



Department of Veterans Affairs Office of Inspector General

ADMINISTRATIVE SUMMARY Primary Care Access, Scheduling, and Consult Management Concerns Erie VA Medical Center Erie, Pennsylvania

1. Why the inspection was initiated:

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merits of concerns made regarding access to primary care, scheduling practices, and consult management at the Erie VA Medical Center (facility), Erie, PA. We conducted a survey in advance of a December 2014 Combined Assessment Program review.¹ Anonymous survey respondents alleged the following:

- Primary care providers (PCP) were assigned too many patients, which resulted in access issues for patients.
- Patient appointments were both scheduled and later “cancelled by patient,” without patient knowledge.
- Non-VA Care Coordination (NVCC) and inter-facility transfer consults were delayed.²

¹ OIG conducted a Combined Assessment Program review at the facility during the week of December 1, 2014 to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. During that review, we electronically surveyed employees regarding patient safety and quality of care at the facility.

² Facility staff may refer patients for care through other VA medical centers (referred to as inter-facility transfers), other facilities as part of sharing agreements, or community providers when consult services are not available or not available timely through the facility. In this report, we use the term “NVCC” to refer collectively to VA mechanisms for purchasing care from community providers, including the Veterans Choice Program (Choice). Choice was established by the Veterans Access, Choice, and Accountability Act of 2014. Under Choice, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice, if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of third-party administrators.

2. How the inspection was conducted:

- **Site Visit:** We conducted a site visit to the facility and two community based outpatient clinics March 23–26, 2015.
- **Interviews Conducted:** We interviewed the Facility Director, Acting Chief of Staff, Associate Director, Quality Management staff, a patient advocate, clinical and administrative staff, NVCC managers and staff, and other knowledgeable staff.
- **Records Reviewed:** We reviewed Veterans Health Administration (VHA) handbooks and directives, facility policies and procedures, relevant electronic health records (EHR), quality management and staffing documents, data from the VHA Support Service Center (VSSC), and patient complaints. We also reviewed data extracted from the VA Corporate Data Warehouse and patients' EHRs to evaluate the extent of inter-facility and NVCC consult delays in fiscal years (FY) 2015 and 2016, and if patients were clinically impacted by delays.

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

3. Summary of our findings:

PCP Panel Sizes

We substantiated that some PCPs were assigned more than the maximum number of patients specified under VHA procedures and local policy at the time of our onsite visit in March 2015.

We found that 11 of 22 providers (50 percent) had adjusted panel sizes outside the expected panel size range specified in VHA Handbook 1101.02 (1,000–1,400).³ We observed panel sizes both above the maximum and below the minimum range values. Further, 12 of 22 providers (54.5 percent) had adjusted panel sizes outside the expected panel size range specified in facility policy (1134–1323).⁴

³ VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. This VHA Handbook was scheduled for recertification on or before the last working date of March 2014 and has not yet been recertified. We considered the policy to be in effect as it had not been superseded by more recent policy or guidance.

⁴ Medical Center Memorandum No. 111-10, *Outpatient Scheduling Policies and Procedures (Erie, PA)*, December 4, 2013.

According to facility leaders and staff we interviewed, a key contributor to large panel sizes was provider turnover. The facility also faced challenges with recruiting and retaining qualified PCPs at least in part because of the competitiveness of salaries. Since our onsite visit, facility leaders implemented a number of strategies to enhance PCP recruitment and retention, including the following:

- Prioritized the processing of PCP job announcements.
- Ensured that PCP job announcements highlighted available incentives, such as sign on bonuses, relocation assistance, and student loan repayment.
- Mailed recruitment letters to over 250 local community PCPs to announce vacancies.
- Implemented compressed work schedules to retain existing PCPs.
- Increased several PCPs' salaries to lessen the gap between pay at the facility and other community employers.

Since implementation of these strategies, the facility experienced some improvement in the size of PCP panels. At the end of FY 2016, we found that 10 of 22 providers (45.5 percent) and 11 of 22 providers (50 percent) had adjusted panel sizes outside the expected ranges specified in VHA and facility policies, respectively.

Access to Primary Care

We did not substantiate that patients had limited access to primary care appointments. We found that appointment wait times based on preferred date were relatively short, on average, both at the time of our onsite visit in March 2015 and at the end of FY 2016. However, staff we interviewed noted challenges to maintaining reasonable access to appointments, particularly during times of episodic increases in demand for appointments.

Alleged Inappropriate Scheduling Practices

We could not substantiate that patient appointments were scheduled and subsequently "cancelled by patient," without patient knowledge. Because the allegation was vague and lacked additional information such as specific patient appointments, location or service area, staff involved, or time period, we were unable to fully address the anonymous survey respondent's specific concern. However, we learned that two behavioral health providers instructed schedulers to document patient no shows as "cancelled by patient" until supervisors reportedly intervened and corrected the erroneous practice in 2015.

Inter-Facility Transfer and NVCC Consult Delays

We substantiated that inter-facility transfer and NVCC consult delays occurred in FY 2015. Facility leaders initiated multiple actions to address those delays and consult timeliness improved in FY 2016.

In FY 2015, there were apparent delays for 1,276 of 3,768 (33.9 percent) patients with at least one inter-facility transfer consult. According to facility leaders and staff we interviewed, those delays were due at least in part to another VA medical facility leader's decision to decline certain transfer requests in an effort to address wait time concerns at the other facility.

As a result of the inter-facility transfer consult delays, facility staff reported that the number of NVCC consults increased, which resulted in a greater workload for the NVCC department staff and contributed to delays in NVCC scheduling and payments. Consistent with that concern, we found that among patients with NVCC consults ordered in FY 2015, there were the following apparent delays:

- 1,360 of 1,576 (86.3 percent) patients who had at least one Choice consult.
- 2,025 of 5,626 (36.0 percent) patients who had at least one traditional non-VA care consult.

In early FY 2015, the newly appointed Facility Director identified delays in scheduling of NVCC consults and initiated the following steps to address delays:

- Collaborated with a subject matter expert from the Veterans Integrated Service Network (VISN) who reviewed the facility's consult management process and offered assistance and recommendations.
- Assigned additional staff to assist with processing NVCC consults.
- Initiated efforts to hire more permanent staff for the department.
- Addressed a backlog of outside EHRs that needed to be scanned so that associated NVCC consults could be closed.

Following these actions, consult timeliness improved. In particular, in FY 2016, there were apparent delays for 274 of 4,439 (6.2 percent) patients with at least one inter-facility transfer consult. Additionally, among patients with NVCC consults ordered in FY 2016, there were the following apparent delays:

- 1,822 of 5,561 (32.8 percent) patients who had at least one Choice consult.
- 299 of 2,522 (11.9 percent) patients who had at least one traditional non-VA care consult.

However, we did not identify patients who were clinically impacted by consult delays.

4. Conclusions:

We substantiated that some PCPs were assigned more than the maximum number of patients specified under VHA and local policy in March 2015. Since then, facility leaders implemented a number of strategies to enhance PCP recruitment and retention. The facility experienced some improvement in the size of PCP panels.

We found that average appointment wait times based on preferred date were relatively short, both at the time of our onsite March 2015 visit and at the end of FY 2016. We could not substantiate that patient appointments were scheduled and subsequently “cancelled by patient” without patient knowledge. Although we substantiated that inter-facility transfer and NVCC consult delays in FY 2015, facility leaders initiated multiple actions to address those delays and consult timeliness improved in FY 2016. Further, we did not identify patients who were clinically impacted by delays.

We made no recommendations.

Comments. The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes B and C, pages 9–10 for the Directors’ comments.) No further action is required.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Prior OIG Reports

Facility Reports

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Erie VA Medical Center, Erie, Pennsylvania

2/11/2015 | 14-04389-106 | [Summary](#) | [Report](#)

Combined Assessment Program Review of the Erie VA Medical Center, Erie, Pennsylvania

2/10/2015 | 14-04224-107 | [Summary](#) | [Report](#)

Reports on Consult Delays

Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana

3/10/2017 | 16-00621-175 | [Summary](#) | [Report](#)

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System

10/4/2016 | 15-04672-342 | [Summary](#) | [Report](#)

Combined Assessment Program Summary Report – Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities

5/23/2016 | 16-01489-311 | [Summary](#) | [Report](#)

Healthcare Inspection – Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina

5/3/2016 | 14-02890-286 | [Summary](#) | [Report](#)

Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California

3/30/2016 | 14-04897-221 | [Summary](#) | [Report](#)

Healthcare Inspection – Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, SC

1/6/2016 | 15-00992-71 | [Summary](#) | [Report](#)

Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, ME

6/17/2015 | 14-05158-377 | [Summary](#) | [Report](#)

Healthcare Inspection – Documentation of Patient Enrollment Concerns in Home Telehealth John D. Dingell VA Medical Center Detroit, Michigan

2/9/2017 | 14-00750-143 | [Summary](#) | [Report](#)

Healthcare Inspection – Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas

12/22/2015 | 15-00268-66 | [Summary](#) | [Report](#)

Prior OIG Reports

Healthcare Inspection – Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California

10/28/2015 | 14-02890-497 | [Summary](#) | [Report](#)

Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ

10/15/2015 | 14-00875-03 | [Summary](#) | [Report](#)

Healthcare Inspection – Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois

9/29/2015 | 14-02952-498 | [Summary](#) | [Report](#)

Review of VHA’s Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC

8/31/2015 | 15-02397-494 | [Summary](#) | [Report](#)

Healthcare Inspection - Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama

7/29/2015 | 14-04530-452 | [Summary](#) | [Report](#)

Healthcare Inspection – Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado

7/7/2015 | 14-04049-379 | [Summary](#) | [Report](#)

Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues

7/1/2015 | 14-04116-408 | [Summary](#) | [Report](#)

Healthcare Inspection – Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, OK

6/16/2015 | 14-04573-378 | [Summary](#) | [Report](#)

Healthcare Inspection – Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland

4/14/2015 | 14-03824-155 | [Summary](#) | [Report](#)

Healthcare Inspection — Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois

3/3/2015 | 14-04473-132 | [Summary](#) | [Report](#)

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

2/18/2015 | 14-04194-118 | [Summary](#) | [Report](#)

Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ

1/28/2015 | 14-00875-112 | [Summary](#) | [Report](#)

Prior OIG Reports

Healthcare Inspection – Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, NC

11/6/2014 | 14-03298-20 | [Summary](#) | [Report](#)

Healthcare Inspection - Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA

8/12/2014 | 14-03010-251 | [Summary](#) | [Report](#)

Healthcare Inspection – Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama

5/19/2014 | 13-04474-157 | [Summary](#) | [Report](#)

Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, South Carolina

12/20/2016 | 14-02890-352 | [Summary](#) | [Report](#)

Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii

9/22/2016 | 15-04655-347 | [Summary](#) | [Report](#)

Review of the Implementation of the Veterans Choice Program

1/30/2017 | 15-04673-333 | [Summary](#) | [Report](#)

Review of VA's Award of the PC3 Contracts

9/22/2016 | 15-01396-525 | [Summary](#) | [Report](#)

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 29, 2017

From: Director, VA Healthcare – VISN 4 (10N4)

Subj: Administrative Summary: Primary Care Access, Scheduling, and
Consult Management Concerns, Erie, Pennsylvania

To: Director, Baltimore Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed the draft report of the Inspector General Administrative Summary of Primary Care Access, Scheduling, and Consult Management Concerns of the Erie VA Medical Center. I concur with the conclusions outlined in this report.

Michael D. Adelman, MD

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ou=InternalStaff, cn=Adelman,
Michael
Date: 2017.07.06 13:36:07 -04'00'

Michael Adelman
VISN 04 Network Director

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 28, 2017
From: Director, Erie VA Medical Center (562/00)
Subj: Administrative Summary: Primary Care Access, Scheduling, and Consult Management Concerns, Erie, Pennsylvania
To: Director, VA Healthcare – VISN 4 (10N4)

2. I have reviewed the draft report of the Inspector General Administrative Summary of Primary Care Access, Scheduling, and Consult Management Concerns of the Erie VA Medical Center. I concur with the conclusions outlined in this report.
3. The substantiated findings are continually monitored to ensure actions taken are sustained. The Primary Care Management Module (PCMM) Coordinator provides oversight and ongoing monitoring of Provider panel sizes in order to serve Veterans and maintain continuity of quality care. Leadership oversight continues to ensure the inter-facility transfers and NVCC consults are completed timely.

DiGiacomo,
David C

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Date: 2017.06.29 08:00:18 -0400

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Medical Center Director (00)

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