US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians

Audit | **24-03319-213** | **September 24, 2025**

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Executive Summary

The MISSION Act of 2018 directed VA to improve healthcare access for veterans in underserved areas.[1] In response, VA created "clinical resource hubs" within the Veterans Health Administration (VHA), one for each of VHA's 18 Veterans Integrated Service Networks (VISNs) based on a hub-and-spoke organization.[2] The hubs offer support to clinical staff at medical facilities in each VISN, which are generally referred to as spoke sites and are in areas experiencing staffing or service gaps. These gaps may be the result of facility staff attrition, recruiting difficulties, or growth in the veteran population.[3]

Hub services are provided mostly virtually through real-time interactive videoconferencing that allows physicians to assess, treat, and provide care to patients remotely; however, some hub services are provided to veterans in person.[4] Hub patient encounters—interactions between a patient and a healthcare provider for treatment, evaluation, or management of care—increased from almost 482,000 in fiscal year (FY) 2021 to about 1.2 million in FY 2024.[5] The hubs spent about $462 million in FY 2024 with subsequent expected increases in funding needs.[6]

Given steady growth in use and expenditures, the VA Office of Inspector General (OIG) conducted this audit to assess how VHA managed the productivity of its clinical resource hub physicians in FY 2024, with a specific focus on providers of primary, specialty, and mental health care.[7] The audit team examined hub productivity data for FY 2024 and VHA's actions to develop a hub-specific directive as of September 2025. Because actions still need to be taken to improve the quality of hub provider productivity data and guidance, the OIG believes the issues identified from its analysis of FY 2024 data persisted in FY 2025.

In facility settings, VHA measures specialty physicians' productivity using work relative value units (work RVUs), a national standard for assessing the amount of work that goes into providing

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[1] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

[2] "Veterans Integrated Services Networks (VISNs)" (web page), VHA, accessed June 6, 2025, https://www.va.gov/HEALTH/visns.asp. VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

[3] VHA, Clinical Resource Hub Training and Operations Guide, June 2019.

[4] VA Office of Inspector General (OIG) analysis of VA's Pyramid Analytics data showed about 68 percent of all hub encounters from October 2023 through February 2025 occurred via telehealth, while only about 2 percent were done in person. VA, *Office of Connected Care Telehealth Manual*, June 2023.

[5] Encounter information from FY 2021 through FY 2024 is based on VA OIG analysis of VA's Pyramid Analytics data for hub encounters.

[6] The FY 2024 amount was reported in the FY 2024 clinical resource hub annual report. Increases in patient encounters generally spur greater expenditures.

[7] This audit did not review productivity related to positions such as nurse practitioners and physician assistants. The full scope and methodology appear in appendix A.

clinical services. Using work RVUs, VHA establishes an acceptable range of productivity for specialty group practices like cardiology and gastroenterology at VA medical facilities. This helps VHA understand its capacity to meet current and future patient demand.[8] Medical facilities are supposed to use reporting tools to monitor specialty groups' productivity and report annually on groups that do not fall within the acceptable range.[9]

The productivity of primary care physicians at facilities is measured using patient panel size (the number of patients assigned to each physician). The baseline for a primary care physician is 1,200 patients. It is adjusted based on a facility's support staff and the rooms available to arrive at the expected number; hubs strive to achieve at least 85 percent of that.[10]

What the Audit Found

Clinical resource hubs continue to see an increase in patient encounters and spending. From FY 2022 through FY 2024, the hubs realized an increase of about 81 percent in total patient encounters and about 48 percent in spending. Yet the hub specialty group practices generally did not appear to meet established minimum productivity thresholds.[11] The apparent failure to meet these thresholds may have been caused, however, by gaps and inaccuracies in the data used to measure productivity—highlighting the need for VHA to improve its data to make sure hub physicians are achieving the appropriate level of productivity.

Using the VHA reporting tool developed to measure facility physicians' productivity, the audit team found 42 percent of hub specialty group practices did not meet the minimum productivity measure during FY 2024.[12] The team found this was because the Office of Productivity, Efficiency, and Staffing (OPES) dashboard—which captures and identifies productivity data, like the minimum productivity threshold for specialty group practices—did not accurately reflect all hub physicians' workloads, underreporting data. The audit team determined this happened

[8] Specialty group practices represent cohorts of providers who deliver clinical services and have privileges to provide specialty and routine patient clinical care and related procedures. For productivity management, the group practice can refer to an entire discipline. VHA Directive 1065(1), *Productivity and Staffing Guidance for Specialty Group Practice*, amended May 19, 2023.

[9] VHA Directive 1065(1).

[10] VHA Directive 1406, *Patient Centered Management Module (PCMM) For Primary Care*, April 17, 2024. The executive director for the Office of Primary Care told the audit team there is no mandate through policy or directive for panel size; however, VISN directors' performance plans for FY 2025 called for at least 85 percent of the expected number by the end of the fiscal year. The executive director said in March 2025 the expectation for hub panel sizes is no different for medical facilities.

[11] VHA develops thresholds to measure specialty group practice productivity. An acceptable range of productivity is set to not compromise quality and patient access standards. A minimum productivity threshold is established below the lower end of the acceptable range. The audit team used the minimum threshold for productivity rather than the lower end of the acceptable range to conservatively assess productivity.

[12] The reporting tool refers to the Chief of Staff Dashboard report published by the Office of Productivity, Efficiency, and Staffing (OPES) (referred to in this report as the OPES dashboard).

because some physicians are assigned to a VISN rather than a specific medical center and because of how some hub physicians document their patient encounters. Hub physicians can document encounters at the spoke site (where a veteran presents for care) or at the host site (the facility where the hub physician's labor is allocated or mapped). The reporting tool did not consistently give physicians credit for work documented at a spoke site. Moreover, VHA lacked formal guidance on how hubs should measure and monitor specialty physicians' productivity. Without formal guidance, hub officials relied on various approaches to measure productivity, such as patient encounters and veterans served, instead of productivity metrics based on the work RVU.

Furthermore, the audit team found that without guidance on which productivity metric to use, VHA does not have a hubs-specific process to identify and improve hub services that fall outside the acceptable range of productivity. While hub officials monitored hub physicians' productivity regularly, they generally did not do annual productivity assessments or prepare required formal improvement plans.[13]

VHA's Office of Primary Care was developing a directive to establish standards and responsibilities specifically for hubs, but the OIG determined the draft directive lacked sufficient detail as of September 2025, such as what metrics the hubs should use as the basis for assessing productivity. As it refines the draft, VHA has an opportunity to clarify guidance and benchmarks to ensure hub physicians' productivity is objectively and consistently measured. Without this, VHA lacks assurance that hub services are optimized to best serve veterans.

What the OIG Recommended

The OIG made three recommendations to the under secretary for health.[14] The first was to implement procedures to ensure the data used to measure hub physicians' productivity are accurate and reflect all work of hub physicians. The second recommendation called on the under secretary to engage with appropriate officials to determine whether hub physicians should be subject to existing productivity measures. If so, VHA should issue clear guidance requiring constant adherence to existing measures; if not, it should define new productivity measures and issue detailed guidance for hubs to implement consistently. Finally, VHA should clarify oversight responsibilities for monitoring productivity, including who should implement procedures and corrective actions when productivity thresholds are not met.

[13] VHA Directive 1065(1).

[14] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

VA Management Comments and OIG Response

The acting under secretary for health concurred with all three recommendations, acknowledging the OIG's findings persisted in FY 2025 and actions need to be taken to address the findings. The National Clinical Resource Hub Clinical Service Council will review physician productivity and evaluate compliance with business rules for labor mapping and notify the appropriate VISN of any noncompliant practices. VHA will establish an integrated project team that will partner with OPES to develop recommended productivity measures and benchmarks for hub physicians. The project team will also provide recommendations to update policies related to physician productivity. Additionally, the National Clinical Resource Hub Team will review and publish hub productivity information quarterly and will provide reports to VISNs when hub productivity falls below minimum thresholds. The VISNs will be responsible for addressing underperformance. The National Clinical Resource Hub Team will also provide language that identifies the roles and responsibilities for monitoring hub performance for inclusion in the National Clinical Resource Hub Operational Guide and draft VHA Directive 1407.

The acting under secretary for health's planned corrective actions are responsive to the recommendations. The OIG will monitor VHA's progress on its proposed actions and will close the recommendations when adequate documentation has been provided to demonstrate sufficient progress on implementation and fulfillment of the recommendations' intent. Appendix B includes the full text of the acting under secretary's comments.

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Contents

Abbreviations

FY	fiscal year
MISSION Act	VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency, and Staffing
RVU	relative value unit
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

In 2018, the MISSION Act directed VA to improve veterans' access to health care in underserved areas.[15] Underserved areas are those in which the VA facility lacks staff or services to meet the needs of assigned veterans.[16] Gaps may be due in part to attrition at VA medical facilities, difficulties recruiting staff given the location of a medical facility, or an expanding veteran population.[17] VA responded by creating a hub-and-spoke model with clinical resource hubs to backstop facilities (spokes) in each of VA's 18 Veterans Integrated Service Networks (VISNs).[18] All hubs offer primary and mental health care, including suicide prevention support, but other specialty offerings vary across the hubs and are determined by each VISN. For example, only some hubs offer cardiology, dermatology, and gastroenterology clinics.

The VA Office of Inspector General (OIG) conducted this audit to assess how the Veterans Health Administration (VHA) manages the productivity of clinical resource hub physicians in primary care, specialty care, and mental health care.[19] The audit team examined hub productivity data for fiscal year (FY) 2024 and VHA's actions to develop a hub-specific directive as of September 2025. Because actions still need to be taken to improve the quality of hub provider productivity data and guidance, the OIG believes the issues identified from its analysis of FY 2024 data persisted in FY 2025.

How Hubs Work

Hubs are governed by VISNs and are supported by a host medical facility in the VISN's jurisdiction. Every VISN decides which of its facilities will host the hub. The responsibility of the host facility includes ensuring hub personnel

- are credentialed and receive privileges as medical facility staff,
- have adequate information technology support, and

[15] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

[16] VA, "MISSON Act: Underserved Areas," June 7, 2019.

[17] VHA, *Clinical Resource Hub Training & Operations Guide*, June 2019.

[18] VHA, *Clinical Resource Hubs FY 2022 Annual Report*; "Veterans Integrated Services Networks (VISNs)" (web page), VHA, accessed June 5, 2025, https://www.va.gov/HEALTH/visns.asp. VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

[19] This audit did not review the productivity of providers such as nurse practitioners and physician assistants.

- have labor mapped in accordance with guidance from VHA's Managerial Cost Accounting Office.[20]

Hubs offer the services of clinical staff to all medical facility sites in their VISN. The hub typically assigns primary care physicians to one spoke site, while mental health or other specialty physicians usually are assigned to several spoke sites. Multiple hub staff can also be assigned to one spoke site to provide comprehensive team-based care (figure 1).

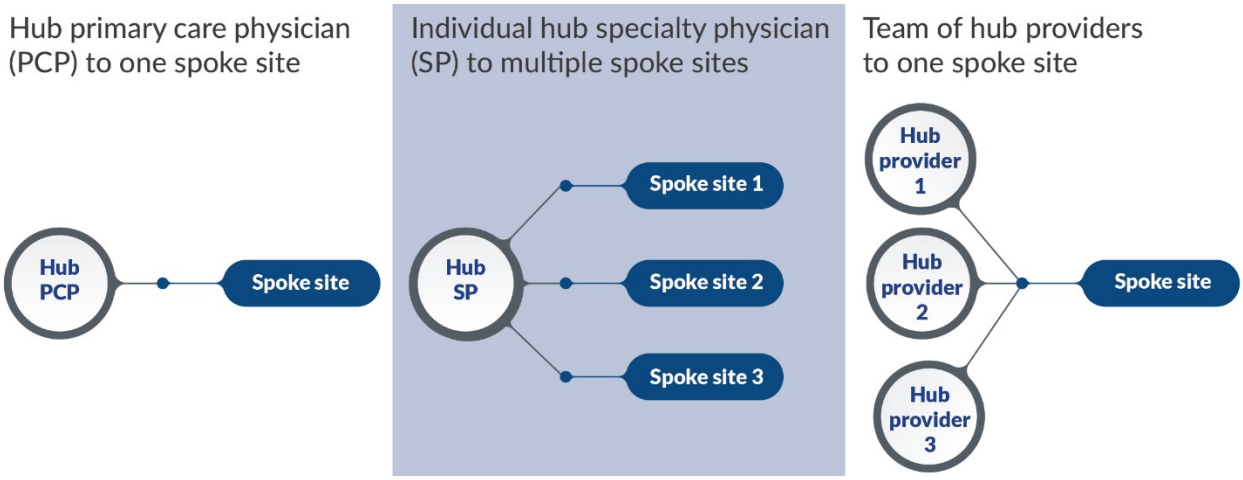

Figure 1. *Illustration of how hub clinical staff are assigned to one or more spoke sites.*
Source: VA OIG analysis of Clinical Resource Hub Training and Operations Guide*, June 2019.*

Hub staff can be assigned from anywhere in the United States; most are dedicated full time to hub work.[21] Hub services are provided virtually and in person at VA medical centers and community-based outpatient clinics, in a veteran's home, at telehealth access points in community spaces (such as libraries), or in veterans service organization facilities. From October 2023 (the start of FY 2024) through February 2025, about 68 percent of all hub encounters occurred through one of three primary telehealth modalities, while about 2 percent

[20] Credentialing is "the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system," while privileging is "the process by which a VA medical facility authorizes a [licensed independent practitioner] to independently" provide care at a facility. Labor mapping ties employees' labor to the departments where they work. VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 11, 2024; VHA Directive 1100.21(1), *Privileging*, April 26, 2023.

[21] The national hub director expressed concerns in February 2025 regarding the mandate of return to in-person work, required under the January 20, 2025, Return to In-Person Work Presidential Action. The director said hubs are a fully virtual program, and a return to in-person work could disrupt the continuity of care, reduce the flexibility of scheduling, and create barriers to access. Additionally, the director noted hub providers do not need to be physically present to deliver care, and requiring the more than 2,500 hub staff to report to VHA facilities would consume clinical spaces needed for in-person care. In June 2025, the director said the hub program experienced staff attrition due to the return-to-office requirement. However, until October 1, 2025, nonclinical staff, like medical support assistants, must return to the office—whereas clinical staff may be required to return to an office if space is available. He said whether clinical staff return is a decision for local medical facility leaders.

occurred in person.[22] The remaining encounters were completed via telephone, which is not considered part of telehealth; via secure messaging; or through a clinical team conference.[23]

Hub Governance Structure

Nationally, the hubs align under VHA's Office of Primary Care, as shown in figure 2 on the next page. The hubs benefit from an advisory board, which provides high-level guidance and support and makes recommendations regarding the sizing, staffing, governance, and use of the hubs, while encouraging the sharing of clinical resources across VISNs.[24] In addition, hubs receive consultation, education, and support from the national hub leadership team.[25]

[22] Encounter information from October 2023 to February 2025 is based on the OIG's analysis of VA's Pyramid Analytics data for hub encounters. The three modalities are known as synchronous telehealth (real-time interactive videoconferencing that allows physicians to assess, treat, and provide care to patients remotely), asynchronous or store-and-forward telehealth (the use of approved technologies and processes to acquire and store clinical information that can later be retrieved by another provider for clinical evaluation and remote patient monitoring), and home telehealth (the use of telecommunication technologies such as in-home and mobile monitoring to transmit information from the veteran's home to a VA medical facility for providing clinical care). VA, *Office of Connected Care Telehealth Manual*, June 2023.

[23] A "clinical team conference" refers to a meeting between healthcare professionals to form an integrated plan of care without a patient being present. "Secure messaging" refers to communication between a physician and patient via My HealtheVet Secure Messaging. "Common Stop Code Combinations for Audiology and Speech Pathology Clinics" (SharePoint site), VHA Audiology and Speech Pathology Services, accessed June 10, 2025. (This site is not publicly accessible.)

[24] The advisory board is composed of members from offices including the Office of Primary Care, the Office of Rural Health, and the Office of Telehealth Services.

[25] VHA, *Clinical Resource Hub Operational Guide*, August 2024.

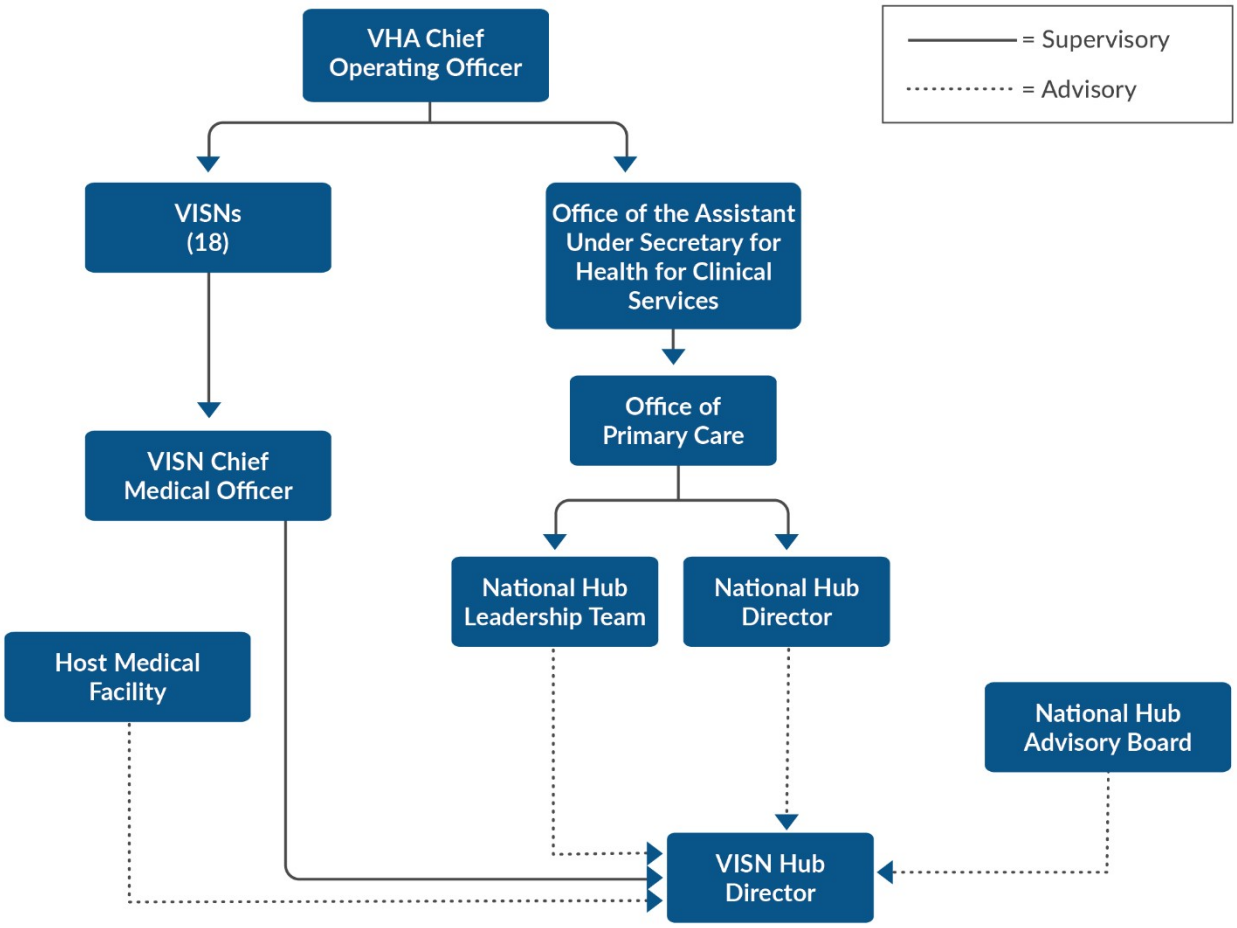

Figure 2. *Organization of clinical resource hubs within VHA.*

Source: OIG analysis of VHA organizational chart as of July 2023 (in effect during this review) and VHA's Clinical Resource Hub Operational Guide*, August 2024.*

Each VISN determines its hub's organizational structure based on distinct needs in that region. The operational guide for hubs recommends each hub director report to the VISN's chief medical officer.[26]

Funding for Clinical Resource Hubs

Hubs spent about $312 million in FY 2022, about $440 million in FY 2023, and about $462 million in FY 2024 with subsequent expected increases in funding needs.[27] Nearly all spending went toward staff salaries; smaller amounts were used to cover costs associated with training and travel.

[26] VHA, *Clinical Resource Hub Training & Operations Guide.*

[27] These amounts were provided in the clinical resource hub annual reports for FYs 2022, 2023, and 2024.

Expenditures drew on specific purpose funds from various VHA program offices, such as the Office of Rural Health and the Office of Connected Care, as well as general purpose funds from their respective VISN.[28] The need for specific purpose funding is determined in various ways. For example, an Office of Rural Health official reported each hub's funding is based on how rural a VISN is, whereas the Office of Connected Care's telehealth executive director said funding is based on a hub's specific needs. As shown in figure 3, hubs are largely funded by VISN general purpose funds.

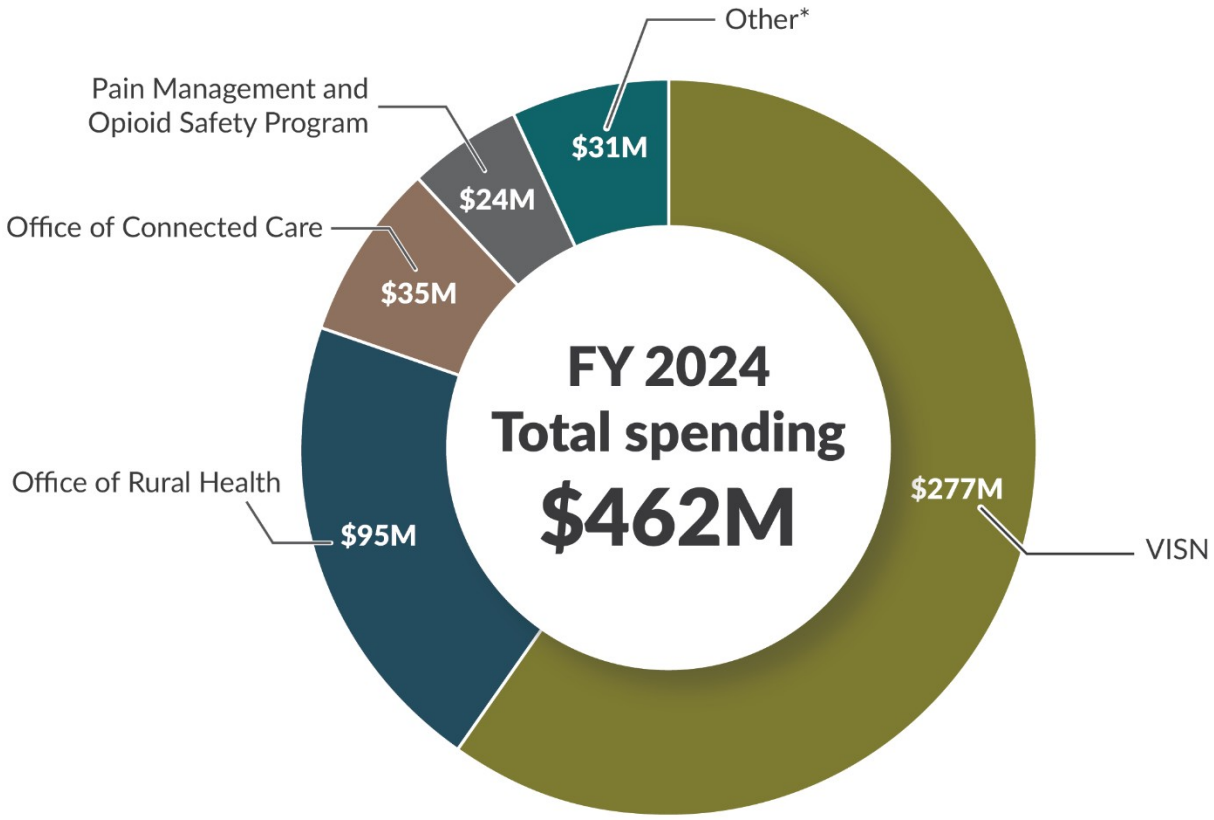

Figure 3. *Hub spending for FY 2024.*

Source: FY 2024 clinical resource hub annual report.

** Other sources of funding include the Suicide Prevention Program, Caregiver Support Program, and the Office of Women's Health.*

[28] General purpose funds are allocated based on the number of patients treated, and specific purpose funds are allocated based on legal, programmatic, or other requirements. VHA Directive 1048, *Prosthetic and Sensory Aids Service Specific Purpose Funding*, March 17, 2020.

Measuring Physician Productivity

VHA has published two directives related to facilities' physician productivity, one for specialty providers and the other for primary care providers.[29] Figure 4 provides a list of key terms to understand the productivity measures referenced in the directives. The OIG notes that formal guidance on whether these measures apply to hubs is lacking.

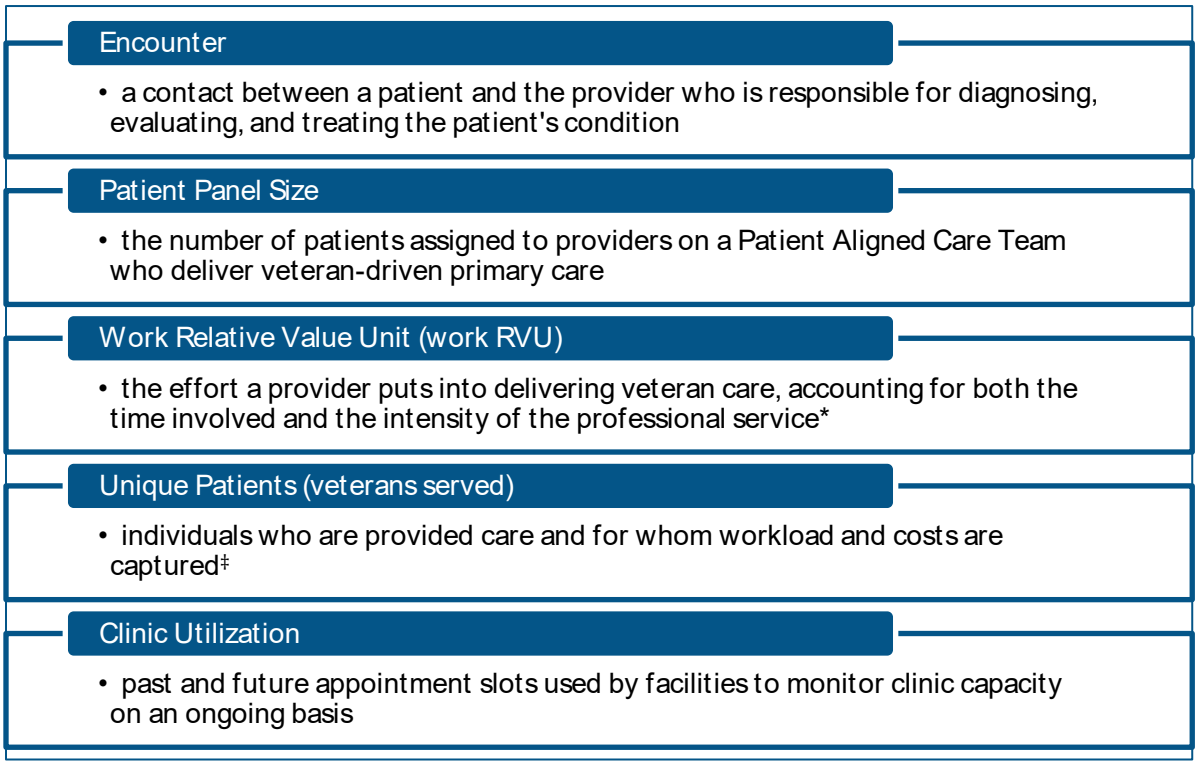

Figure 4. *Key productivity terms and definitions.*

Sources: OIG analysis of VHA Directive 1065(1), Productivity and Staffing Guidance for Specialty Group Practice*, amended May 19, 2023; VHA Directive 1406,* Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017; the VHA Support Service Center access team's clinic utilization report; the VHA Office of Integrated Care's Clinic Profile Management Business Rules, updated May 24, 2023; and Clinical User Support Reports' data definitions from the Managerial Cost Accounting Office, updated November 2021.*

** Other relative value unit components used for financial management and cost estimating for provider payments are not relevant to this report.*

‡ For this report, the audit team uses the terms "unique patients" and "veterans served" interchangeably.

[29] VHA Directive 1065(1), *Productivity and Staffing Guidance for Specialty Group Practice*, amended May 19, 2023; VHA Directive 1406, *Patient Centered Management Module (PCMM) For Primary Care*, June 20, 2017.

Physician Productivity for Specialty Care

VHA Directive 1065(1) requires productivity and staffing for specialty group practices to be monitored and assessed at least annually using standardized methods to ensure providers can deliver services to veterans.[30] While the directive does not reference hubs-specific roles and responsibilities, it does not say hubs are exempt. The following explains how relative value units (RVUs) are calculated and used:

- When physicians provide a specialty service, they use a procedure code that designates a related description, which is assigned an RVU. The number of RVUs associated with these codes is determined by the Centers for Medicare & Medicaid Services, with more complex services receiving higher RVUs. The total RVU is made up of three components: physician work, practice expense, and malpractice expense.
- Work RVUs are used to establish targets that physicians and provider group practices are measured against. Target productivity measures are established for each specialty by dividing workload (measured in work RVUs) by workforce (measured by the number of full-time-equivalent providers). Target productivity measures are used to develop an acceptable range and a minimum threshold for productivity.
- Annual assessments must be performed, and improvement plans are supposed to be developed when specialty group practices fall outside the acceptable range of productivity for the year. These responsibilities lie with facilities' specialty service chiefs, in collaboration with medical facility chiefs of staff. Information to be addressed in the improvement plans includes a summary of prior-year efforts or issues, validation of data inputs for the productivity analysis, and a review and discussion of whether staffing is sufficient for productivity improvement.[31]
- The Office of Productivity, Efficiency, and Staffing (OPES) should develop reports to monitor productivity and identify potential causes for productivity and staffing

[30] Specialty group practices represent a cohort of providers who deliver clinical services (excluding primary care) and have privileges to provide specialty and patient clinical care and related procedures. The group practice can refer to an entire discipline for productivity management purposes. VHA Directive 1065(1).

[31] According to a Chief Operating Officer memorandum, VA is updating its healthcare productivity targets to better reflect employee workload, increase efficiency, and promote consistency across the entire system. These updates will enhance transparency, promote increased efficiency and sustainability, and respond to rising healthcare costs. The new targets are consistent with current policy (VHA Directive 1065(1)) and are set by clinical area using RVUs. Because of this, VHA medical centers received a waiver and are not required to conduct the annual productivity review for FYs 2024 and 2025. Chief Operating Officer, "For Action: SET PHASE of the READY-SET-GO Campaign for Updated Productivity Targets," memorandum to VISN directors, VISN chief medical officers, medical center directors, and chiefs of staff, January 15, 2025.

concerns.[32] As of July 2025, no separate productivity measures existed for hub specialty group practices.

Physician Productivity for Primary Care

VHA Directive 1406 applies to primary care physicians. According to the national hub director, primary care hub physicians' productivity is measured using patient panel size. The directive establishes a baseline of 1,200 patients. The maximum number of patients a physician is *expected* to care for reflects a baseline adjustment for factors like support staff and room availability.[33] Hub primary care physicians strive to achieve at least 85 percent of the adjusted number.[34]

Table 1 compares the two directives.

Table 1. Relevant Features of VHA Directives on Productivity

Item	VHA Directive 1065(1) Specialty Providers	VHA Directive 1406 Primary Care Providers
Unit of measure	Work RVU	Patient panel size (baseline=1,200 patients)
Productivity calculation	Work RVUs divided by the number of providers	N/A*
Data source	OPES productivity data	Clinical Resource Hub Panel Size Report‡
Remediation for provider groups	Annual reviews, with improvement plans for low performers	N/A

Source: OIG analysis of VHA Directive 1065(1) and VHA Directive 1406.

** Although the target for primary care physicians of 85 percent of the expected number is not referenced in Directive 1406, this is the expectation for medical facilities and hubs as reported by the executive director of the Office of Primary Care.*

‡ *This report is published on the clinical resource hub portal.*

[32] According to VA's functional organizational chart, OPES—which is under VHA's Office of the Assistant Under Secretary for Health for Quality and Patient Safety—helps VHA healthcare leaders make educated decisions about their facilities and VISNs through data-driven analytics. It develops management tools to monitor clinical productivity among other objectives.

[33] VHA Directive 1406.

[34] The executive director for the Office of Primary Care told the audit team in March 2025 there is no policy or directive that mandates panel size; however, VISN directors' performance plans for FY 2025 required facility panel sizes to be at least 85 percent of their modeled capacity at the end of the fiscal year. The executive director said the expectation for hub panel sizes is the same as that for medical facilities.

Patients Served by Hubs

According to VA data, the number of veterans receiving care through clinical resource hubs increased from about 188,000 in FY 2021 to about 261,000 in FY 2022 (about 38 percent) before climbing to about 502,000 in FY 2024 (about a 166 percent increase from FY 2021). The number of veteran encounters associated with hubs rose substantially as well. From FY 2021 to FY 2024, the number of encounters more than doubled from almost 482,000 to about 1.2 million (an increase of about 151 percent). VA's data also revealed that veterans receive care through the hubs multiple times a year.

The under secretary for health issued a memo in May 2024 that highlighted the use of clinical resource hubs to support VHA's efforts to reduce overall staffing levels without sacrificing care provided to veterans.[35] Specifically, the memo said VHA should consider redistributing the work of departing staff to other areas, such as hubs. As a result, the hubs could see continued growth to provide services to veterans.

Figure 5 shows the number of veteran patients and associated encounters from FY 2021 through FY 2024.

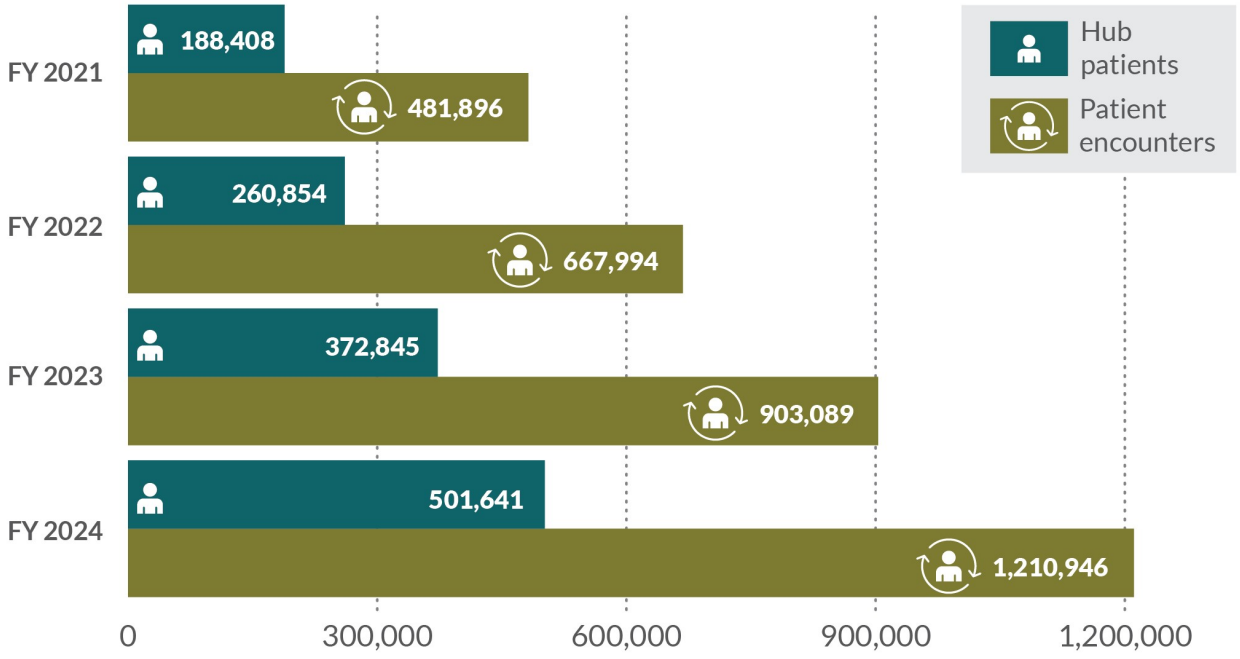

Figure 5. *Total patients and encounters for the hub program, FYs 2021–2024.*

Source: VA OIG analysis of VA's Pyramid Analytics data for hub encounters and patients served.

[35] Under secretary for health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to VISN directors, medical center directors, and VHA central office program office leaders, May 31, 2024.

Results and Recommendations

Finding: Improved Data and Clearer Guidance Would Help VHA Ensure Optimal Productivity of Hub Providers

Despite the significant increases in both veterans using hubs and their number of encounters, the OIG found many hub specialty group and primary care practices did not appear to meet established minimum productivity thresholds. However, what appears to be a deficiency may be affected by gaps and inaccuracies in VA data—underscoring the need for improvements to ensure appropriate levels of productivity.

The audit team found that 11 of 26 hub specialty group practices identified in the Chief of Staff Dashboard report published by OPES (referred to in this report as the OPES dashboard) did not seem to meet minimum productivity measures during FY 2024.[36] As mentioned earlier, the hubs *appeared* to fall short because the dashboard report OPES developed to capture and report data for monitoring the productivity of specialty group practices often underrepresented the workload of hub physicians. The team determined these issues occurred because some physicians were assigned to a VISN rather than a specific medical center, from which the data were drawn, and because some hub physicians documented their encounters in ways the OPES dashboard could not capture. For example, the OPES dashboard did not capture work that hub physicians performed that was documented at a spoke site.

Furthermore, VHA did not set hubs-specific productivity measures. Without formal guidance on how hubs should measure and monitor their specialty physicians' productivity, hub officials used various measures—such as the number of encounters and veterans served—instead of the productivity targets established based on the work RVU, which is the standard for specialty group practices established before the creation of hubs. This lack of uniformity in metrics not only affects the evaluation of individual physicians' performance but also prevents VHA from effectively comparing productivity across hubs.

Additionally, VHA lacks hubs-specific processes that would help leaders identify underperforming hub specialty group practices and inform improvements. Hub officials said they were doing regular monitoring, but the team found hubs generally did not perform or take part in the annual productivity assessment required (unless waived) under VHA policy to identify specialty group practices that fall outside the acceptable range of productivity. Therefore, hubs

[36] The audit team examined hub productivity data for FY 2024 and VHA's actions to develop a hub-specific directive as of September 2025. Because actions still need to be taken to improve the quality of hub provider productivity data and guidance, the OIG believes the issues identified from its analysis of FY 2024 data persisted in FY 2025.

did not prepare the required formal improvement plans to address practices that might have fallen short.[37]

The OIG learned in October 2024 that VHA's Office of Primary Care was developing a hubs-specific directive with clearer standards and responsibilities. But as of September 2025, the draft the office provided lacked a crucial detail: the metric hubs should use as a basis for productivity, whether the work RVU or another one. As it refines this draft, VHA should issue guidance on measuring hub physicians' productivity and either clarify that the annual assessment requirement applies to hubs or develop new processes tailored to them. Furthermore, VHA should specify who must decide what actions to take when productivity measures are not met.

As hub spending continues to increase along with the number of veterans served, VHA must be able to measure hub physicians' productivity, particularly for specialty groups. The methods hubs use to show work is increasing, but there are no benchmarks for the various metrics—as there are for the work RVU—that could help ensure more efficient application of hub resources. Without benchmarks, VHA does not know whether hubs are as productive as they could be.

This finding is based on the following determinations:

- Errors and gaps in data impeded accurate assessments of whether hub specialty group practices met minimum productivity thresholds.
- The lack of formal guidance specific to hubs leaves VHA without a consistent benchmark to measure, monitor, and address specialty groups' productivity.
- VHA lacks hubs-specific processes to improve less-productive hub specialty group practices.
- The Office of Primary Care's draft directive on clinical resource hubs needs more detail.

What the OIG Did

The audit team used the OPES dashboard to identify productivity measures and thresholds for hub specialty groups and associated physicians. This dashboard includes a filter that allowed the team to identify hub physicians, along with their respective groups—cardiology, nephrology, psychology, or other—and their associated productivity measures for FY 2024.[38] The team used these data to analyze the specialty groups and physicians to determine who did not meet the

[37] VHA Directive 1065(1).

[38] The productivity measure is a number that is generated and used to compare productivity to established thresholds. This number is based on the sum of the work RVUs generated by specialty physicians. This number is calculated for groups and individual physicians.

minimum benchmark for productivity.[39] The team identified six VISN hubs (those for VISNs 1, 2, 7, 9, 16, and 23) where most group practices did not meet the minimum benchmark based on the available data. The team also identified one hub (VISN 8) for which no physicians appeared in the dashboard. Additionally, the team spoke to directors from six hubs with group practices that appeared to be above the minimum threshold to understand how these hubs measure and monitor physicians' productivity.

The team sent the productivity reports to the six less-productive hubs to assess the accuracy of the information in the reports and followed up with the VISN 8 hub to determine why none of its physicians appeared in the dashboard. The audit team also used a report on staff panel size from the clinical resource hub portal to determine whether hub primary care physicians met requirements.[40] Finally, the team conducted extensive virtual interviews to understand how hubs measure and monitor productivity, as well as how hubs are funded. The full scope and methodology appear in appendix A.

Errors and Gaps in Data Impeded Accurate Assessments of Whether Hub Specialty Group Practices Met Minimum Productivity Thresholds

The audit team found hub patient encounters increased on average about 36 percent a year from FY 2021 through FY 2024. Despite the continued increases, the data suggested many hub specialty group practices did not meet the minimum productivity threshold for specialty physicians in FY 2024.[41] Similarly, many hub primary care physicians seemed not to meet the primary care productivity measure.

However, the team found that available data sources did not accurately report all hub specialty group physicians' productivity information because of how their labor is mapped and where they record their work—making it difficult to rely on existing data sources to determine whether hub specialty practice groups and their physicians are meeting established productivity measures.

Unreliable Measures for Specialty Group Physicians Showed Minimum Thresholds Were Not Met

Productivity for specialty groups and primary care physicians is measured differently. VA medical facilities are supposed to monitor and assess specialty group practices' productivity using standardized methods to ensure specialty physicians deliver appropriate, high-quality, and

[39] The audit team used the minimum threshold for productivity rather than the lower end of the acceptable range to be conservative in analyzing productivity.

[40] The clinical resource hub portal is an internal VA SharePoint site that includes information on services provided by the hubs, as well as data on staffing, encounters, patient panel size, and other information related to the performance of the hubs.

[41] The audit team excluded primary care physicians from the measurement of the specialty group practices because they are not considered specialty physicians. VHA Directive 1065(1). They are considered separately in this report.

timely health care and services to veterans. As previously noted, the standard way to measure specialty group practices' productivity relies on work RVUs.[42]

VHA establishes an acceptable range of productivity for specialty group practices at VA medical facilities to understand their capacity to meet current and future patient demand.[43] To that end, OPES's reporting tools—such as the Facility Outlier Report and the OPES dashboard—are designed to allow medical facilities to monitor specialty groups' productivity and determine whether they are meeting established productivity measures.[44] Using the OPES dashboard, the audit team found that about 42 percent of the hub specialty group practices did not meet the minimum threshold for productivity during FY 2024.[45] In these practice areas, the team found 316 of the 627 reported specialty care hub physicians did not meet the minimum threshold. For example, the dashboard-reported minimum productivity threshold for cardiology in FY 2024 was 6,563 (calculated as the median of the specialty group practice adjusted downward based on the range of productivity values previously recorded for the group).[46] However, the productivity of cardiologists in the VISN 1 hub measured only about 4,871 using work RVUs and adjusted workload. Of the nine VISN 1 hub cardiologists identified in the OPES report, only one-third were recorded as meeting the minimum threshold.

The audit team learned that some hub leaders were uncertain whether VHA's guidance on monitoring specialty physicians' productivity applied to the clinical resource hubs. As a result of this lack of clarity, some hub leaders said they were using other data to measure productivity instead and developed other standards to measure their hub outcomes.

Meanwhile, the national hub director told the audit team in October 2024 that primary care physicians' productivity is measured based on patient panel size, as defined in VHA Directive 1406. The baseline, which is adjusted for factors like the number of available exam rooms and the number of female veterans, is 1,200 patients.[47] According to the executive director for the Office of Primary Care, VISN directors' performance plans for FY 2025 said panel sizes for a facility must be at least 85 percent of their modeled capacity at the end of the fiscal year—yet the audit team's analysis of the hub portal dashboard found about 45 percent of hub primary

[42] VHA Directive 1065(1).

[43] The acceptable range of productivity is the range of productivity that encompasses the set of acceptable group practice productivity values for a fiscal year. The range is set at the medical facility group practice level and assumes that production does not compromise quality and patient access standards.

[44] VHA Directive 1065(1).

[45] The minimum productivity threshold is established below the lower end of the acceptable range. The audit team used the minimum threshold for productivity rather than the lower end of the acceptable range to conservatively assess productivity.

[46] The productivity measures are used to compare and measure a physician's productivity.

[47] VHA Directive 1406. According to this directive, panel size is adjusted to factor in the complexities of primary care issues for female veterans; therefore, the panel capacity for the proportion composed of women veterans is reduced by 20 percent.

care physicians did not meet that threshold as of September 11, 2024 (which was just 19 days before the end of FY 2024).

Hub directors and service chiefs gave various reasons that primary care physicians may not meet their productivity thresholds: Hub primary care physicians might go to locations too small to permit being assigned 1,200 patients; they may need time to set up clinics; and they may gradually ramp up their patient loads. Additionally, hub officials said the number of support staff at these locations may be insufficient. Care provided by hub physicians is generally provided via clinical video telehealth, where the veteran is seen at a medical facility, but the hub physician is in another location. This requires the services of facility support staff, like nurses and telehealth technicians, who help the veteran during their appointment. Not having available support staff can affect the number of patients who can be seen at that medical facility.

Hubs Rely on Different Data to Measure Their Specialty Physicians' Productivity

Eight of the 13 hub directors the team interviewed reported using RVU-based productivity targets or reports developed by OPES to measure physicians' productivity.[48] Most hub directors who reported using OPES reports said they do not rely solely on those reports because they do not capture all work hub physicians perform. The directors said they use other data to measure productivity, like the number of veterans served, clinic utilization, and patient encounters.[49]

Some hub directors said they rely on reports developed by their staff or on reports included in the dashboards available on the clinical resource hub portal. The hub dashboard includes information on encounters and veterans served, as well as patient panel size and capacity for primary care physicians. The data are available by fiscal year at the national and hub level.

The audit team learned that the hub program has been working on other tools to add to its dashboard that can be used to assess the hub value, along with measuring physicians' productivity. The VISN 1 hub director reported working with the national hub program office on a cost-avoidance tool to show how much money was saved when veterans received service through a hub versus in the community. A VISN 9 hub health system specialist similarly reported the national hub program has been developing a report that would identify productivity thresholds for specialty group practices. The team noted, however, the data used to populate this

[48] The 13 hub directors comprise the six directors from hubs that appeared to have less-than-optimally productive group practices, the director from the VISN that did not appear in the dashboard report (VISN 8), and six directors from hubs that appeared to have more-than-optimally productive group practices.

[49] For example, one hub director said spoke sites, on request, provide encounter data for a physician in a similar specialty at a facility, so they can see how their physicians compare. The director also mentioned looking at encounters nationally, by VISN, and by provider to see how the hub compares.

report were coming from the same source as the OPES dashboard report and, therefore, may be incomplete.

Available Data Sources Do Not Capture or Are Not Suited to Monitor Hub Specialty Groups' Productivity

Medical facilities are supposed to use OPES's tools to determine whether specialty groups are meeting productivity thresholds for a given specialty.[50] However, the audit team found OPES reports did not capture all hub physicians, making it difficult to determine whether they and their respective specialty groups were truly meeting established productivity measures.

The OPES dashboard includes a filter that allows users to identify hub physicians. Using this, the audit team identified 794 hub physicians in the dashboard report as opposed to the 925 hub physicians identified in a hub staff listing.[51] One discrepancy in the numbers related to missing physicians was due to a hub assigning its physicians to a VISN instead of a medical center where they would have been included in the dashboard. Namely, the report for the VISN 2 hub showed only the psychiatry and psychology specialty groups, even though hub staff included other specialty care and primary care physicians. The hub director said the specialty care and primary care physicians were assigned to VISN 2 rather than a particular medical facility.

Officials from OPES told the audit team they included a flag in the dashboard report to identify hub physicians and their productivity information based on how their labor is mapped at the host facility they are assigned to.[52] When mapping a hub physician, host facilities are supposed to set up a separate cost center with an "HB" suffix, which is used to track hub staffing and workload.[53] But OPES officials said there is no way to map labor to a VISN, and when a hub assigns staff to a VISN, the hub loses its ability to capture those physicians' productivity.

The audit team also found the dashboard identified some physicians who are not part of the hubs as hub physicians. Specifically, physicians associated with the hematology–oncology specialty group practice were reported as being part of the VISN 6 hub, but according to a hub program analyst for that VISN, those physicians are part of the national teleoncology program at the Durham (North Carolina) VA medical facility. The team determined the error was because the facility mapped them to a cost center that included the "HB" suffix.

[50] VHA Directive 1065(1).

[51] This OIG review was based on the team's data pull from the OPES dashboard for October 1, 2023, through September 30, 2024. The team obtained a hub staff listing from the clinical resource hub portal as of the end of FY 2024 as well.

[52] The OPES dashboard report includes a drop-down option that allows the user to filter data on the hub physicians. Without this filter, the report identifies all physicians regardless of whether they are facility or hub physicians.

[53] VHA Managerial Cost Accounting Office, *Clinical Resource Hub (CRH) – MCA ALBCC Guidelines*, November 13, 2019. An account-level budget cost center identifies where work occurs and houses the costs and hours for the products or services provided.

OPES officials said the errors in capturing all hub physicians' workloads were due to the methods OPES uses to identify hub physicians, which is based on current guidance and does not take into account hubs that track physicians' labor in different ways. These officials said if they had a framework everyone uses, they could establish a way to identify all hub physicians' workloads.

Established Productivity Measures May Not Accurately Reflect the Work Hub Physicians Perform

Compounding the data accuracy issues, some hub directors said RVUs are not always comparable to reflect the work done by hub staff. The audit team found hub specialty care physicians are generally mapped to hub facilities that are identified as level 1a (high complexity) facilities, and their productivity measures are based on the measures established for those facilities.[54] But the VISN 17 hub director, for example, said the complexity of the work hub physicians do—such as a hub cardiologist providing care to veterans in rural areas—is less complex than services provided by physicians at a level 1a facility.[55]

As described previously, the RVU focuses on the effort a provider puts into delivering veteran care, accounting for both the time involved and the intensity of the professional service. When physicians provide a service, they use a procedure code to describe the service provided, which is assigned an RVU. Therefore, in theory, complexity of care is already accounted for in the establishment of the RVU.

To assess hub officials' concerns about the comparability of work at hubs versus medical facilities, the audit team conducted an analysis using the dashboard report on the productivity measures of specialty group practices from 10 hubs against corresponding groups at level 1a (most complex) and level 3 (least complex) medical facilities in the hub VISNs.[56] The analysis results generally showed hub specialty practice groups appeared less productive than their counterparts at level 1a facilities, but as noted, the OPES dashboard report may not capture all hub physician productivity data—which limits its usefulness in comparing hub physicians' productivity to that of physicians at medical facilities. The analysis also showed some hub

[54] VHA medical facilities are rated based on complexity, with 1a being the most complex and 3 being the least complex. A level 1a facility usually has a high volume of high-risk patients, offers the most complex clinical programs, and operates large research and teaching programs. In contrast, facilities with a low volume of low-risk patients, offering few or no complex clinical programs, and operating small or no research and teaching programs are typically level 3 facilities. National Academies of Sciences, Engineering, and Medicine, 2020, *Facilities Staffing Requirements for the Veterans Health Administration–Resource Planning and Methodology for the Future*, Washington, DC: The National Academies Press, https://doi.org/10.17226/25454.

[55] VHA Directive 1065(1). This directive states, "Specialty group practice productivity levels must only be compared when there is relative homogeneity in the practice setting."

[56] The team used the Chief of Staff Dashboard report to identify the productivity measure for specialty group practices in hubs and medical facilities for FY 2024 (October 2023 through September 2024).

specialty practice groups appeared less productive than those in level 3 facilities—but the hubs and the level 3 facilities did not offer the same specialty services. For example, the hub for VISN 1 (VA New England Healthcare System) offers cardiology services, whereas the Central Western Massachusetts Healthcare System does not. Conversely, the Central Western Massachusetts Healthcare System offers dermatology services, while the VISN 1 hub does not.

The team also compared the overall work RVUs generated per outpatient encounter by the hubs to medical facilities during FY 2024 and found the hubs generated a higher average work RVU per encounter. Table 2 shows the comparison. Additionally, hub top 10 most frequently performed procedures generated an average work RVU per encounter of 2.28 compared to 2.20 for medical facilities during the same time.

Table 2. Outpatient Encounters and Work RVUs for Hubs and Medical Facilities, FY 2024

Location	Encounters	Procedure work RVU	Average work RVU per encounter
Hubs	1,210,946	2,097,453	1.73
Medical facilities	123,345,865	137,130,470	1.11

Source: VA OIG analysis of VA's Pyramid Analytics data for outpatient encounters during FY 2024.

The audit team was not able to validate hub officials' contention that the work hub physicians perform is not comparable with work performed by medical facility physicians. While the first analysis appears to support the argument, it is difficult to rely on this comparison because of missing data in the dashboard report and differences in the specialties offered. The second analysis contradicts the claim because the hubs appear to be more productive when looking just at encounters and work RVUs. The results of the team's analysis highlight the need to identify a way to consistently measure hub physicians' productivity.

Another hub director said RVUs do not capture all work hub specialty physicians perform in his hub—thus, underreporting their true workloads. The VISN 9 hub director said his hub's environmental service physicians provide burn pit and toxic exposure registry exams, actions that do not generate the "encounterable [patient] workload" needed to assign RVUs. That is, the work they perform is not accounted for in the dashboard report. Therefore, data from the OPES reports would suggest these physicians are not meeting minimum performance measures (example 1) when, in fact, there is insufficient data to make that determination. Only the VISN 9 hub offers environmental health and occupational health services, so this particular weakness may not affect other VISNs' hubs.

Example 1

The VISN 9 hub environmental health physicians group practice, which is made up of one physician, had a minimum productivity threshold of 2,368 in

September 2024 according to the OPES dashboard, but that physician had a productivity measure of only about 423. The environmental health service chief said she uses other ways to measure productivity, including the number of toxic exposure registry screenings per week (set at four) and the number of calls attempted per day (set at 20). According to the report the service chief uses to track productivity, even by this metric, the physician did not meet two of the three targets due to performing an insufficient number of toxic exposure screenings but demonstrated productivity above what the 423 score would suggest.

Furthermore, the audit team found that how hub physicians document their work affects OPES's ability to capture workloads and measure productivity. While interviewing VISN hub leaders, the team learned hubs used two methods to document clinical encounters:

- In the first, a hub physician documents the progress note and encounter at the spoke site (where the veteran presents for care). When this happens, the hub does not receive credit for the physician's encounter because the encounter was documented at the spoke site rather than at the hub's host site (the facility the physician's labor is mapped to).
- In the second, a physician creates a progress note at the spoke site but documents the encounter at the host site. In this instance, the hub receives credit for the encounter.

Example 2 illustrates how this difference in documentation affects reported productivity.

Example 2

When reviewing entries in the OPES dashboard for hubs that record encounters at a spoke site, the audit team identified a hub physician who appeared to have provided care at only one medical facility. However, the same type of entries in a VA Pyramid Analytics report showed the hub physician had provided care at four medical facilities—evidencing additional encounters not credited to the hub physician. In contrast, when the team found encounters recorded at the host site where physicians' time was mapped, those engagements were generally being captured in the dashboard, and the hub physician was given credit for all completed encounters.

VHA needs to ensure all hub physicians' workloads are fully captured and accounted for in the data sources used to measure physician productivity. To this end, the OIG recommends the under secretary for health implement procedures to monitor the data used to measure productivity to ensure the data accurately reflect the complete work of hub physicians.

Additionally, the productivity of specialty group practices must be compared only when there is relative likeness in the practice setting.[57] Therefore, after establishing procedures to monitor data, VHA needs to determine whether it is appropriate for hub specialty group practices and their physicians' productivity to be measured against targets based on the complexity level of their host facility, like those for a level 1a complexity facility. Defining appropriate and consistent ways to measure hub physicians' productivity will help hubs optimize their capacity to provide services to veterans.

The Lack of Formal Guidance Specific to Hubs Leaves VHA Without a Consistent Benchmark to Measure, Monitor, and Address Specialty Groups' Productivity

Since establishing the hubs, VHA has not issued hubs-specific productivity standards, nor has it clarified whether existing standards for medical facilities' primary care and specialty group physicians should be used to measure hub physicians' productivity.[58] For instance, while VHA's directive on specialty group practices does not reference hubs-specific roles and responsibilities for monitoring productivity, it also does not say hubs are excluded from this monitoring.[59] Yet hub directors said they have not received guidance from VHA on which benchmarks they should use to monitor and measure hub specialty physicians' productivity, and this leaves hub directors without the certainty they need to consistently and accurately measure productivity.

Although patient encounters can be used to show how much work a physician performed throughout a year, no standard or measure indicates how many encounters represent an appropriate number for a physician. As figure 5 previously demonstrated, encounter data alone show from FY 2022 through FY 2024, the hubs have increased their workloads from about 668,000 encounters to about 1.2 million.[60] The average annual encounters per hub clinical full-time-equivalent position increased from about 648 to almost 800.[61] However, these figures do not reflect encounters by service or individual physician, and VHA has not developed a

[57] VHA Directive 1065(1).

[58] VHA Directive 1065(1) establishes productivity measures for specialty group practice, and VHA Directive 1406 establishes the baseline capacity for a patient panel for primary care physicians.

[59] VHA Directive 1065(1).

[60] Encounter numbers are based on the team's analysis of VA's Pyramid Analytics data for hub encounters and patients served from FY 2021 through FY 2024.

[61] To calculate the average annual encounters per hub clinical full-time-equivalent positions, the team identified the total number of hub clinical positions—using the clinical resource hub portal—at the end of FY 2022 and FY 2024 and divided those numbers by the number of encounters for those years.

benchmark that can be used to measure this growth.[62] For example, the VISN 9 hub has one full-time cardiologist whose annual average encounter number for FY 2024 was about 821; by comparison, the VISN 19 hub has two full-time cardiologists who totaled 1,134 (or about 567 each) encounters in FY 2024.[63] But VA cannot assess optimization because it lacks a productivity standard that takes into account complexity and other factors, or a benchmark for encounters.

Using encounters as a metric requires capturing *all* workload. Yet the audit team found encounter data available on the hub dashboard did not accurately reflect all those completed by hub physicians. The VISN 16 hub director said, as the team observed and noted above, when hub physicians go on-site to medical facilities to provide in-person services to veterans, the work is not captured as an encounter in the hub dashboard. Example 3 elaborates on this gap in the data.

Example 3

According to the hub dashboard, a gastroenterologist with the VISN 16 hub had 1,240 encounters in FY 2024. However, when identifying encounters at all facilities where this physician provided service, the team found the physician had 1,834 encounters. The dashboard understated this physician's workload by almost 600 encounters.

While the hub dashboard, along with hub-developed reports, may include useful information about physicians' workloads, the value is limited without benchmarks. The absence of consistent measurements makes it difficult for VHA to compare physician productivity within and across the hubs.

In its second recommendation, the OIG asks the under secretary for health to work with appropriate officials, such as Office of Primary Care and clinical resource hub leaders, to determine whether hubs should be subject to existing productivity measures and, if so, issue clear guidance requiring compliance. If not, officials should clearly define what should be used and issue thorough guidance on the steps hubs must take to measure physician productivity consistently.

[62] VHA provided the audit team with a copy of the draft for VHA Directive 1407, *Clinical Resource Hubs*. As of September 2025, the directive did not establish benchmarks or measures for hub physician productivity. Recommendation 2 addresses the need for VHA to determine whether hub physicians should be subject to existing productivity measures or whether VHA should clearly define what measures should be used.

[63] According to the clinical resource hub portal dashboard, the VISN 9 hub cardiologist started in the hub on April 7, 2024. The team annualized the number of encounters for comparison purposes.

VHA Lacks Hubs-Specific Processes to Improve Less-Productive Hub Specialty Group Practices

Medical facilities are supposed to review specialty group practices' productivity annually.[64] When a group falls outside the acceptable range of productivity, service chiefs are supposed to develop improvement plans. The medical center director is then responsible for reviewing these plans and submitting them to the VISN director for final approval. These plans should include a summary of prior-year efforts or issues, validation of data inputs for the productivity analysis, and a review of any potential issues related to insufficient support staffing required for productivity improvement.[65] But most service chiefs of the six hubs that the OIG identified as being less-than-optimally productive using the productivity data reported in the dashboard report did not perform an annual review of their specialty group practices as required. The same was true for service chiefs from the hub excluded from the dashboard report. Consequently, hub service chiefs reported they generally did not develop formal improvement plans for specialty group practices the OIG identified as falling short.

For example, the audit team found the virtual eye care service in the Minneapolis VA Health Care System in Minnesota did not meet the productivity threshold, based on the team's data assessments, which would require an improvement plan. The VISN also identified this facility as underperforming and developed a plan that included information related to the VISN 23 hub specialty group practice (ophthalmology). The plan highlighted problems with the OPES dashboard report—specifically, that it did not capture all work by physicians at facilities other than where they were coded. This was one of only a few instances across the six less-than-optimally-productive hubs where a specialty service was included in an annual review performed by the VISN or a facility improvement plan. However, while interviewing VISN 23 officials, the team learned the hub service chief—the person who would be responsible for effecting any corrective action—was unaware of the VISN 23 improvement plan or the inclusion of the hub's group practice. This instance shows the importance of guidance that not only clarifies the need for conducting annual reviews and developing improvement plans but also emphasizes communication among all concerned parties.

Even though the hubs do not generally review specialty group practice productivity yearly, the audit team found the hubs do regularly monitor physicians' productivity. Hub directors reported meeting with VISN leaders (generally the deputy chief medical officer and the chief medical officer) at least quarterly to discuss performance, and the service chiefs said they meet with their physicians weekly or every other week to discuss productivity. Hub officials said these

[64] According to the OPES director, medical facilities received a waiver from the annual review requirement for FYs 2024 and 2025 because VA updated healthcare productivity targets in January 2025. The team's discussion with hub officials regarding the annual review requirement was not focused on a certain year but was in reference to whether they had ever done or taken part in an annual productivity review.

[65] VHA Directive 1065(1).

discussions usually focus on increases or decreases in veterans served and the number of encounters, as well as reasons for any decreases. Most said the discussions generally do not produce formal action plans to address productivity issues.

Hub directors and service chiefs generally attributed decreases in specialty service encounters to factors such as referring physicians' lack of awareness of hub services and issues with scheduling. Officials said attempts to address challenges and increase workloads include meeting regularly with medical facility service chiefs, talking to medical facility staff to reeducate them about the hubs, and proactively reaching out to facilities that are not using the hubs to see whether the facilities need help.

After establishing processes to measure hub physicians' productivity, VHA should ensure hubs not meeting standards comply with requirements to develop improvement plans. These steps should include clarifying who specifically has the oversight responsibility to monitor productivity and act when measures are not met. Role delineation will also help make certain that hubs address data accuracy issues and provide information to the advisory board and national leaders of the clinical resource hub program that helps identify enterprise-wide issues. The OIG's last recommendation is for the under secretary of health to clarify the oversight responsibilities for monitoring hub physicians' productivity, including detailed procedures and actions that should be taken when thresholds are not achieved.

The Office of Primary Care's Draft Directive on Clinical Resource Hubs Needs More Detail

According to the national hub director interviewed in August 2024, a hubs-specific directive is being developed. A review of the draft directive showed the Office of Primary Care would be responsible for the directive's contents and that it establishes standards and responsibilities for hubs. This includes promoting the use of resources and technologies across VHA to resolve issues like staff attrition or gaps in clinical or specialty services at a VA medical facility.[66] According to the national hub director, this draft directive was with the Office of Governance, Regulations, Appeals, and Policy as of July 2025. While the draft offers information on developing productivity targets and providing oversight of the hubs, the OIG notes that it does not address what specifically hubs should use to measure productivity (such as encounters, clinic availability, work RVUs, or some other metric). Additionally, it does not provide standards or thresholds—as Directive 1065(1) establishes with its use of work RVU-based productivity measures—that should be used to monitor and assess the productivity of hub specialty group practices and physicians. Last, the draft does not address what hubs should do when a specialty group practice does not meet established standards or thresholds, as VHA Directive 1065(1) does when it requires medical facilities to develop an improvement plan.

[66] VHA Directive 1407.

As discussed, VHA's lack of guidance has already resulted in inconsistencies in how hubs measure physician productivity, making it difficult to compare within and across hubs. It has also hindered determining whether the hubs are optimizing resources to enhance veterans' access to quality care. Establishing a consistent methodology to measure hub physicians' productivity will position VHA to better understand hub capacity to meet current and future patient demands and to decide whether to expand hub services.

Conclusion

Clinical resource hubs are increasingly used in VHA to provide needed care to veterans, as evidenced by the increase of about 166 percent in the number of veterans who accessed care from a hub physician from FY 2021 through FY 2024. However, weaknesses in how VHA measures hub physicians' productivity limits its ability to determine to what extent hubs deliver care to veterans efficiently. The lack of standardized metrics, combined with data inaccuracies and inconsistent reporting, makes it difficult for VHA to effectively monitor hub performance and optimize service capacity. To address these challenges, VHA should consider implementing a more structured methodology to measure hub productivity, one that captures and benchmarks all hub physician workloads accurately. Taking these steps will help VHA meet the growing demand for hub services while ensuring their long-term success and sustainability.

Recommendations 1–3

The OIG recommends the under secretary for health take the following steps:[67]

1. Implement procedures to monitor the data used to measure productivity to ensure the data accurately reflect the complete work of clinical resource hub physicians.
2. Work with appropriate officials, such as Office of Primary Care and clinical resource hub leaders, to determine whether hub physicians should be subject to existing productivity measures. If so, issue clear hubs guidance requiring adherence; if not, clearly define what should be used, and issue thorough guidance on the steps hubs must take to measure physician productivity consistently.
3. Clarify oversight responsibilities for monitoring productivity measures, including detailed procedures and actions that should be taken when thresholds are not met.

VA Management Comments

The acting under secretary for health concurred with the recommendations, acknowledging the OIG's findings persisted in FY 2025 and actions need to be taken to address those findings. To

[67] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

address recommendation 1, the National Clinical Resource Hub Clinical Service Council will review physician productivity data and take action to (1) review prior work that examined the visibility of interfacility physician productivity measures and data integrity, (2) evaluate compliance with business rules for labor mapping and interfacility physician workload capture, and (3) formally notify the accountable VISN director of any instances of noncompliance quarterly. Additionally, the council will provide two quarterly progress reports to the assistant under secretary for health for clinical services with a goal of monitoring 90 percent of data used.

In response to recommendation 2, VHA will establish an integrated project team to analyze hub physician clinical care delivery models and processes. This team will develop recommended productivity measures and benchmarks for hub physicians and provide recommendations to update relevant policies as they relate to physician productivity. OPES will partner with the integrated project team to provide subject matter expertise.

For recommendation 3, the National Clinical Resource Hub Team will be responsible for overseeing and monitoring clinical resource hub productivity. The team will review and publish hub clinical practice area productivity on a quarterly basis and will provide reports to VISN leaders when VISN hub productivity falls below minimum thresholds. The VISNs will identify and execute any corrective actions needed to address underperformance. The National Clinical Resource Hub Team will also provide language to be included in the National Clinical Resource Hub Operational Guide and draft VHA Directive 1407 that will delineate the roles and responsibilities for monitoring performance of the clinical resource hubs.

OIG Response

The acting under secretary for health's planned corrective actions are responsive to the recommendations. The OIG will monitor VHA's progress on these actions and will close the recommendations when adequate documentation has been provided to demonstrate sufficient progress on implementation and fulfillment of the recommendations' intent. Appendix B includes the full text of the acting under secretary's comments.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from August 2024 through July 2025. The scope of the audit included an analysis of hub physicians' productivity and hub related oversight to determine whether they met established measures from October 2023 through September 2024.

Methodology

To understand how VHA measures and provides oversight of hub physicians' productivity, the audit team reviewed applicable VHA policies, procedures, and directives including VHA Directive 1065(1), VHA Directive 1406, and VHA's *Clinical Resource Hub Operational Guide*.

The team interviewed

- directors and service chiefs from the six hubs that appeared to have less-than-optimally productive group practices and from the hub (in VISN 8) that did not appear in the Chief of Staff Dashboard report, published by the Office of Productivity, Efficiency, and Staffing (OPES; referred to as the OPES dashboard);
- directors from six hubs that appeared to have more-than-optimally-productive group practices to understand how these individuals measure and monitor hub physicians;
- the hub national director and officials from the hub advisory board to understand their oversight roles and responsibilities;
- representatives from OPES to determine how hub physician productivity is measured and captured in reports; and
- officials from the Office of Rural Health, the Caregiver Support Program, the Office of Connected Care, and the Offices of Mental Health and Suicide Prevention to understand how these programs determine the amount of funding hubs should receive.

The team used data from OPES reports to assess whether hub specialty practice groups and physicians had clear minimum productivity thresholds and met them from October 2023 through September 2024. The team also used data from VA Pyramid Analytics to identify data on encounters and related relative value units. In addition, the team used the hub portal dashboard to identify panel size, encounters, and hub staffing information. This information was used to identify physicians and workloads not captured in the OPES reports.

Internal Controls

The team assessed the internal controls of the hub program significant to the audit objective. This included an assessment of the five internal control components: (1) control environment, (2) risk assessment, (3) control activities, (4) information and communication, and (5) monitoring.[68] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified three components and four principles as significant.[69] The team identified internal control weaknesses during this audit and made recommendations to address those listed in table A.1.

Table A.1. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this report
Control activities	10. Management should design control activities through policies.	VHA lacks hubs-specific guidance for what hubs should use to monitor their specialty group physicians' productivity.
Information and communication	13. Management should use quality information to achieve its objectives. 14. Management should internally communicate the necessary quality information to achieve the entity's objectives.	The OPES dashboard report did not accurately report all hub specialty group physicians' productivity. Without hubs-specific guidance to measure productivity, hub leaders rely on different data to measure productivity.
Monitoring	16. Management should establish and operate activities to monitor the internal control system and evaluate the results.	VHA lacks hubs-specific processes to identify and improve less-productive hub specialty group practices.

Source: VA OIG analysis of internal control components and principles. The principles listed are consistent with the GAO's Standards for Internal Control in the Federal Government.

Data Reliability

The OIG used computer-based data from reporting tools, specifically the OPES dashboard, to help determine the productivity of hub physicians and whether they and the hub specialty practice groups met minimum productivity targets. To assess the reliability of the data, the audit team asked hub officials to verify information in the dashboard, such as the number of physicians

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

[69] Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that could have existed at the time of this audit.

and their workloads, and provide documentation for any differences. The team also used data from the hub portal dashboard and VA Pyramid Analytics to determine whether the OPES dashboard captured all hub physicians and their workloads. The team concluded the collective data consulted on hub physicians and their productivity were appropriate and sufficient for the purpose of this audit.

The OIG also used the Staff Panel Sizes report from the clinical resource hub portal to examine whether hub primary care physicians met productivity standards in September 2024. To assess the reliability of the data, the team obtained the active panel list report from the VHA Support Service Center and compared the information in this report to the report from the hub portal. The team also used patient medical records to verify physician and panel information in the active panel list report. The team concluded the available data were appropriate and sufficient for the purpose of this audit.

Government Standards

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

Appendix B: VA Management Comments, Acting Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: August 25, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians (VIEWS 13461026).

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians.

2. The Veterans Health Administration (VHA) greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. VHA concurs with the recommendations and is committed to enhancing our data integrity, defining appropriate performance measures, and clarifying oversight responsibilities for the full spectrum of interfacility resource sharing programs. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, MD, MBA, FACHE

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report – Better Guidance and Measures Would Help Optimize the Productivity of Clinical Resource Hub Physicians (2024-03319-AE-0018)

Recommendation 1: Implement procedures to monitor the data used to measure productivity to ensure the data accurately reflect the complete work of clinical resource hub physicians.

VHA Comments: Concur. The National Clinical Resource Hub (CRH) Clinical Service Council, which reports to the National CRH Advisory Board (CRH-AB), will review interfacility physician productivity data and invite key stakeholders to participate. The National CRH Team will facilitate this work. The National CRH Clinical Service Council will take the following actions:

- Review prior work completed examining the visibility of interfacility physician productivity measures and data integrity. This will include validation and correction of the data inaccuracies identified in the OIG report and gathering additional relevant information.
- Evaluate compliance with current business rules for labor mapping and interfacility physician workload capture.
- Identify instances of non-compliance and formally notify the accountable Veterans Integrated Services Network (VISN) Director on a quarterly basis.

The National CRH Clinical Service Council will provide two quarterly progress reports to the Assistant Under Secretary for Health (AUSH) for Clinical Services via the CRH-AB with a goal of monitoring 90% of data used.

The Office of Productivity, Efficiency, and Staffing (OPES) began revisions to the current Productivity methodology in late fiscal year (FY) 2025 quarter 1 (Q1). This update will ensure the data accurately captures workload performed at spoke sites. The timeline of implementation included input from program offices, end-user quality assurance testing, and technical revisions, and will be published in the initial datasets for FY 2026.

Status: In Progress Target Completion Date: June 2026

Recommendation 2: Work with appropriate officials, such as Office of Primary Care and Clinical Resource Hub leaders, to determine whether hub physicians should be subject to existing productivity measures. If so, issue clear hub guidance requiring adherence; if not, clearly define what should be used and issue thorough guidance on the steps hubs must take to measure physician productivity consistently.

VHA Comments: Concur. Veterans Health Administration (VHA) concurs that a clearly defined methodology for measuring productivity is required for physicians engaged in CRH.

- VHA will establish an Integrated Project Team (IPT), led by the National CRH Team.
- As the entity responsible for productivity measurement, OPES will partner with the IPT by providing subject matter expertise.
- The IPT will analyze VISN CRH physician clinical care delivery models and processes.

- The IPT will develop recommended productivity measures and benchmarks for VISN CRH physicians.
- The IPT will provide recommendations to update relevant policies (e.g., VHA Directive 1065: "Productivity and Staffing Guidance for Specialty Provider Group Practice") as they relate to physician productivity for all interfacility resource sharing.

The IPT will provide recommendations for productivity measures for physicians in VISN CRHs and recommended updates to relevant policies to the National CRH-AB and AUSH for Clinical Services.

Status: In Progress Target Completion Date: September 2026

Recommendation 3: Clarify oversight responsibilities for monitoring productivity measures, including detailed procedures and actions that should be taken when thresholds are not met.

VHA Comments: Concur. The National CRH Team will take the following actions:

- Assume responsibility for oversight and monitoring by reviewing and publishing VISN CRH aggregated Clinical Practice Area productivity on a quarterly basis. The National CRH Team will provide reports to VISN leadership when VISN CRH aggregate productivity falls below minimum thresholds. The VISNs will then retain responsibility for determining and executing any corrective actions needed to address underperformance.
- Provide language in the National CRH Operational Guide and draft VHA Directive 1407 that explicitly delineates the roles and responsibilities for performance monitoring for VISN CRHs.

The National CRH Team will publish oversight and monitoring guidance in the National CRH Operational Guide.

Status: In Progress Target Completion Date: September 2026.

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

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