know probably the arrangements that we are trying to move forward on with Cerner based on Secretary Shulkin's determination and findings from early June are probably of greatest interest to you and Chairman Bergman. However, those negotiations have not resulted yet in a contract, so it would be premature probably for me to comment on that, specifically what the software would bring to the table in terms of telehealth support.

I would say, though, that IT and the Office of Information Technology and Veterans Health Administration, my office, partnering with another element, the Enterprise Program Management Office in particular and Dr. Galpin's office in VHA have formed a very tight partnership in terms of the vision for telehealth and what the IT supports are that are required to undergird that. Many of those, not all but many of those, I would say even most, are not electronic health record-specific. It is more in the area of infrastructure and capacity to build out that strategy.

So assuming we go forward with Cerner and the contract is let, we will have some work that interfaces with Cerner, but a lot of the work that we have in terms of expanding infrastructure is independent of the electronic health record choice that we take.

Ms. KUSTER. I will yield back, but we may take back to our Committee. I would suggest that we have a presentation for the Full Committee on telehealth and the expansion of telehealth, and then maybe if we do it in a way that is timely to the announcement about where we are headed with the electronic health record, and then you could describe that infrastructure. I think that would be of interest certainly as we—we have some big hearings coming up this fall about the future of the VA and what it looks like in terms of facilities and care in the community and care in the home. I think it is going to be important for our Members to have a thorough understanding of what is possible, and potentially the VA can be on the cutting edge, as the VA has been in so many other areas. It would be really exciting to see the VA be leading the way in telehealth.

Thank you. I appreciate you taking the trip, and I definitely appreciate the testimony.

I will yield back.

Mr. BERGMAN. Thank you.

I guess I have never heard this question asked in a hearing like this, but this is your opportunity, any of the four of you, to offer to myself and Ranking Member Kuster your thoughts on where Congress either could be more helpful or, in some cases, less helpful.

I will open it up to anyone who would like to offer a comment on that.

Dr. Galpin?

By the way, we don't shoot the messenger here.

[Laughter.]

Dr. GALPIN. I will be respectful.

Mr. BERGMAN. And I appreciate that.

Dr. GALPIN. I appreciate that question, but I think this is a partnership. I mean, we look to you all for leadership and direction as much as we do from our own agency. So it is important that we are all working together and you understand where we have challenges and can look to you for help in those areas.

I will go through just a couple. The first is legislation, that Anywhere-to-Anywhere legislation, that and overcoming some of the issues with our ability to provide comprehensive care through telemedicine, so with the Controlled Substance Act, the portion of that which is the Online Pharmacy Consumer Protection Act of 2008. These are things where we need action from somewhere to help overcome.

I think legislation is, again, still the best approach. It is the most comprehensive. It could potentially still be done faster than we can get regulations through comment periods. That is still something we need to put out through the public. So that is an area that we would certainly love very comprehensive support.

The other is IT infrastructure. I am going to put that in the category of both IT and community IT. In the VA, our IT is separate. They have a separate budget from us. Sometimes we have needs in our program, and I will give you the figures I have. We did an assessment of what we wanted to do with VA Video Connect, the services in the home, and to do what we felt we wanted to do, it was going to require an additional \$25 million of IT funds per year to make that happen. That is something that currently we don't have funds for, and those monies sit in a very different pocket from the other money that we may have.

Mr. BERGMAN. Are those funds restricted? In other words, restricted within that pot? Is that by legislative or by what means restricted? What put up the barrier?

Mr. CONSTANTIAN. In 2006 there was legislation to create a separate IT appropriation for IT expenditures, and there was a rationale for that. There was the ability to account across the Department for whatever IT expenditures there were. It had perhaps an unintended consequence, by separating out the monies, whereby there might be enough money in situations like telehealth where you need medical funds for clinicians, for some of the infrastructure that is not IT, but you also need to partner those funds with IT.

In terms of responding to your question, Chairman Bergman, I was going to say that one thing we experience in the Office of Information Technology in health care is that there are so many excellent ideas that require IT funding, often between three times and five times the amount of money that we have available for development of those services. So we have to make very difficult choices. There are safety issues, there are suicide prevention demands, other demands for that IT support, and we can't fund all of the good ideas that the Veterans Health Administration has in terms of benefitting veterans.

Dr. GALPIN. Yes. So I will sort of skip ahead and come back to the IT infrastructure, because the appropriations thing, this falls under the big category of let's make government more simple and intuitive. So I have a budget, but it is split into three pockets. I may have plenty of money in this pocket, but I need to buy something that requires this money and I can't do it.

Mr. BERGMAN. Because of legislation.

Dr. GALPIN. Because of legislation. I believe it is legislation. It is separate appropriations, and there is a lot of anxiety and fear in the government over this. If I use this for the wrong purpose—

Mr. BERGMAN. So I am going to put words in your mouth here. You are the boots on the ground. You are in the middle of a fight. You have assets over here, and you have assets over here, and you are being limited from using the assets to do the right thing for the right reason at the right time because of legislation. Did I get that right?

Dr. GALPIN. Correct. And in the area of telehealth, it is particularly confusing because we have a clinical bucket of money and we have a technology IT bucket of money, and where do we sit? When I buy a tablet for a veteran, is it IT money? Is it clinical money? And depending on the situation, it could be either. So that confuses people. And if you buy it for one purpose and want to re-purpose it for another, then you have used the wrong type of money. It is confusing.

Mr. BERGMAN. So the legislation is inhibiting or preventing you as a leader who is in the fight, boots on the ground, from basically winning the battle—

Dr. GALPIN. Doing the right thing.

Mr. BERGMAN [continued].—that you are in the middle of.

Dr. GALPIN. Correct.

Mr. BERGMAN. Okay. I just wanted to make sure that I was hearing what you were saying.

Mr. CONSTANTIAN. Sir, I would add that there are mechanisms for transferring between those buckets of money, but they are—

Mr. BERGMAN. Who created the mechanisms?

Mr. CONSTANTIAN. Sorry I can't comment on that in terms of different appropriations. But what I would say is that it requires notification of Congress. So the shifts between the appropriations can't be done quickly. There is some lag period.

Mr. BERGMAN. Okay. So the process exists.

Mr. CONSTANTIAN. Yes.

Mr. BERGMAN. Okay.

Dr. GALPIN. But that creates for us a lot of challenges in the telehealth space, and along with simplifying government, I think our

ability to buy things in the government is incredibly complex. Sometimes we go through years of contracting and protests and after-actions, and it becomes incredibly challenging.

So you start out, again, working with the buckets of money. You have a budget that comes for one or two years at a time, and then the time to actually act on something you are trying to act on is incredibly complex and long. So I think for us in telehealth, that is another area. When we are trying to move things quickly and we are in an area of significant growth, and we want to be the leader in this area, having to wait for a couple of years to get new technology in is an incredible challenge. And again, there is a lot of anxiety about how do you do it right, how do you make sure you follow all the rules.

So just, again, simplifying.

I would say hiring is in the third category of that. Again, we just need to simplify the way we do things so we have an intuitive system that people can—if they are doing the right thing that should be in line with the laws and regulations. I think that is a huge area of opportunity.

Going back to the initial question, though, about what we can do for telehealth right now, the legislation, the IT infrastructure, helping with that Internet expansion in the community, helping with our IT expansion in the VA to support what we are trying to do, and then simplification of policies and procedures that just make our system very complex to move quickly.

Mr. BERGMAN. Okay. Well, we have had a little discussion up here amongst the Ranking Member and myself, and I believe you are all set and satisfied. We are going to move forward, if you will.

Do you have any closing statements or anything that you want to say? Because I am just going to close the hearing off.

Ms. KUSTER. Just to say thank you, and I have had a wonderful time in Michigan. Thank you for the invitation. Thank you to all of you for traveling here as well.

Mr. BERGMAN. I am going to just, again, echo the Ranking Member's words and thank you for making the effort to be here. Thank you for the continuing education on both parts, because in good business group, it doesn't make any difference what the unit of measure is, interactions, everybody works together, everybody knows what their responsibilities are, everybody should know what they are being held accountable for. But probably most importantly, we need to feel as though we are in an environment where we can clash in a collaborative, positive way and come out maybe a little bit bloodied in the short term, but nonetheless nothing that is going to cause permanent damage, and our mission moves forward because of the fact that we tangled with one another. So I thank you for that.

Roles and missions we talk a lot about in the military, and I was kind of alluding to it in my comments there about what is the role of Congress, what is the role of the VA, what is the role here and there. Roles and missions is something that is continuing based on the fight you are in and based on the capabilities you have been assigned to bring to the table.

I will tell you, Dr. Reeves, as someone in the military who holds people accountable, I really don't think a 21-day suspension was



enough. I just want to let you know that. That has stuck somewhere in my system right now because no matter what you are doing, in the end if somebody gets hurt because somebody didn't do the right thing, there is no excuse for that and you have to send a message that is so strikingly clear that if anyone even considers doing something like that again, it means that the message wasn't right on the front end. So I would just offer that advice as a former military commander.

I just wanted to thank you all, all of you witnesses today for being with us and for your thoughtful testimony.

The panel is now excused.

The VA has long recognized the opportunities that telehealth presents to bridge the distances not only between its facilities and its veterans in rural areas but utilizing these techniques to build on what the expectations will be for future veterans who have yet to even—if you will, the folks we are talking about now are the ones who haven't even signed up to join the military, yet they are the toddlers using their screens at home that have their Fitbit on who will know their provider through some type of device, and that is the future that we are looking at.

But we have an opportunity as veterans' health care especially and providers of services to our veterans to be on the leading edge, and we cannot miss that opportunity. So after rolling out the telehealth nationally in 2003 and significantly expanding it in 2011, I believe the Department is at another key moment for growth, for opportunity. Telehealth is already a billion-dollar enterprise for the VA. It seems to be headed into the multi-billions. We have to make sure that those administrative systems and enabling technologies keep up with the needs, if you will, in such a way that there is such a thing as being on the leading edge but not so far out on the edge that you are assuming unnecessary technological risk, if you will. We are not going to be the R&D in some ways, but yet we will be the implementers of good R&D.

We also have to stay mindful of previous incidents of well-intentioned performance metrics motivating bad behavior. We already talked about that. VA is engaged in a very consequential planning for its future. So the big issues are where and how new hospitals should be built, if at all; what is the best mix of in-house and community care, what that looks like; and how to move forward with an optimal technology for the moment, because we know when we put something in place, it is going to change.

Telehealth touches every issue, and I want to make sure that that is always part of our conversation. As you heard Ranking Member Kuster talk about the rural nature of her district, the rural nature of my district, if it will work in our districts, it will work anywhere. We look forward to being that test bed, if you will, in some ways, to see what works and what doesn't, because I will guarantee our constituents don't beat around the bush. They will get to it very quickly. So thanks for making that part of the conversation.

I look forward, as always, to working with Ranking Member Kuster, and I am also looking forward to talking with her back in D.C. and hearing of her exploits here in our beautiful 1st District and all the hospitality she enjoyed.

We are going to be all in this together to make telehealth what it can be.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and to include extraneous material.

Without objection, so ordered.

Again, once again, thank you to all of you.

And to those of you in the audience who came today, thanks for joining us here this morning.

With that, this hearing is now adjourned.

[Whereupon, at 10:10 a.m., the Subcommittee was adjourned.]

## A P P E N D I X

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### **Prepared Statement of Kevin Galpin, M.D.**

Good morning, Chairman Bergman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss VA telehealth, telehealth information technology (IT), and our home telehealth program. I am accompanied today by Dr. Pam Reeves, Medical Center Director of the John D. Dingell VA Medical Center (VAMC) in Detroit, Michigan and Dr. Alan Constantian Deputy Chief Information Officer for the Office of Information and Technology and VHA Account Manager for Clinical Functions.

#### **Introduction**

VA Telehealth is a modern, Veteran- and family-centered health care delivery model. It leverages information and telecommunication technologies to connect Veterans with their clinicians and allied or ancillary health care professionals, irrespective of the location of the provider or Veteran. It bridges enhanced access and expertise across the geographic distance that would otherwise separate some Veterans, including those in rural areas, from the providers best able to serve them.

Telehealth is mission-critical to the future of VA care. Its potential to expand access and augment services is both vast and compelling. While telehealth is capable of enhancing the health care system in multiple ways, three are specifically essential for the successful operation of our national, integrated VA enterprise.

First, telehealth increases the accessibility of VA care. It brings VA provider services to locations most convenient for Veterans, including for those Veterans with mobility or other health challenges that make travel difficult. Through telehealth, Veterans are able to receive care in their community-based clinic and at home.

VA is committed to increasing access to care for Veterans and has placed special emphasis on those in rural and remote locations. This means transitioning from older systems and a health care delivery model that has been in place for decades to a system that works for Veterans and is focused on contemporary practices in access. VA is empowering Veterans and their caregivers to be in control of their care and make interactions with the health care system a simple and exceptional experience.

Second, telehealth increases quality of care. It enables VA to model its services so that national experts in rare or complex conditions can effectively care for Veterans with those conditions, regardless of the Veterans' location in the country. Telehealth leverages health informatics, disease management principles, and communications technologies to deliver care and case management to Veterans. Telehealth changes the location where health care services can be provided, making care accessible to Veterans in their local communities and their homes.

Third, telehealth enhances the capacity of VA clinical services for Veterans in rural and underserved areas. The mission of VA Telehealth Services is to provide the right care in the right place at the right time through the effective, economical, and responsible use of health information and telecommunications technologies. This is accomplished by empowering VA to hire providers in major metropolitan areas, where there is a relative abundance of clinical services, for the purposes of serving Veterans in rural and even frontier communities where medical services may be insufficiently available.

Leveraging telehealth technologies affords VA an opportunity to increase access to care for Veterans, especially for those in rural or underserved areas. It allows Veterans access to VA health providers or services that may otherwise be unobtainable locally. Telehealth is now considered mission-critical for effectively delivering quality health care to our Veterans. VA remains committed to ensuring that America's Veterans have access to the health care they have earned through their service, and we will continue to expand telehealth services to meet the growing needs of our Veterans.

#### **VA Telehealth By The Numbers**

VA is recognized as a world leader in the development and use of telehealth technology. To ensure excellence in care delivery, VA aspires to elevate and expand telehealth in the coming years. VA has substantially increased access to care for Veteran patients using telehealth services and is a recognized pioneer in the practice of telehealth. Since 2002, over two million Veterans have accessed VA care through telehealth services, and Veterans are utilizing more telehealth services from VA than ever before. In fiscal year (FY) 2016, of the more than 5.8 million Veterans who used VA care, approximately 12 percent received an element of their care through telehealth for a total of 2.17 million telehealth visits. This represented more than 702,000 Veterans, with 45 percent of those Veterans served living in rural areas. In total, this amounted to over 2.17 million telehealth episodes of care.

VA recognizes three broad category types of telehealth to deliver services to Veterans in 50 clinical specialties. The first of the three categories, Clinical Video Telehealth, is defined as the use of real-time interactive video conferencing to assess, treat, and provide care to a patient remotely. Typically, Clinical Video Telehealth links a Veteran at a clinic or his or her home to a provider at a VA medical center in another location. Clinical Video Telehealth allows clinicians to engage patients in the comfort and convenience of their homes and facilitates delivery of a variety of clinical services including primary and specialty care. Clinical Video Telehealth means that instead of having the cost and inconvenience of the Veteran traveling by road, rail, or air to see a provider, the VA provider delivers care through telehealth to the Veteran. VA Video Connect represents the next step for Clinical Video Telehealth. It provides fast, easy, encrypted, real-time access to VA care. It allows for video health care visits, such as telemental health visits, where a hands-on physical examination is not required. It also makes it easier for Veterans to choose where they'd like to receive services, whether those services are in their home or any other place the Veteran desires.

Cumulative Veterans using the Real Time/Clinic Based Video Telehealth program:

Fiscal Year	July	EOFY
FY15	247,942	282,319
FY16	269,135	307,985
FY17	293,291	

The second category of telehealth is Store-and-Forward Telehealth, which is the use of technologies to asynchronously acquire and store clinical information (such as data, images, sound, and video) that is then assessed by a provider at another location for clinical evaluation. VA's national Store- and-Forward Telehealth programs deliver services such as Dermatology and Retinal Screening, where a health care provider can use a photo or a series of photos for diagnosis or triage.

Cumulative Veterans using the Store and Forward Telehealth Program:

Fiscal Year	July	EOFY
FY15	249,489	298,802
FY16	254,018	304,760
FY17	257,282	

In FY 2016, the number of Veterans treated by Clinical Video Telehealth and Store and Forward Telehealth in Michigan was more than 11,800. This was accomplished via more than 33,000 telehealth encounters. Compared to the previous fiscal year, these two telehealth modalities in Michigan grew by approximately 13 percent in encounters and 14.5 percent in unique Veterans treated.

The third broad category of telehealth is Home Telehealth. Home Telehealth uses VA-provided devices via regular telephone lines, mobile broadband, or cellular modems, or Veteran-owned devices using landline or mobile phones for interactive voice response, or Veteran-owned smart phones, laptops, or tablets via secure web browser, to connect a Veteran with a VA care coordinator, most often a registered nurse. Overall, 68 percent of Veterans participating in VA Home Telehealth use a

VA-supplied home telehealth vendor contracted device and 29 percent use their own personal device (3 percent are not yet assigned at time of data capture). There are none using a mix of both at this time. For the 29 percent Veterans utilizing their own device, 24 percent use Interactive Voice Response (IVR) using Veteran's own landline or mobile phone and 5 percent use Web-Enabled Browser using Veteran's PC, laptop, smartphone or tablet to access a secure vendor website.

Using Home Telehealth technologies, the VA care provider can monitor the Veteran's health status, provide clinical advice, and facilitate patient self-management as an adjunct to traditional face-to-face health care. The goal of VA's Home Telehealth program is to improve clinical outcomes and access to care while reducing complications, hospitalizations, and clinic or emergency room visits for Veterans who are at high-risk due to a chronic disease (e.g., Diabetes). Not every patient is suitable for this type of care; however, for those Veterans who are, Home Telehealth can help them live independently and spend less time on medical visits. Over 85,000 Veterans are regularly using Home Telehealth services. VA found that patients easily learn how to use their Home Telehealth technologies and are highly satisfied with the program. Home Telehealth makes it possible for Veterans to become more involved in their medical care and more knowledgeable about their conditions, providing an opportunity to more effectively self-manage their health care needs.

All Veterans enrolled in the Home Telehealth program are assessed and assigned to a Category of Care. This assessment is completed using the Continuum of Care Form and is based on the Veteran's behavior, symptoms, cognitive status, living situation, caregiver support, functional ability (activities of daily living), and prognosis. The Veteran is reassessed every six months and when there is any change in status.

The Categories of Care (in descending order of health care complexity) include:

- **Non-Institutional Care (NIC)** - Includes Veterans with deficits in three activities of daily living (ADL), one or more behavioral / cognitive deficits, or less than six months to live. If a Veteran does not meet one of these requirements but has two or more ADL deficits in combination with three or more deficits in instrumental activities of daily living (IADLs) or is age 75 or older, lives alone, or has 12 or more clinic encounters in the past 12 months, they also meet NIC criteria
- **Chronic Care Management (CCM)** - Includes Veterans who do not meet NIC criteria but who have one or more chronic illnesses amenable to Home Telehealth care and require on-going intensive case management, monitoring, and interventions.
- **Acute Care Management (ACM)** - Includes Veterans with short-term clinical needs such as, but not limited to, post-operative care, transition management, or post-hospital care (enrollment <=6 months).
- **Health Promotion / Disease Prevention (HPDP)** - Includes Veterans who have a primary need for health promotion, disease prevention, and self-management education for maintaining healthy behaviors. This category also includes any enrolled Veterans (including those who meet NIC criteria) who respond less than 70% of the time through the technology for at least 90 days.

The categories of care represent different levels of workload for the care coordinators. Based on the national recommendations, care coordinators monitoring more complex patients are expected to monitor fewer patients than a care coordinator with less complex patients. The needs of the Veterans served at a local VA facility help determine the strategy for the panel size mix and the panel size for the Care Coordinators.

Cumulative Veterans using the Home Telehealth program:

Fiscal Year	July	September
FY15	145,720	156,016
FY16	140,429	150,620
FY17	136,650	

#### VA OIG Reports

Between 2013 and 2014, the VA Office of the Inspector General (OIG) audited the management of VHA's Home Telehealth program and provided their final report in 2015. As part of their audit, the OIG analyzed outcomes for about 15,600 patients

in the six months following their enrollment in the Home Telehealth Program, and concluded that “the program was successful in reducing inpatient admissions for all three main patient categories” of enrollment, inclusive of the Non-Institutional Care (NIC), Chronic Care Management (CCM), and Health Promotion/Disease Prevention (HPDP) enrollment categories. In its conclusion, the OIG described the program as a “transformational modality for delivering quality healthcare that is convenient and accessible to veterans who cannot travel or who live hours away from the medical facility.”

However, the OIG also concluded that the VA “missed opportunities to expand enrollment for Non-Institutional Care,” the category of enrollment with the best outcomes based on their analysis methodology. In response, they recommended, and VHA agreed, to system enhancements that would help identify demand for NIC enrollments and establish new performance measures to promote enrollment of NIC patients into the Home Telehealth Program. In response, VHA addressed the following three OIG Action Items such that OIG closed its report on December 2, 2016:

**1. Revised Care Assessment Need (CAN) Score Report:** In February 2016, VA completed modifications to the CAN score report so that it would automatically identify patients at risk for institutional care who might benefit from Home Telehealth (HT) as a NIC patient. The CAN score is a tool used by PACT teams to identify patients at highest risk of health care decline so that appropriate care and services can be targeted to intervene appropriately to improve outcomes and reduce utilization. Guidance and training regarding this modification was communicated nationally to VHA Patient Aligned Care Teams (PACT) and other appropriate services/providers so they can use the CAN score report to identify and refer patients to Home Telehealth that potentially meet NIC criteria. This training was also provided to HT staff so they could proactively identify patients at risk for institutional care who likely fall under the NIC Category of Care for HT.

**2. Created and Implemented HT National Templates:** In addition to the modification to the CAN Score report, national HT reminder dialog templates were completed and have recently been released to the field. The reminder dialog templates help standardize home telehealth documentation but also remind home telehealth staff to reassess their enrolled patients at specified intervals to ensure they are in the most appropriate category of care, including the NIC category of care. In addition to correctly assigning Veterans to the correct enrollment category, the templates will facilitate the creation of national home telehealth reports because they include nationally standardized data elements. As an example of a potential report, VA Telehealth services would be able to assess the overall percentage of Veterans enrolled in the program who have not had their category of care assessed in a designated time period.

**3. Defined NIC Quality Indicators:** At the start of FY 2017, VHA proposed NIC quality indicators that employed a population-based model analyzing the number of Veterans from the previous year to determine specific number-related NIC performance indicators for each VISN. This proposal was presented on the national VISN leads Program Manager call in August 2016 and was included in a report to the OIG.

This proposal, however, raised concerns among Telehealth field staff and was ultimately not enacted. VHA recognized that the initial proposal for FY2017 clinical indicators needed revision to help avoid unintended consequences of a new metric.

Following discussions in the third and fourth quarter of FY 2017, a new proposal for a NIC enrollment quality indicator has been developed that targets 50 percent NIC enrollment by mid-year FY 2018 and 55 percent by the end of FY 2018.

The proposal has been presented to the Performance Accountability Work Group (PAWG), VISN Telehealth Leads council, and National Telehealth Advisory Board with the expectation of enacting the new quality indicators in FY 2018.

#### **Future of VA Telehealth**

As recently announced on August 3rd, 2017, by the President and VA Secretary Dr. David Shulkin, VA has begun several initiatives using telehealth technology and mobile applications to connect with more Veterans and provide services where they live.

VA has sent a proposal to the Office of Management and Budget (OMB) to address barriers that are adversely affecting our ability to deliver telehealth services to our Nation's Veterans. Once OMB is done reviewing this proposal, VA will make it publicly available for comment. We encourage all affected stakeholders to send in comments, and we look forward to working with all parties to make this proposal

as workable and effective as possible for all Veterans who seek VA health care services.

VA is also initiating the nationwide rollout of a new application called VA Video Connect. VA Video Connect provides a secure and web-enabled video service that makes it easy for Veterans to connect with their VA providers by video on their own mobile phones or personal computers. VA Video Connect is currently being used by more than 300 VA providers at 67 hospitals and their associated clinics. It will be rolled out to more VA providers and Veterans across the country over the next year.

Dr. Shulkin also announced the nationwide roll-out of an application to make it easier to schedule or change appointments with VA. The Veteran Appointment Request (VAR) app, is an application that makes it possible for Veterans to use their smartphone, tablet, or computer to schedule or modify appointments at VA facilities. The VAR capability is currently available to Veterans at several locations nationwide. During its initial rollout, Veterans used the app to book more than 4,000 appointments with their providers. VA will continue to roll out the application nationwide - bringing the capability to all VA facilities and clinics.

### **Conclusion**

VA is a leader in providing telehealth services, which remains a critical strategy in ensuring Veterans can access health care when and where they need it. With the support of Congress, we have an opportunity to shape the future and ensure that VA is leveraging cutting-edge technology to provide convenient, accessible, high-quality care to Veterans.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to testify before the Committee today. We appreciate your support and look forward to responding to any questions you and Members of the Committee may have.

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### **Prepared Statement of Thomas Wong, D.O.**

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>

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

<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.

<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

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 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 se-

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>.



quence 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 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

<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.

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 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.

## 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

<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.

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

<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.

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 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

