VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of Management of Primary Care Panels

December 6, 2017
15-03364-380

ACRONYMS

FTE	Full-time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
OIG	Office of Inspector General
PCMM	Primary Care Management Module
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

EXECUTIVE SUMMARY

Why We Did This Audit/Review

Primary care is an important component of care provided by the Veterans Health Administration (VHA) to eligible veterans. Primary care gives eligible veterans easy access to health care professionals familiar with their needs. It serves as the foundation of VHA health care and is the first point of contact with the health care system for veterans enrolled in VHA.

Veterans are assigned to a particular primary care provider for their care, and the group of veterans assigned to each provider is the provider's panel. The OIG evaluated whether VHA effectively managed provider primary care panels to maximize access to primary care providers. This included evaluating how new enrollees are processed into panels as well as the panel sizes. Provider panels define both VHA's capacity to provide managed outpatient care and provider efficiency based on the number of veterans managed for primary care.

What We Found

In the first seven months of FY 2015, VHA had not effectively managed provider panels to maximize access. VHA facilities' methods for processing and scheduling veterans into panels varied. The OIG identified an average of 29 days from the date a veteran enrolled seeking care until the facility scheduled their appointment, but VHA's wait time calculation does not include the total number of days between the date the veteran enrolled and the date the facility scheduled their appointment. In addition, VHA facilities had panels below VHA's panel size recommendations, with six of the seven facilities reviewed showing provider panel sizes 13 to 30 percent below VHA's model expectations.

VHA lacked standard procedures for processing new enrollees, and its data did not track the wait time from the date of enrollment[1] to the date of scheduling the first patient appointments. As a result of not monitoring from the date of enrollment, which is generally when VHA can determine eligibility, VHA's recorded wait times did not accurately reflect the wait experienced by the population of veterans the OIG reviewed. VHA's recorded wait time showed about 8 percent of newly enrolled veterans in the first seven months of FY 2015 waited more than 30 days. However, when including the time between the date a veteran enrolled seeking care until the date the facility scheduled them for their appointment, the OIG determined about 53 percent of newly enrolled veterans completed their first appointment more than 30 days past the determined eligibility date.

The OIG also determined that VHA did not ensure compliance with recommended panel sizes or require facilities to explain why they deviated from those recommendations. The OIG believes

[1] For the purpose of this report, the enrollment date is the first day VHA staff could make an eligibility determination after the veteran submitted a completed enrollment form, including all required supporting material.

that smaller panel sizes can have negative ramifications in two ways: 1) decreased access, as underutilized providers are paid but not available to newly enrolled veterans, or 2) an over-expenditure on salaries and other expenditures for providers who are not functioning at full capacity. VHA spent about $1.3 billion in salaries in FY 2015 for primary care providers. The lower panel sizes equated to almost $169 million in underutilized provider salaries paid in FY 2015. If recommended actions are not implemented to strengthen panel management, this would equate to about $843 million over the next five years.

What We Recommended

The OIG recommended the Acting Under Secretary for Health establish standardized new enrollee scheduling procedures that properly track wait times, and ensure facilities either set panel sizes at VHA's model goals or justify deviations.

Agency Comments

The Acting Under Secretary for Health concurred with Recommendation 3 and concurred in principle with Recommendations 1 and 2. The OIG considers the corrective action plans acceptable and will follow up on their implementation.

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TABLE OF CONTENTS

INTRODUCTION

Objective

The OIG initiated this audit to ensure that management of primary care panels is effective, efficient, and does not impede veterans receiving timely health care services. The audit objective was to determine if the Veterans Health Administration (VHA) effectively managed provider primary care panels to ensure appropriate access for eligible veterans to primary care providers. The OIG examined the process for veteran enrollment and assignment to primary care panels, as well as how VHA facilities' methods of establishing panel sizes affected veterans' access.

Program Size

In FY 2015, VHA spent almost $4.2 billion for primary care services. Of that, almost $3.8 billion was for personnel-related expenses, with about $1.3 billion attributable to primary care provider salaries. VHA has approximately 5,500 full-time equivalent (FTE) primary care providers for approximately 5.3 million individual primary care patients, or about 971 veterans per FTE provider.

Wait Time Policy

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010), and VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016), prescribe that VHA measure new patient wait times from the veteran's preferred date of care to the completed appointment date. VHA's wait time goal is to provide new patients a scheduled appointment within 30 days of their preferred date.

PCMM: Panel Size and Efficiency

VHA's Primary Care system strives to balance efficiency with quality, access, and patient service. To do this, VHA assigns a panel of veterans to each primary care provider. The provider is responsible for providing primary care access and coordinated care to the veterans on their panel. For this reason, provider panels define both VHA's capacity to provide managed outpatient care and provider efficiency, based on the number of veterans managed. VHA Handbook 1101.02, *Primary Care Management Module (PCMM)* (April 21, 2009), established guidelines for setting panel sizes and panel assignment, which VHA tracked using the Primary Care Management Module (PCMM). PCMM is a software package facilities use to record numbers of veterans assigned to each provider. The handbook indicates that veterans are assigned to a panel at the time of the first completed appointment. PCMM gives VHA decision makers the ability to analyze VHA's primary care workload at all levels—nationally, by Veterans Integrated Service Network (VISN), and by facilities and their substations. Accurate PCMM workload data allow VHA to quantify its primary care capacity[2]; align delivery of services to match the needs of veterans; and make meaningful comparisons between VISNs, medical facilities, and their substations.

[2] The total number of patients for whom VHA can provide care.

RESULTS AND RECOMMENDATIONS

Finding 1 VHA Needed To Establish Standardized Procedures for Scheduling New Enrollees

VHA needs to improve new enrollee processing and scheduling to minimize delays in access to primary care services. It also needs to establish milestones that allow for proper monitoring of the time it takes for a veteran to obtain their first appointment after enrolling, as VHA's method of calculating wait times did not track delays in processing.

The process for a veteran to enroll and for VHA to determine eligibility starts when the veteran submits an enrollment form[3] online, by mail, or directly at a VA medical facility. The application is processed via the Health Eligibility Center in Atlanta for an authoritative eligibility determination. According to medical facility staff, those who are assisting a veteran with their enrollment application can determine eligibility at that time and proceed with scheduling the veteran's first appointment immediately. Despite the ability to immediately determine eligibility and schedule veterans, VHA facilities' methods for processing and scheduling veterans into panels varied and did not always include immediate scheduling. This contributed to an average delay of 29 days in scheduling veterans for their first primary care appointment, which is not included in VHA's wait time calculation.

As a result, delays occurred for an estimated 53 percent of newly enrolled veterans. These veterans waited longer than 30 days to complete their first primary care appointment. However, VHA-reported wait times indicated only 8 percent of the newly enrolled veterans waited longer than 30 days, because VHA calculated wait times from the preferred date[4] rather than the enrollment date[5]. Without accurate wait time data, VHA cannot adequately monitor and make necessary changes to improve the process by which veterans access primary care.

VHA's Method of Calculating Wait Times for Access to an Initial Primary Care Appointment

VHA's policies establish a goal of scheduling appointments no more than 30 calendar days from the preferred date—the date an appointment is deemed clinically appropriate by a VA health care provider or 30 days from the date the veteran requests outpatient health care. VHA Directive 2010-027 directed schedulers to obtain the preferred date when communicating with the veteran during the scheduling process. The process of scheduling the appointment should occur within seven days after the request. VHA

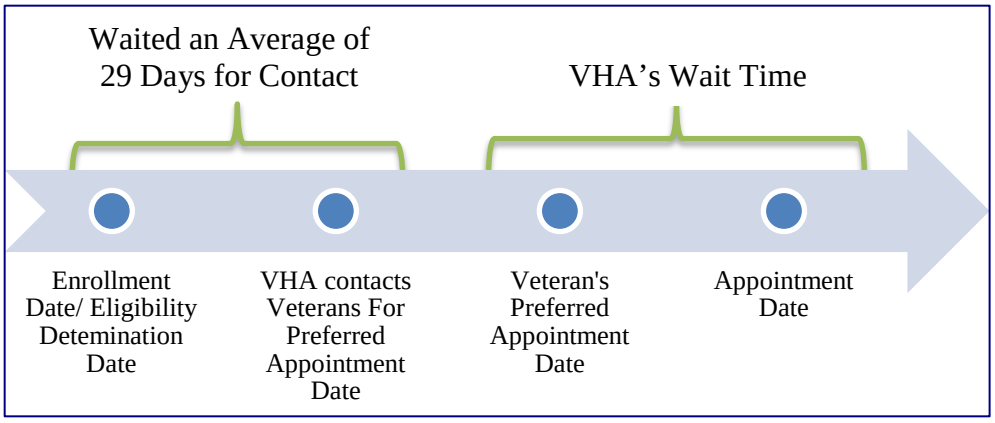
[3] VA Form 10-10EZ.
[4] The date an appointment is deemed clinically appropriate by a VA health care provider when not available, the date the veteran requests outpatient health care.
[5] The date the facility could make an eligibility determination.

Directive 1230[6] superseded VHA Directive 2010-027 and states VHA's goal to schedule appointments no more than 30 calendar days from the clinically indicated date or the preferred date. It requires schedulers to obtain the preferred date when communicating with the veteran during the scheduling process. VHA Directive 1230 provided a prescribed method of calculating the waiting time for new veterans that did not include the time between the dates the veteran enrolled for care and VHA could determine eligibility and the date staff contacted the veteran about their preferred date.

VHA tracks wait times for a first appointment with a primary care provider. The OIG determined that VHA's wait time calculation does not include the total number of days between the enrollment date[7] to the first attempt to schedule, nor does it include from the enrollment date to the actual scheduling date.[8] On the scheduling date, VHA schedulers establish the veteran's preferred date for care (preferred date) and the date of the scheduled appointment (the appointment date).

The OIG reviewed a nationwide statistical sample of 119 veterans from a population of 11,700 veterans who enrolled during the first seven months of FY 2015 and completed an appointment for primary care. The OIG estimated that VHA averaged about 29 days between the enrollment date and the date when VHA schedulers contacted the veteran for scheduling. Figure 1 is a timeline of the veterans' wait for an appointment that also shows the time not included in VHA's calculation of wait times.

Figure 1. Days in Establishing Veteran Preferred Appointment Date



Source: OIG statistical analysis of average wait between VHA's eligibility determination and the scheduling date with VHA Directive 2010-027

[6] *Outpatient Scheduling Processes and Procedures*, July 15, 2016.
[7] The date the veteran enrolled and/or the date the facility could make an eligibility determination.
[8] The date VHA successfully scheduled the veteran.

In the first seven months of FY 2015, VHA's recorded wait time data showed about 8 percent of newly enrolled veterans waited more than 30 days for their first appointment with a primary care provider. However, when the OIG included the time it took VA medical facilities to contact veterans to schedule an appointment, it estimated about 6,200 of 11,700 newly enrolled veterans (53 percent) who completed a primary care appointment waited more than 30 days from their enrollment date to their completed appointment date. In the OIG's sample, veterans who remained unscheduled for more than 30 days had waits ranging from 33 to 273 days. This reveals that VHA records only part of a veteran's wait time by measuring from the preferred date to the appointment date, rather than including wait starting at the enrollment date.

By not considering the total number of days veterans wait between the enrollment date and the appointment date, VHA-reported wait times do not reflect the actual wait experienced by the newly enrolled veteran trying to establish care with VHA. Without accurate wait time information, VHA cannot adequately monitor and make necessary changes to improve the process by which veterans access primary care. VHA could improve the transparency of the actual wait times experienced by veterans and use these data to continue its efforts to improve on timely access to care.

New Enrollee Scheduling Procedures

This additional wait time is attributable to a lack of specific guidance from VHA on when to contact veterans about scheduling, in addition to inconsistent processing and scheduling methodologies at medical facilities. The OIG visited seven VA medical facilities, each of which used different techniques to process and schedule newly enrolled veterans. The variety of methods contributed to delays for their first appointment. The OIG evaluated new enrollment scheduling at these facilities and found that five of the seven facilities did not always attempt to schedule veterans for their first primary care appointment on the enrollment date.

Of the seven facilities, staff at two VA Medical Centers (VAMC) used a process that provided an opportunity to schedule the veterans' primary care appointment immediately. Staff in these facilities stated they attempted to schedule veterans in person when entering the enrollment application or through a phone call when the veteran submitted the enrollment application online or via mail. In these instances, the facilities were able to establish the veteran's preferred date on the enrollment date, providing quicker access to care and reducing the potential for unreported delays in VHA's wait times.

The remaining five facilities all required additional actions by the facility or the veteran before the appointment could be scheduled, potentially creating unnecessary delays. Instead of attempting to contact the veteran after staff processed the enrollment application, enrollment staff added delays by instructing clinic staff to contact the patient. In some cases, enrollment staff put the burden of scheduling on the veteran by requiring the veteran to

contact the clinic for scheduling. The following is an example of a medical facility requiring veterans to make efforts to get their appointment scheduled.

Example 1

Enrollment staff at a VAMC with panels below VHA's modeled capacity stated that after they processed the veterans' enrollment applications, they verbally instructed veterans to either report to the primary care clinic or call the clinic to set up an appointment. The OIG reviewed records for nine veterans who enrolled in the first seven months of FY 2015 and who requested to be contacted for scheduling on their enrollment forms. The OIG found eight of the veterans waited an average of 53 days prior to their appointment being scheduled, while only one veteran was scheduled on the same day as enrollment. This occurred in part due to the VAMC putting the burden on the veterans to set up their appointments.

The consult lead of VHA's Access and Clinic Administration Program confirmed that VHA has no standard requirement in place for facilities to follow when processing and scheduling new enrollees. Specifically, VHA did not prescribe who should schedule veterans and when. However, in her opinion, facilities should schedule newly enrolled veterans immediately upon making the eligibility determination. According to enrollment supervisors at all seven facilities the OIG visited, enrollment staff could immediately determine a veteran's eligibility for care at the time of enrollment for most veterans and immediately take action to schedule the veteran's appointment with a primary care provider.

By eliminating additional actions required by facility staff or the veteran, VHA could more quickly provide the veteran their first primary care appointment.

The following example shows a veteran's wait for an appointment when staff delayed in contacting the veteran for scheduling. This was due to the lack of specific procedures for action.

Example 2

A veteran requested on his enrollment form to be contacted for scheduling. There were no documented attempts of VA staff trying to schedule an appointment for the veteran for approximately three months, when VHA staff scheduled the veteran for an appointment seven days later. The enrollment date was 86 days before the medical facility staff first contacted the veteran for a preferred appointment date. VHA's official wait time showed seven days because staff, adhering to VHA procedures, recorded the patient's preferred date as the date when the veteran was first contacted and did not record the enrollment date. From the veteran's perspective, he had waited 93 days for his first appointment after enrolling for care.

Government Accountability Office Audit

While the OIG was performing its audit on these issues, the Government Accountability Office (GAO) issued a report called that found not all newly enrolled veterans were able to access primary care.[9] The report also found that other veterans experienced wide variation in time they waited for care and that VHA records did not capture the veterans' wait time between enrollment and scheduling. GAO recommended that the Secretary of Veterans Affairs direct the Under Secretary for Health take action to:

1. Review and revise processes to ensure all newly enrolled veterans are contacted in a timely manner for scheduling
2. Monitor the full amount of time newly enrolled veterans wait, starting with the date veterans request they be contacted for scheduling
3. Finalize a new scheduling policy

VA concurred with all three recommendations. VA stated that VHA would, as appropriate, review and revise the process from enrollment to scheduling to ensure staff contact veterans in a timely fashion. It would also correct the process for monitoring the full amount of time that newly enrolled veterans wait to be seen. VA set target completion dates of December 31, 2016 for both of these actions. According to VHA staff, they provided documentation and requested closure of these recommendations as of June 16, 2017. For the third GAO recommendation, VA issued VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016).

GAO's recommendations are consistent with the OIG's findings and the OIG concurs with them. Because the GAO recommendations do not appear to have been fully implemented, however, the OIG provided its own recommendations.

Conclusion

Veterans waited an estimated average of 29 days from the primary care enrollment date to the date VHA contacted them to obtain their preferred appointment date. Including the 29 days, the OIG estimated about 53 percent of veterans experienced waits in excess of 30 days from the enrollment date to their completed appointment date. VHA needs to take action to establish standardized new enrollee scheduling and to measure elapsed wait time for an initial appointment from the date of enrollment. By creating uniform scheduling practices and measuring wait time from enrollment application to scheduling, VHA can improve timely access of newly enrolled veterans to primary care and increase transparency.

[9] *VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care*, GAO-16-328, March 18, 2016.

Recommendations

1. The OIG recommended the Acting Under Secretary for Health establish standardized primary care scheduling processes that provide newly enrolled veterans an opportunity to schedule an appointment at the time of enrollment.

2. The OIG recommended the Acting Under Secretary for Health establish metrics to monitor the time it takes facilities to offer scheduling for an initial primary care appointment, beginning with the date the veteran submits a completed enrollment form.

Management Comments

The Acting Under Secretary for Health concurred in principle with Recommendations 1 and 2.

For Recommendation 1, the Acting Under Secretary reported that the Office of Veterans Access to Care, in collaboration with the Member Services Health Eligibility Center, will establish standardized procedures to ensure newly enrolled veterans are offered an appointment timely, pursuant to enrollment requirements. She also reported that Member Services recently established an action plan standardizing policy and procedures for VHA enrollment. The action plan streamlines how facilities manage their responsibilities for processing applications and initiating the scheduling process for newly enrolled veterans. The Acting Under Secretary anticipated implementation of actions for Recommendation 1 by March 2018.

For Recommendation 2, the Acting Under Secretary reported the start date to monitor the duration it takes for a veteran to schedule an initial appointment is based on the eligibility determination date, not the date the veteran submits a completed enrollment form. However, she acknowledged VHA needed to develop metrics that measure the entire wait time from the point when a veteran is deemed eligible for health care to the time they are seen. She reported that VHA will work toward developing a more complete set of measures to reflect veterans' experience with obtaining their first appointment after enrollment. The Acting Under Secretary reported actions were completed in September 2017. Appendix E provides the full text of the Acting Under Secretary's comments.

OIG Response

The Acting Under Secretary for Health's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the identified issues.

While the Acting Under Secretary reported the start date to monitor the veteran's wait for an initial appointment is based on the eligibility determination date, the OIG's review measured from the first day VHA staff

could make an eligibility determination once the veteran provided sufficient support. The OIG acknowledges that veterans may not always provide sufficient support when submitting their enrollment forms, which is why the OIG recommended establishing a measure from when the veteran submits a completed enrollment form. VHA's efforts to measure from the eligibility determination date and develop metrics that measure the entire wait time should provide greater transparency over veterans' experience.

Finding 2 VHA Needed To Hold Facilities to Primary Care Panel Model Goals

VHA's panel management practices did not ensure facilities adhered to primary care panel size recommendations established by VHA.[10] In order to arrive at appropriate panel sizes, VHA uses a model that incorporates different variables applicable to its disparate facilities. Variables include patient characteristics—like disease severity—and facility characteristics—like number of clinic rooms and support staff. The baseline expected panel is 1,200 patients for a full-time physician's panel. After variable adjustments, VHA-modeled panel size expectation falls in the range of 1,000 to 1,400 for undifferentiated[11], or non-specialized, primary care providers.[12] Using VHA's model adjusted panel sizes, the OIG determined that for six of the seven facilities it visited, primary care providers served 13 to 30 percent fewer veterans on average than VHA's modeled expectations. The seventh facility was larger than VHA's modeled expectations, with adjusted panel sizes averaging 101 percent of VHA's modeled panel size expectation.

This occurred primarily because VHA did not:

- Ensure facilities set panel sizes consistent with VHA's model
- Require facilities to justify panel sizes above or below the modeled expectations

As a result, VHA was paying for services it did not fully use. In addition, the OIG believes smaller panel sizes decreased access to primary care providers. When comparing VHA's expected panel size to actual panel sizes nationally, the OIG estimated that actual panel sizes for providers were about 19 percent below VHA's model expected panel sizes. This 19 percent equated to $169 million in underutilized services out of the almost $900 million VHA paid in FY 2015 provider salaries. Without implementation of recommended actions to strengthen panel management, this will equate to paying approximately $843 million in underutilized primary care provider salaries over a five-year period.[13]

[10] The OIG reviewed undifferentiated and women's health panels and compared this to VHA modeled panel size for undifferentiated and women's health panels.
[11] An undifferentiated provider treats patients who do not have specific or complex diseases or conditions. Undifferentiated providers should not need additional specialty training to treat a large portion of patients on their panels.
[12] VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009, page 11, section 17, paragraph b.
[13] See Appendix D.

VHA's Panel Size Standard

VHA Handbook 1101.02 established guidelines for setting undifferentiated panel sizes.[14] While the guidance stated the facilities were responsible for setting panel sizes, it also provided the facilities a standard model panel size for each physical location in a facility, based on the facility's number of exam rooms, amount of support staff, and intensity of patient needs. At the seven facilities visited, including the community-based outpatient clinics, VHA provided a modeled panel size for each of the 49 locations that ranged from 960 to 1,446 veterans per panel for a full-time provider. The handbook stated the model might not be appropriate for specialized panels populated by patients with specific, complex diseases or care needs such as spinal cord injury, women's primary care, and infectious disease. For example, the average specialized panel at the Durham facility on September 1, 2015 was about 334 veterans. Without an applicable model, the OIG did not assess or analyze specialized panels, with the exception of women's primary care panels. VHA Handbook 1330.01, *Health Care Services for Women Veterans* (May 21, 2010), established a reduction of 20 percent from VHA's modeled panel size for the total number of women on a panel to compensate for additional medical needs related to women's primary care.

Facility Panel Sizes Were Below Modeled Expectations

VHA facilities do not follow VHA's modeled panel size. At six of the seven facilities the OIG visited, primary care providers served 13 to 30 percent fewer veterans on average than VHA's modeled expectations. The seventh facility had an average panel size of 101 percent of VHA's expected panel size.

[14] An undifferentiated panel is a panel that is not composed of patients with specific or complex diseases. Providers with undifferentiated panels should not need additional specialty training to treat a large portion of patients on their panels.

As shown in Table 1, the average panels at the seven facilities ranged from 29.7 percent below to 0.8 percent over VHA's standard panel size model for undifferentiated panels, including the adjusted model for women's health panels.

Table 1. Percent of VHA Modeled Panel Size Used for Undifferentiated and Women's Health Panels at Seven Facilities as of September 1, 2015

Facility VAMC	Veterans on Panels	Adjusted Modeled Capacity	Percent Below Model
San Francisco	23,848	33,941	29.7%
Los Angeles	40,503	55,823	27.4%
West Palm Beach	25,307	31,242	19.0%
Detroit	27,263	32,950	17.3%
Connecticut	44,102	51,666	14.6%
Durham	41,623	47,729	12.8%
Dallas	79,609	79,014	-0.8%

Source: PCMM Data as of September 1, 2015 and OIG analysis of facility data provided from June 8 through September 10, 2015

Why This Occurred

VHA did not ensure facilities adhered to VHA's modeled expectation or require facilities to justify panels that fell outside of an acceptable range. VHA monitored both the maximum panel sizes set by the facility and the assigned panel[15] sizes.

For maximum panels set by the facility, the facility was responsible for setting the number of veterans each provider could handle. While VHA's modeled expectation for undifferentiated panels and an adjusted model for women's health panels would have been appropriate maximums, facilities were not required to use VHA's modeled panel size. However, VHA's expectation[16] was that the average maximum panel size set by the facilities would be within 20 percent of VHA's modeled panel size.[17]

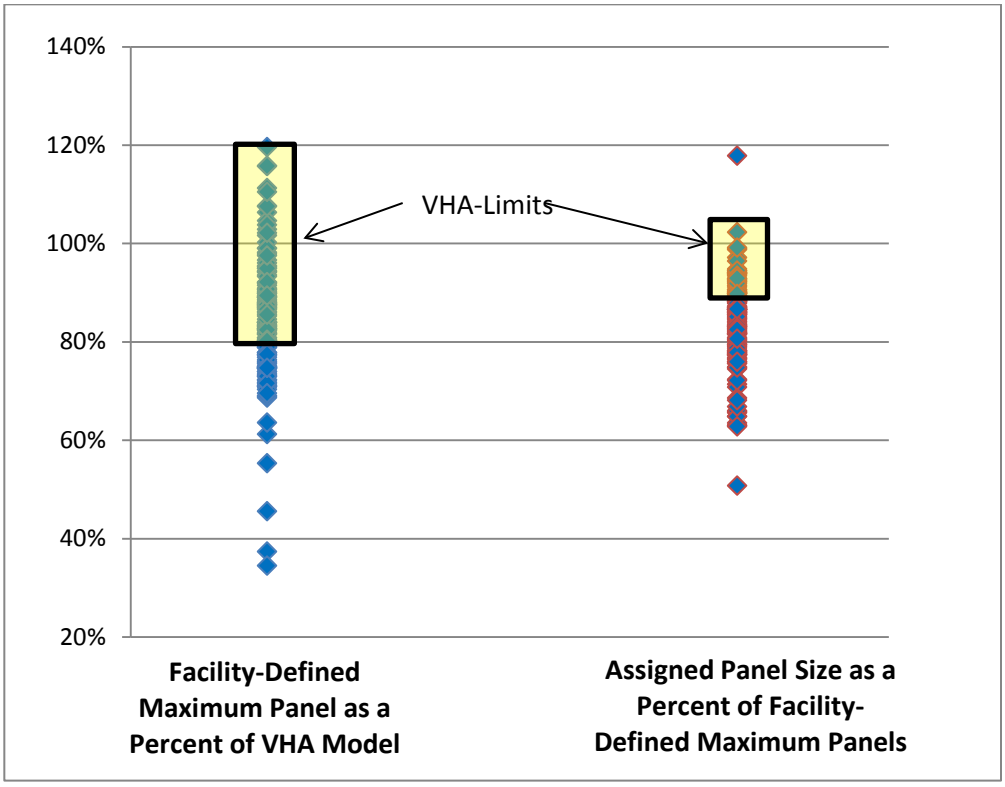
[15] The number of veterans actually assigned to each panel by that facility.
[16] VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009: Adjusted MD Equivalent Capacity (denominator) versus the Modeled Capacity.
[17] For the purposes of this calculation, VHA included undifferentiated, women's health, and other specialized panels for this analysis. Although specialized panels tend to be smaller in size, VHA's calculation does not take that into consideration. For specialized panels, VHA policy acknowledged panels may need to be determined locally.

VHA established expectations that a facility's panels would average between 90 and 105 percent of the facility's maximum panel size. To monitor assigned panels, VHA measured and averaged the number of veterans that were assigned to each panel at a facility.

On September 1, 2015, VHA's data showed that 16 of the 141 facilities had maximum panels outside of VHA limits, and 74 of the 141 facilities had assigned panels outside of VHA's limit. The OIG assessed the same VHA panel data on April 26, 2017, which showed that facilities continued to fall outside of VHA's expectations.

As shown in Figure 2, VHA's data showed 49 of the 141 facilities had maximum panels set more than 20 percent below VHA's model. In addition, 110 of the 141 facilities had assigned panel sizes below 90 percent of the facility-set maximum panel, with only one facility more than 105 percent. In all, 125 of the 141 facilities fell outside of at least one VHA limit.

Figure 2: Facilities Compared to VHA Limits on Deviation (Facility Maximum Panel) From Modeled Panel Sizes and VHA Limits on What Percent of Facility Maximum Was Used (Actual Panels) as of a Specific Point in Time—April 26, 2017



Source: VHA's PACT Panel Report

VHA's former executive director of Primary Care Operations told us that VHA relies on each facility to make panel size decisions. The former

executive director believed the facilities were in the best position to address their unique veteran demand for primary care services. The former executive director also stated that facilities are not required to explain any adjustments from VHA's expected panel size to the facilities' actual panel size. In addition, the former executive director did not express concern that facilities had established panels that were significantly below VHA's panel size. Ensuring facilities achieve VHA's modeled panel sizes and requiring a justification for panel sizes outside the acceptable range will help facility leadership identify potential access or resource issues.

Recommendation 3 addresses the improved oversight actions VHA needs to ensure facilities are meeting VHA's modeled expectations. It also addresses requirements for each facility to submit an explanation of any deviation so VHA can take further action, as appropriate, to ensure appropriate panel size and utilization.

Decreased Access

The OIG estimated facilities operated at about 81 percent of the modeled panel size, or about 19 percent below VHA's modeled panel size, for undifferentiated and women's health providers as of September 1, 2015. The OIG determined that lower panel sizes could decrease access—if providers are serving fewer veterans than they could or should be, fewer appointments are available to newly enrolled veterans. The OIG estimated VHA spent almost $900 million in salaries for undifferentiated and women's health providers. Assuming an underutilization rate of 19 percent, this equals almost $169 million in underutilized provider salaries paid in FY 2015. This would equate to about $843 million over the next five years if panel management is not improved.

Prior GAO Audit

GAO's prior audit report[18] found VHA lacked assurance that facilities' PCMM data were reliable. It also found that VHA lacked assurance facilities were not managing primary care panels in a manner that meets VA's goals of providing efficient, timely, and quality care to veterans. GAO recommended that the Secretary of the Department of Veterans Affairs direct the Under Secretary for Health to incorporate oversight for primary care panel management by:

- Assigning responsibility for verifying panel data
- Monitoring panels in relation to the modeled panel size
- Assisting facilities in taking steps to address panels that vary widely from modeled panel sizes

[18] *VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care*, GAO-16-83, October 8, 2015.

VA concurred with GAO's recommendations and agreed to assign greater oversight responsibility for data accuracy to VISNs and VA Central Office. In addition, VHA pledged to develop and implement a process for interacting effectively with sites that deviate significantly from other similar sites.

The OIG concurs with GAO's recommendations. The OIG further believes that VHA should require facilities to document the basis for any deviation from VHA's recommended model primary care panel size, and that VHA leadership monitor and assess any such deviations and take action as appropriate to ensure appropriate primary care panel sizes and utilization at each facility.

Conclusion

VHA needs to improve panel management by ensuring facilities follow recommended panel sizes developed by VHA or be required to justify why panel sizes should deviate from VHA expectations. Facilities averaged about 19 percent below VHA's modeled panel size. VHA's actions resulted in reduced provider efficiency as measured by almost $169 million in salaries paid in FY 2015 to underutilized providers, and the OIG believes this reduced newly enrolled veterans' access to providers. By making the recommended improvements, VHA could achieve more efficient panel sizes, identify potential resource issues, and provide increased access to primary care.

Recommendation

3. The OIG recommended the Acting Under Secretary for Health improve oversight by ensuring facilities set panel sizes consistent with VHA's recommended model panel sizes, submit written justification for panel sizes that deviate from VHA's model panel sizes for review and approval by VHA, or implement corrective action to mandate appropriate panel size.

Management Comments

The Acting Under Secretary for Health concurred with the recommendation. She reported that VHA deployed new panel management software in October 2016 that helps manage access to health care. If the number of patients assigned to a provider varies significantly from VHA's expected panel size, the primary care manager must document justification for the variation in the new software. She also reported that to improve oversight, VHA's Office of Primary Care will direct each VISN to perform quarterly audits of all panel capacities that are not consistent with VHA's recommended modeled capacities and to review justifications for differences. VHA's Office of Primary Care will perform biannual audits of the VISN's findings to determine trends that warrant further action through policy or oversight. The Acting Under Secretary anticipated implementation of these actions by March 31, 2018. Appendix E provides the full text of the Acting Under Secretary's comments.

In her response, the Acting Under Secretary for Health stated the OIG's draft report did not fully describe the many responsibilities that VHA providers and mental health providers take on. She pointed out that providers devote time to training residents, taking care of hospitalized patients, teaching at medical schools, conducting medical research, serving on local and national health care committees, and speaking at professional conferences. To accommodate these demands on their time, VHA assigns primary care providers and mental health providers fewer patients. The Acting Under Secretary appreciated the OIG's findings that many sites had not documented their justification for decreasing provider panels and agreed there is an opportunity to achieve better standardization.

OIG Response

The Acting Under Secretary for Health's comments and corrective action plan is responsive to the intent of the recommendation. The OIG will monitor implementation of planned actions and will close the recommendation when it receives sufficient evidence demonstrating progress in addressing the identified issues.

Regarding the Acting Under Secretary's statement that the OIG's report did not fully describe the many responsibilities of providers, the report focused on primary care provider panel sizes compared to VHA's modeled expectations. This included identifying each provider's direct patient care time devoted to outpatient care for veterans on their panels. By VHA's model definition, the calculated expectations for direct patient care already excluded time used for hospitalized patients, which is inpatient care, as well as time devoted to teaching and research. In evaluating time devoted to training residents, our results were inconclusive as to the effect on panels. Specifically, some locations assigned higher numbers of veterans to panels during time devoted to training residents, while other locations assigned fewer veterans to panels.

Appendix A Background

VHA's Modeled Panel Size Policy

VHA Handbook 1101.02 established guidelines for setting panel sizes using PCMM. VHA scheduled the handbook for recertification on or before the last working date of March 2014, but as of February 18, 2016, VHA had not recertified or replaced this handbook. VHA required facilities to enter in PCMM:

- Provider and associate provider direct patient care time, including the time to prepare for, provide, and follow up on the clinic needs of patients
- Clinic support staff dedicated to primary care
- Number of exam rooms
- Maximum panel of each provider determined by facility

In addition to these data, VHA created an intensity score for each facility. VHA analyzed patient characteristics to identify factors that affected demand for services. These factors included demographic information like age and priority group, as well as diagnoses. The intensity score estimates the average number of visits the facility population is likely to make.

To set modeled capacity for each facility location, VHA used a baseline of 1,200 veterans for a full-time provider and adjusted the baseline up or down depending on three factors: average support FTE, average exam rooms, and intensity score. For example, a facility with an average of 3.3 exam rooms per provider FTE would increase its modeled capacity by 2.5 percent, or 30 veterans. Tables 2, 3, and 4 show actual adjustments for each metric.

Table 2. Modeled Panel Size Adjustment for Support Staff

Average Support Staff FTE per Provider FTE	Adjustment to Panel Size
≥ 0.0 and < 1.20	- 10 percent
≥ 1.20 and < 1.40	- 7.5 percent
≥ 1.40 and < 1.60	- 5.0 percent
≥ 1.60 and < 1.80	- 2.5 percent
≥ 1.80 and < 2.20	No adjustment
≥ 2.20 and < 2.40	+ 2.5 percent
≥ 2.40 and < 2.60	+ 5.0 percent
≥ 2.60 and < 2.80	+ 7.5 percent
≥ 2.8	+ 10 percent

Source: VHA's PCMM Handbook

Table 3. Modeled Panel Size Adjustment for Exam Rooms

Average Exam Rooms per Provider FTE	Adjustment to Panel Size
≥ 0.0 and < 2.0	- 5 percent
≥ 2.0 and < 2.75	- 2.5 percent
≥ 2.75 and < 3.25	No adjustment
≥ 3.25 and < 3.75	+ 2.5 percent
≥ 3.75	+ 5 percent

Source: VHA's PCMM Handbook

Table 4. Modeled Panel Size Adjustment for Intensity Score

Intensity Score	Adjustment to Panel Size
≥ 0.0 and < 0.6	+ 10 percent
≥ 0.6 and < 0.7	+ 7.5 percent
≥ 0.7 and < 0.8	+ 5 percent
≥ 0.8 and < 0.9	+ 2.5 percent
≥ 0.9 and < 1.1	No adjustment
≥ 1.1 and < 1.2	- 2.5 percent
≥ 1.2 and < 1.3	- 5 percent
≥ 1.3 and < 1.4	- 7.5 percent
≥ 1.4	- 10 percent

Source: VHA's PCMM Handbook

After making the percent adjustments, the calculated modeled capacity becomes VHA's expected panel size for a full-time medical provider. The expectation is further adjusted for newly hired providers and non-physician providers. Non-physician providers include nurse practitioners and physician assistants. The expected panel size for a newly hired provider is set at 50 percent of a full-time medical provider's for the first six months of their first year, and set at 75 percent for the second six months. After the first 12 months, the expected panel size increases to 100 percent of a full-time provider. If the newly hired provider assumes the responsibility of a previously established panel, VHA's expected panel size is 75 percent of a

full-time medical provider for the first nine months and 100 percent after. For non-physician providers, VHA's expected panel size is set at 75 percent of the expected panel size of a full-time medical provider.

Specialized Panels

Specialized panels included panels that were dominantly or entirely populated by patients with specific conditions or complex diseases, such as women's health, geriatric care, or spinal cord injuries. VHA policy recognizes that the intensity score did not sufficiently account for these panels, and the specialized panels may need to be smaller and determined locally. Therefore, the OIG excluded specialized panels from our analysis except for women's health panels, because VHA policy provided additional guidance to adjust VHA's model for panels providing care to women. For its analysis using women's health panels, the OIG used VHA Handbook 1330.01. The handbook instructed a reduction of 20 percent from VHA's modeled panel size for the total number of women on a panel to compensate for additional medical needs related to women's care.

Panel Size Targets

VHA's handbook provided performance targets with specialized and undifferentiated panels combined. The targets used the averages of actual panel sizes, maximum panel sizes set by each facility, and VHA's modeled panel size. One facility performance target stated the average maximum panel size of the specialized and undifferentiated provider panels should be between 80 and 120 percent of VHA's modeled panel size. The second performance target stated the average panel sizes of the facility's specialized and undifferentiated provider panels should between 90 to 105 percent of the maximum panel size set by the facility.

Appendix B Scope and Methodology

Scope

The OIG conducted its audit work from April 2015 through August 2017. The audit focused on VHA's management of primary care panels in FY 2015 and newly enrolled veteran access to primary care from enrollment applications completed in the first seven months of FY 2015. The OIG did not review VHA's efforts to provide veterans access to non-VA primary care.

Methodology

To address its audit objective, the OIG performed the following actions:

- Conducted site visits to statistically selected VHA facilities in Dallas, TX; Detroit, MI; Durham, NC; Los Angeles, CA; San Francisco, CA; West Haven, CT; and West Palm Beach, FL
- Interviewed VHA's Office of Primary Care Operations officials, the executive director of Access and Clinic Administration Program, primary care providers, facility chiefs of staff, facility chiefs of Primary Care, and administrative officers
- Obtained and analyzed data from VHA's Health Eligibility Center, VHA Support Service Center's Completed Appointments Cube, VHA's Primary Care Management Module, and VHA's Financial Management System

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by soliciting the OIG's Office of Investigations for indicators. The OIG did not identify any instances of fraud during this audit.

Data Reliability

The OIG used computer-generated data from VHA's Veterans Health Information Systems and Technology Architecture. The OIG compared key elements from its sample selection to test the reliability of data, such as patient name and appointment dates, against source documentation accessed via the online Compensation and Pension Records Interchange system. The OIG did not identify any material inconsistencies with the reviewed records.

The OIG determined a data limitation existed with regard to the completeness of Veterans Health Information Systems and Technology Architecture's newly enrolled veterans data compiled in the Administrative Data Repository. The OIG compared summary results with similar data from the Corporate Data Warehouse and found the Corporate Data Warehouse contained additional veterans identified as newly enrolled. The OIG tested 10 records and determined those records were newly enrolled veterans, and they were excluded from the Administrative Data Repository data the OIG relied upon. The OIG derived its results from the population of 11,700 veterans it reviewed as described herein.

Despite the limitations discussed in this appendix, the OIG concluded the data used were sufficiently reliable to meet the audit objectives and support our recommendations.

Government Standards

The OIG's assessment of internal controls focused on those controls relating to audit objectives. The OIG conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that the OIG plans and performs the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objective. The OIG concludes that the evidence obtained provides a reasonable basis for its findings and conclusions based on the audit objective.

Appendix C Statistical Sampling Methodology

To determine if VHA effectively managed veterans' enrollment and scheduling processes, as well as the utilization of provider primary care panels to maximize access to primary care providers, the OIG evaluated statistical samples to determine:

- Elapsed days between eligibility determination to the date of scheduling and completed appointment, as well as the wait time recorded by VHA
- Whether undifferentiated and women's health panel sizes met VHA's modeled panel size

Populations

The facility population was composed of 140 VHA facilities. The population of veterans enrolling for benefits in the first seven months of FY 2015 who requested to be contacted for an appointment was divided into 11,700 veterans who received and 14,700 who did not receive a primary care appointment during that same period. The population of veterans on undifferentiated and women's health panels as of September 1, 2015 was an undefined subset of all provider panels that contained 5.4 million veterans assigned.

Sampling Design

Sample designs generally used simple random samples to ensure all samples were representative of the entire populations. When a review required physical reviews of facility operations or records, the OIG stratified the populations by each facility's panel sizes in relation to VHA's panel size expectation, as reported in VHA's PCMM. The OIG stratified the panel sizes using the former executive director of Primary Care Operation's statement that facilities should evaluate staff when they are above 90 percent panel capacity. The OIG divided facilities into groups above and below the stated 90 percent. Upon observing the number of facilities below that level, the OIG further stratified facilities that were more than 10 percent below the stated 90 percent. The OIG selected three facilities below 80 percent, two above 90 percent, and two between 80 and 90 percent. Table 5 provides the number of facilities and sampled facilities reviewed for each stratum.

Table 5. Stratification of Facilities by Percent of PCMM Panel Sizes to VHA's Expected Panel Size as of September 1, 2015

Strata	Facilities	Sampled Facilities
Less Than 80 Percent	76	3
80–90 Percent	38	2
Greater Than 90 Percent	26	2
Total	**140**	**7**

Source: PCMM data and OIG analysis of facility data

Newly Enrolled With Appointment

Using a national population, the OIG selected a simple random sample of 119 newly enrolled veterans who received care. Using a simple random sample allowed analysis of all facilities and the ability to later increase sample size based on availability of audit resources.

Undifferentiated and Women's Health Panels

Using the facility stratification from Table 5, the OIG reviewed both primary care provider FTE used for primary care management and related panel data from the selected facilities. The OIG used facility stratification to obtain accurate FTE and panel data by comparing PCMM data with up-to-date facility information. The OIG compared the number of veterans assigned to undifferentiated and women's health panels to VHA's expected panel sizes. The OIG applied VHA's expected panel size as defined by VHA Handbook 1101.02, which included adjustments for non-providers, newly hired providers, and prorating expectations based on time devoted to panel management. The OIG excluded contract providers from analysis. For newly hired providers, the OIG conservatively treated all newly hired providers as if they were not assuming the responsibility of a previously established panel. In addition, the OIG limited assigned panel levels for newly hired providers to the level of the adjusted expected panel sizes, which avoided masking lower panel assignments of providers with more than 12 months of experience.

Weights

The OIG calculated estimates in this report using weighted sample data. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time. Estimates were rounded for presentation purposes.

Table 6 shows the audit projections of the sample results from 119 records selected nationally. The projections include elapsed days between eligibility determination, scheduling, and completion of a primary care appointment. The OIG estimated an average of 29 days before the first scheduling of newly enrolled veterans. The OIG estimated about 53 percent of newly enrolled veterans waited more than 30 days past the veteran's earliest request for scheduling. Finally, the OIG estimated VHA's recorded wait showed an estimated 8 percent of newly enrolled veterans waited more than 30 days.

Table 6. Projections of Elapsed Days Between Enrollment Date to Scheduling Date and Date of Completed Appointment as Well as VHA Recorded Wait

Description	Estimated	Margin of Error	90% Confidence Interval Lower Limit	90% Confidence Interval Upper Limit	Sample Transactions With Condition
Average Days Waited From Eligibility to First Scheduling	29	6	23	36	119
Enrollment Date to Appointment <= 30 Days	5,500	890	4,600	6,400	56
Percent <= 30 Days	47%	8%	39%	55%	56
Enrollment Date to Appointment >30 Days	6,200	890	5,300	7,100	63
Percent >30 Days	53%	8%	45%	61%	63
VHA Recorded Wait Time <=30 Days	10,700	500	10,200	11,200	109
Percent VHA Recorded Wait Time <=30 Days	92%	4%	87%	96%	109
VHA Recorded Wait Time > 30 Days	980	500	490	1,500	10
Percent VHA Recorded Wait Time >30 Days	8%	4%	4%	13%	10

Source: OIG statistical analysis of elapsed days and VHA recorded wait

Table 7 shows the audit projections of the reviews of undifferentiated and women's health panels at the selected facilities. From the results, the OIG projected VHA's panel sizes were 19 percent below VHA's modeled panel size.

Table 7. Projections of VHA's Model Panel Size of Undifferentiated and Women's Health Panels as of September 1, 2015

Description	Estimated	Margin of Error	90% Confidence Interval Lower Limit	90% Confidence Interval Upper Limit
Provider Panels Below VHA's Modeled Panel Size	19%	12%	7%	30%
Percent of VHA's Modeled Panels Size Used	81%	12%	70%	93%
Better Use of Funds	$169 Million	$104 Million	$65 Million	$272 Million

Source: OIG statistical analysis

Table 8 shows the audit projections from the reviews of undifferentiated and women's health panels at selected facilities. The reviews estimated the percent of primary care provider FTEs assigned an undifferentiated or women's health panel. The OIG projected about 67 percent of primary care providers' FTEs had undifferentiated and women's health panels. This equated to almost $900 million of the $1.3 billion VHA spent on primary care provider salaries in FY 2015.

Table 8. Projection of the Percent of FTE With Undifferentiated and Women's Health Panels of Total Primary Care Provider FTE in FY 2015

Description	Estimated	Margin of Error	90% Confidence Interval Lower Limit	90% Confidence Interval Upper Limit
Estimated Undifferentiated and Women's Health Provider FTE Percent	67%	14%	53%	81%

Source: OIG statistical analysis

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

Recommendation	Explanation of Benefits	Better Use of Funds (in millions)	Questioned Costs (in millions)
3	VA facilities could have better used an estimated 19 percent of primary care provider panel size. These panels equated to paying almost $169 million in providers' salaries in FY 2015; over a five-year period this would total $843 million.	$843	$0
	Total	$843	$0

Potential Monetary Benefit Calculation

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

- The OIG determined that VHA facilities did not follow VHA guidelines, with average panel sizes about 19 percent below VHA's model.
- The OIG determined the number of provider FTEs with undifferentiated and women's health panel duties at our sample locations. From that, the OIG estimated provider FTE. Undifferentiated and women's health panel duties equaled about 67 percent of all primary care providers, or almost $900 million of about $1.3 billion provider FTE in FY 2015.
- Using the 19 percent reduced panel sizes as the reduced efficiency, the OIG estimated the reduced efficiency equated to about $169 million of the almost $900 million in undifferentiated and women's health primary care provider salaries paid in FY 2015.

This equates to better use of funds totaling about $843 million over five years if panel management is not strengthened.

Appendix E Management Comments

Department of Veterans Affairs Memorandum

Date: September 26, 2017

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of VHA's Management of Primary Care Panels (VAIQ 7825797)

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

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Audit of VHA's Management of Primary Care Panels. I concur in principle with recommendations 1 and 2 and concur with recommendation 3. I provide the attached action plan to address these recommendations.

2. We share OIG's concern and commitment to ensure Veterans have timely access to appropriate high quality health services. The Veterans Health Administration (VHA) has made tremendous strides on management of urgent and routine care appointments since OIG conducted this review. In a dynamic environment, we are continuously working to improve access for Veterans. The Department of Veterans Affairs (VA) now offers same day services in primary care and mental health for care needed right away at all of its medical center locations and at almost 98 percent of the just more than 1000 of VA's Community Based Outpatient Clinics. Twenty-two percent of all VA appointments occur the same day as they are requested. Additionally, the time it takes to complete an urgent referral to a specialist has decreased by over 90 percent from fiscal year (FY) 2014. In primary care, since FY 2014, wait time for a new patient in VA has decreased from 24.3 days to 22.1 days. According to Merritt Hawkins' recent "2017 Survey of Physician Appointment Wait Times," the new patient wait time for private sector Family Practice care was 29.3 days in large metropolitan areas; in mid-sized metropolitan areas, the wait time is 54.3 days. These wait times are longer than VA's wait time of 22.1 days. Services provided in private sector Family Practice care are similar to services provided by VA Primary Care therefore these wait times can be compared with each other.

3. Subsequent to OIG's review, VHA established a new Clinic Practice Management Program (CPM) based on strong practices from Department of Defense and the private health care sector. The program creates a formal oversight structure to ensure clinics are operating efficiently. VHA launched the program in November 2016. Each VA system has at least one Group Practice Manager (GPM) who is responsible for optimizing administrative management and clinical operations. GPMs monitor performance data and oversee the timeliness and accuracy of Veteran appointments. They collaborate with clinical and administrative leadership in Primary Care, Mental Health, Surgery and Medicine. GPMs report to a member of the facility leadership.

4. VHA currently manages over 7,000 primary care patient panels. In 2016, VHA automated the way we calculate the panel sizes by implementing the new Patient Centered Management Module (PCMM) Web. We also revised our policy which standardized our capacity model calculations. At this time, primary care and women's health panels are nearly full at 96.8 percent capacity (3.2 percent gap).

5. We appreciate the need to develop metrics that measure the entire wait time from the point when the Veteran is deemed eligible for health care to the time when they are seen. We will work toward developing a more complete set of measures which will reflect the Veteran's experience with obtaining their first appointment after enrollment.

6. VHA's Welcome to myVA (W2myVA) program, provides a consistent process for contacting newly enrolled Veterans to help them schedule their first VA appointment. Veterans may apply for health care by accessing: www.vets.gov. After an enrollment decision is made, the Health Eligibility Center (HEC)

calls each newly enrolled Veteran within five business days to welcome them to the VA health care system. During that call, the HEC staff asks whether the Veteran is interest in an appointment and if so, can connect the Veteran with a scheduler at the Veteran's preferred facility. HEC staff members make up to three attempts to contact each newly enrolled Veteran and, on average, make contact within 2.7 days. Since the inception of W2myVA, 39 percent of newly enrolled Veterans have been referred to a VA medical center to schedule an appointment. VHA will continue to rollout this approach to all facilities, along with ongoing improvements as outlined OIG Report 16-00355-296 dated August 14, 2017.

7. OIG's draft report doesn't fully describe the many responsibilities that our providers take on. In addition to seeing patients in clinic, primary care providers and mental health providers devote time to training residents, taking care of hospitalized patients, teaching at medical schools, conducting medical research, serving on local and national health care committees, and speaking at professional conferences. To accommodate these demands on their time, many VHA primary care providers and mental health providers are assigned fewer patients. However, it is important for facilities to document when a provider's panel size has been decreased to accommodate these responsibilities. We appreciate OIG's findings that many sites had not documented their justifications for decreasing provider panel sizes and agree that there is an opportunity to achieve better standardization.

8. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(Original signed by)

Poonam Alaigh, M.D.

Attachment

For accessibility, the format of the original documents in this appendix has been modified to fit in this document, to comply with Section 508 of the Americans with Disabilities Act.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report: Audit of VHA's Management of Primary Care Panels

Date of Draft Report: August 16, 2017

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommended the Acting Under Secretary for Health establish standardized scheduling processes that provide newly enrolled veterans an opportunity to schedule an appointment at the time of enrollment.

VHA Comments: Concur in principle

The Office of Veterans Access to Care (OVAC), in collaboration with Member Services Health Eligibility Center (HEC) will establish standardized procedures to ensure newly enrolled Veterans are offered an appointment within a timely manner, pursuant to enrollment requirements in 38 CFR 17.36-38. As part of the standardization, OVAC will provide interim guidance to all medical centers:

a) Immediately offering appointments to eligible Veterans who can demonstrate they are exempt from the requirement to enroll in VHA HealthCare (38 CFR 17.37).

b) Timely offering of appointments to Veterans not exempt from enrollment, and who are required to receive an eligibility adjudication from the Enrollment System (managed by HEC), prior to scheduling an appointment (described below).

Through the Welcome to myVA (W2myVA) initiative, the HEC established a process where each newly enrolled Veteran receives a phone call within five business days of enrollment, welcoming them to the Department of Veterans Affairs (VA). HEC staff members provide help with scheduling their first VA appointment and can connect the Veteran with a scheduler at the Veteran's preferred facility. This process was implemented in July 2015; however, not all VA medical facilities have begun using the W2myVA tools. The combination of interim guidance and the process that has been developed will ensure consistent procedures are defined for providing all newly enrolled Veterans an opportunity to schedule an appointment.

In response to VA OIG Report 16-00355-296, dated August 14, 2017, VHA Member Services established an action plan that standardizes policy and procedures for VHA Enrollment, streamlining how VAMCs manage their responsibilities for processing applications for Health Care, and establishing the responsibilities for initiating the scheduling process for newly enrolled Veterans.

Status	Target Completion Date
In process	March 2018

Recommendation 2: We recommended the Acting Under Secretary for Health establish metrics to monitor the time it takes facilities to offer scheduling to an initial primary care appointment beginning with the date the veteran submits a completed enrollment form.

VHA Comments: Concur in principle

VHA concurs in principle because VHA is not authorized to provide Veterans with health benefits until they are determined to be eligible, unless they are exempt from enrollment (38 CFR 17.37). Thus, the start date to monitor the duration it takes for a Veteran to schedule an initial appointment is based on the eligibility determination date, not the date the Veteran submits a completed enrollment form.

Per the action plan for recommendation 1, if requested by the Veteran, the W2myVA outbound call can include connection with a VAMC scheduler, who inquires whether the Veteran needs a primary care practitioner and when they would like to be seen. The scheduler then books an appointment according to the Veteran's preferred date.

The current W2myVA report provides VHA Leadership visibility of the average duration it takes to contact newly enrolled Veterans to offer them an appointment, beginning from the date of eligibility.

Status	Completion Date
Complete	September 2017

Recommendation 3: We recommended the Acting Under Secretary for Health improve oversight by ensuring facilities set panel sizes consistent with VHA's recommended model panel sizes, or submit written justification for panel sizes that deviate from VHA's model panel sizes for review and approval by VHA, or implement corrective action to mandate appropriate panel size.

VHA Comments: Concur

In October 2016, VHA deployed a new updated version of our primary care panel management software called Patient Centered Management Module (PCMM) Web. This software helps manage access to health care, care coordination and staffing needs. The new PCMM Web automatically takes into account the many variables that would impact the number of patients a provider can take care of. PCMM Web accounts for the number of support staff, number of exam rooms available, and complexity of patient health concerns. For example, providers taking care of patients with multiple medical problems will have a smaller panel size than providers taking care of healthy Veterans.

VHA's policy on PCMM Web provides guidance on the expected number of patients assigned to a primary care provider. We rely on PCMM Web to calculate the exact panel size for each local provider based on the unique characteristics of their practice (eg. staffing, number of exam rooms and patient complexity.) If the number of patients assigned to the provider varies significantly from VHA's expected panel size, then the primary care manager must document justification for the variation.

To improve oversight of facility-set panel sizes, VHA's Office of Primary Care (OPC) will direct each Veterans Integrated Support Network (VISN) and their respective VA medical facilities to verify that they have reviewed and incorporated necessary changes based on the guidance outlined in VHA Directive 1406. Additionally, OPC will direct each VISN to perform a quarterly audit of all panel capacities that are not consistent with VHA recommended modeled capacities and to review the justification for the override. VISNs are expected to document their review of PCMM Web data, which includes staffing, examination rooms, panel capacities and justifications and return their reviews to OPC on a quarterly basis. OPC will conduct a biannual audit of VISN findings to determine trends that warrant further action through policy or oversight strategies. The target completion date accommodates the scheduling for the biannual audit.

At completion of this recommendation, OPC will provide documentation of

1. A sample of VISN quarterly reports that are submitted to OPC
2. The results of OPC's biannual audit of VISN findings

Status	Target Completion Date
In process	March 2018

Appendix F OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Ken Myers, Director Michael Fleak Timothy Halpin Brad Lewis Eric Sanford Jason Schuenemann

Appendix G Report Distribution

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