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Office of Healthcare Inspections

Report No. 17-02686-125

Healthcare Inspection

Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic VA Palo Alto Health Care System

Palo Alto, California

March 8, 2018

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous complaint received in 2017 alleging that patients experienced extended wait times for primary care appointments and that funds intended to maintain or improve primary care services at the Monterey Community Based Outpatient Clinic (clinic), Monterey, CA, were misused. The clinic is associated with the parent facility, VA Palo Alto Healthcare System (system), Palo Alto, CA.

We substantiated that patients experienced extended wait times for clinic primary care appointments. We found the number of new and established clinic primary care appointments taking 30 days or more to schedule increased from fiscal year (FY) 2016 to FY 2017. Veterans Health Administration (VHA) Support Service Center data indicated the percentage of new patients experiencing a wait time of more than 30 days increased from 1.63 percent in FY 2016, quarter (Qtr) 3, to 17.34 percent in FY 2017, Qtr 2. Although the percentage of established patients waiting more than 30 days was less than 10 percent, the data showed an increase from 4.49 percent in FY 2016, Qtr 3, to 8.30 percent in FY 2017, Qtr 2.

We determined that clinic wait times for primary care appointments were negatively impacted by Patient Aligned Care Team (PACT) physician vacancies, PACT scheduling processes, and PACT clinic appointments that were blocked. The appointments were blocked to allow providers to participate in workshops in preparation for opening the new expanded clinic (new clinic) that would serve active duty military members and veterans.[1]

We found PACT physician vacancies in the clinic from FY 2016, Qtr 3 through FY 2017, Qtr 2. When clinic vacancies occurred around that time, HR representatives were not notified until January 5, 2017. The positions were subsequently posted on the federal government website on January 27, 2017 and closed on April 28, 2017. As of August 25, 2017, all clinic PACT physician positions had been filled.

We found a disparity in the scheduling process related to the amount of time clinic PACT providers allotted for follow-up appointments, which impacted wait times. Some PACT providers routinely scheduled established patients for 40-minute follow-up appointments instead of the expected 20-minute appointments, thereby limiting the number of patients they were able to see each day. Other PACT providers scheduled 40-minute follow-up appointments more sparingly. We compared the schedule of two full-time PACT physicians in FY 2017, Qtr 2, who were not impacted by scheduled clinic cancellations. The physician who scheduled fewer 40-minute follow-up appointments saw 174 more patients that quarter and an average of 11 more patients on a weekly basis. The clinic Medical Director informed us that as of June 7, 2017, physicians were no longer permitted to schedule established patients into 40-minute appointment slots.

[1] On August 14, 2017, the Major General William H. Gourley VA-Department of Defense Outpatient Clinic opened and replaced the clinic.

In addition, we found PACT staff participated in planning workshops for the new clinic which opened on August 14, 2017. Due to workshops scheduled in preparation for the opening of the new clinic, staff blocked and rescheduled patient appointments (52 provider PACT clinic days). This delayed next available appointment dates for both new and established patients.

Within the clinic, we also found a medical support assistant shortage, physician patient panel sizes over the recommended maximum, a reported large number of walk-in patients, and a history of minimal oversight. At the time of our site visit in May 2017, 3 of 16 medical support assistant positions were vacant. Part-time physicians carried patient panel sizes ranging between 99–118 percent of the recommended maximum. When a physician has a panel size over recommended capacity, enough appointments may not be available to provide timely care. Additionally, system leaders did not take into account the large number of walk-in patients being seen daily within the PACT clinic. Although the system website stated that the clinic has "no emergency services" and does not "have walk-in appointments available," the clinic developed a process for the management of unscheduled walk-in patients. In April 2016, system leaders created and filled a clinic Medical Director position to provide on-site management.

System and clinic leaders and PACT staff were unaware of adverse patient outcomes that occurred as a result of lengthy wait times for appointments. However, although no specific adverse patient events were identified, the lengthy wait times could have negatively impacted patient outcomes.

We did not substantiate the misuse of clinic funding which was intended to maintain or improve PACT at the clinic. We analyzed the direct[2] and indirect[3] costs for the clinic from FY 2014 through May 31, 2017, and found that funding had not substantially changed throughout this timeframe. We found no evidence that the system misused PACT funding designated for the current clinic or the new clinic.

We recommended that the System Director:

- Review human resources and clinic hiring processes for PACT staff and take action to minimize delays in filling vacancies.
- Assess and ensure patient panel sizes for PACT providers are in compliance with VHA policy.
- Ensure that PACT process improvement projects do not negatively affect clinic patient appointments.

[2] Direct cost is the cost of direct patient care. Examples include medical equipment, salaries of administrative positions in clinical areas, salaries of providers, and the cost of medical supplies.

[3] Indirect cost is not directly related to patient care and cannot be specifically traced to or identified with an individual patient or group of patients. Examples of indirect costs are financial, human resources, and environmental services.

Comments: The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes B and C, pages 15–19 for the Directors' comments.) We consider recommendations 1 and 3 closed. We will follow up on the planned action for recommendation 2 until it is completed.

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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous complaint received in 2017 alleging that patients experienced extended wait times for primary care appointments and that funds intended to maintain or improve primary care services at the Monterey Community Based Outpatient Clinic (clinic), Monterey, CA, were misused. The clinic is associated with the parent facility, VA Palo Alto Healthcare System (system), Palo Alto, CA.

Background

The system has three inpatient facilities located in Palo Alto, Menlo Park, and Livermore, plus seven outpatient clinics in San Jose, Fremont, Capitola, Monterey, Stockton, Modesto, and Sonora. Comprehensive healthcare is provided in areas of medicine, surgery, psychiatry, rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The system operates over 800 beds, including 3 community living centers and a 100-bed homeless domiciliary—all to serve more than 67,000 enrolled patients.

The clinic provides primary care, mental health, laboratory, pharmacy, and multiple specialty services to more than 10,110 unique patients. The system website states that the clinic has “no emergency services” and does not “have walk-in appointments available.” However, the clinic developed a process for the management of unscheduled walk-in patients.

On August 14, 2017, the Major General William H. Gourley VA-Department of Defense Outpatient Clinic opened and replaced the clinic. The “Monterey Health Care Center” (new clinic) is a joint project by leadership from the VA and Department of Defense. The new clinic serves veterans, and active duty military members and their beneficiaries.

Patient Aligned Care Team Model of Care

In 2009, the VA formally adopted a team-based model of care highlighting patient centered care, coordination of care, and access to care. To apply these principles more completely within primary care, Veterans Health Administration (VHA) adopted and customized the patient-centered medical home model of care to create the Patient Aligned Care Team (PACT). The PACT is led by a primary care provider who enables continuous and coordinated care to maximize health outcomes.[4] According to the PACT Handbook, the staffing ratio recommendation is at least 3.0 full time employee equivalent (FTE) staff to 1.0 FTE provider with a full panel of patients receiving comprehensive primary care.

[4] VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

PACT Appointments

VHA primary care wait time data are maintained in the VHA Support Service Center (VSSC).[5] Timeliness of appointments is calculated by the preferred date.[6,7] VHA specified a wait time policy of scheduling appointments no more than 30 calendar days from the preferred date.[8]

Same Day Access

Dr. David J. Shulkin, Under Secretary for Health, announced a roadmap for improvement to veterans' access to care in April 2016. He set "aspirational goals" of same day access to primary care services for veterans and hoped all VA facilities would offer same day appointments when medically indicated. The PACT Handbook defines same day access as "the ability to schedule an appointment within one business day of when the patient contacts the facility." All PACT staff share responsibility for creating and maintaining access for in-person encounters, group visits, telehealth, secure messaging, and telephone encounters for the designated panel of patients.[9]

Patient Panel Sizes

VHA discusses patient panel sizes, primary care staffing, and workload expectations in the Primary Care Management Module Handbook.[10] VHA mandates the use of the Primary Care Management Module software program to manage PACT patient panels. The software allows the system to track patients and assigned providers, allowing VHA to monitor and analyze provider workload nationally, by Veterans Integrated Service Network (VISN), by facility, and by substations such as clinics. The expectation outlined in VHA policy is that a panel size of 1,200 patients is baseline for an FTE physician.[11]

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[5] The VSSC provides data within its stewardship to establish internal VA organization/program offices for the purpose of health care delivery, analysis, and evaluation.

[6] The preferred date is the date a patient prefers to be seen or the date the provider deems clinically indicated.

[7] VHA Directive 2010-027, *Outpatient Scheduling Processes and Procedures,* June 9, 2010. This VHA directive was in effect during part of the time of the events discussed in this report. It was rescinded and replaced in July 2016 by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016. The 2010 Directive used the term desired date (the date which the patient desires or provider wants the patient to be seen). The 2016 Directive established use of the terms clinically indicated date and preferred date versus desired date. We elected to use the term preferred date for the entire review period as it reflects current terminology.

[8] VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006 stated that patients must be able to schedule a routine follow-up appointment with their primary care provider within 30 days.

[9] VHA Handbook 1101.10, *VHA Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

[10] VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, and contains the same or similar language regarding the Primary Care Management Module software program to manage PACT patient panels.

[11] Ibid.

Productivity

VHA Directive 1231[12] states system leadership is responsible for ensuring that "the provider's time is used effectively…is well planned and coordinated with the provider." The directive further stipulates that the Group Practice Manager will "access clinical practice management dashboard metrics and based on data analysis, apply appropriate strategies through performance improvement teams." The VA Central Office Director of Primary Care Operations told us productivity of providers is measured by panel management. The expectation is that a provider's panel enrollment is between 95–105 percent of their expected panel size.

New Clinic Funding

As part of its fiscal year (FY) 2008 Asset Management Plan, VHA commissioned studies to assess the feasibility of leasing facilities in lieu of major construction. VA determined leasing major outpatient clinics would provide the flexibility to increase veterans' accessibility to services and address critical outpatient demand without the need for additional major construction funding.

In October 2009, Congress passed Public Law 111-82 authorizing approximately $150.1 million that would be used for seven clinic leases, including one in Monterey, CA. The clinic lease was awarded in September 2013 and the activation phase began.

The activation phase encompasses activities that identify, plan, manage, and execute logistical and operational requirements to bring a new facility to full operation. In addition, activation funding was allocated for the design and opening of new clinics. Activation activities include, but are not limited to: equipment and furniture inventory; high cost/high tech equipment procurement; recruitment, selection, staffing, orientation and training; validation of infrastructure and equipment commissioning; move planning; and on-site simulation testing and hazard mitigation.[13]

Relevant OIG Reviews Published Within the Last 3 Years

We issued additional reports involving other VA facilities that evaluated patient wait times and the impact of staff shortages. See Appendix A.

Allegations

On March 22, 2017, OIG received an anonymous complaint that the clinic is "grossly understaffed" resulting in extended wait times for veterans. In addition, the complainant alleged misuse of funds intended to maintain or improve PACT at the clinic.

[12] VHA Directive 1231, *Outpatient Clinic Practice Management*, November 15, 2016.
[13] VHA National Activations Office (10NA-NAO), Activation Process Guide, February 2015.

Scope and Methodology

We initiated our review in March 2017 and conducted a site visit May 1–5, 2017. We requested and reviewed updated information in August 2017.

We interviewed the following system personnel: Acting System Director, Chief of Staff, Deputy Chief of Staff, Associate Chief of Staff for Ambulatory Care, and Chief of Health Administration Services. We also interviewed the following clinic personnel: Medical Director; Nurse Manager; Medical Support Assistant (MSA) Supervisor; physicians; nurses; and MSAs.

We reviewed VHA and system policies and procedures, meeting minutes, VHA Corporate Data Warehouse data,[14] VSSC reports, provider productivity reports, Patient Advocate Tracking System data, and other relevant documents.

We reviewed the clinic VSSC wait time data for both new and established PACT appointments for FY 2016, quarters (Qtrs) 3 and 4, and FY 2017, Qtrs 1 and 2. We reviewed the average amount of days a patient waited for a PACT appointment, as well as the percentage of patients who waited greater than 30 days from the preferred date to the appointment date.

We reviewed clinic vacancies and hiring processes for FY 2016, Qtrs 3 and 4 and FY 2017, Qtrs 1 and 2. In addition, we reviewed clinic PACT physician scheduling practices and clinic cancellations for the same timeframe.

The OIG Office of Healthcare Inspections conducted this review except where otherwise stated. The OIG Office of Audits and Evaluations conducted interviews and analyzed policy to assess the merit of the complaint as it relates to funding for PACT staff.

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.

[14] The Business Intelligence Service Line is the section of the Office of Information and Technology that maintains a set of servers and other information technology resources that provide clinical and other data to VA for analytical purposes. Each server contains a national data set, a regional data set, or a VISN data set. The term "Corporate Data Warehouse" is often used to mean the system overall as the metadata and other documentation apply to all environments.

Inspection Results

Issue 1: Wait Times

We substantiated that patients experienced extended wait times for clinic primary care appointments. Staff identified clinic access issues in 24 of 26 interviews. Specifically, staff told us new patients experienced extensive wait times for clinic primary care appointments. VSSC data we reviewed supported staff statements.

VSSC Wait Time Data.

We reviewed the average wait time in days for both new and established patient appointments for FY 2016, Qtrs 3 and 4 and FY 2017, Qtrs 1 and 2, which are outlined in Table 1.

Table 1. Average Wait Time in Days From Preferred Date[15] to Appointment Date FY 2016 Qtr 3 Through FY 2017 Qtr 2

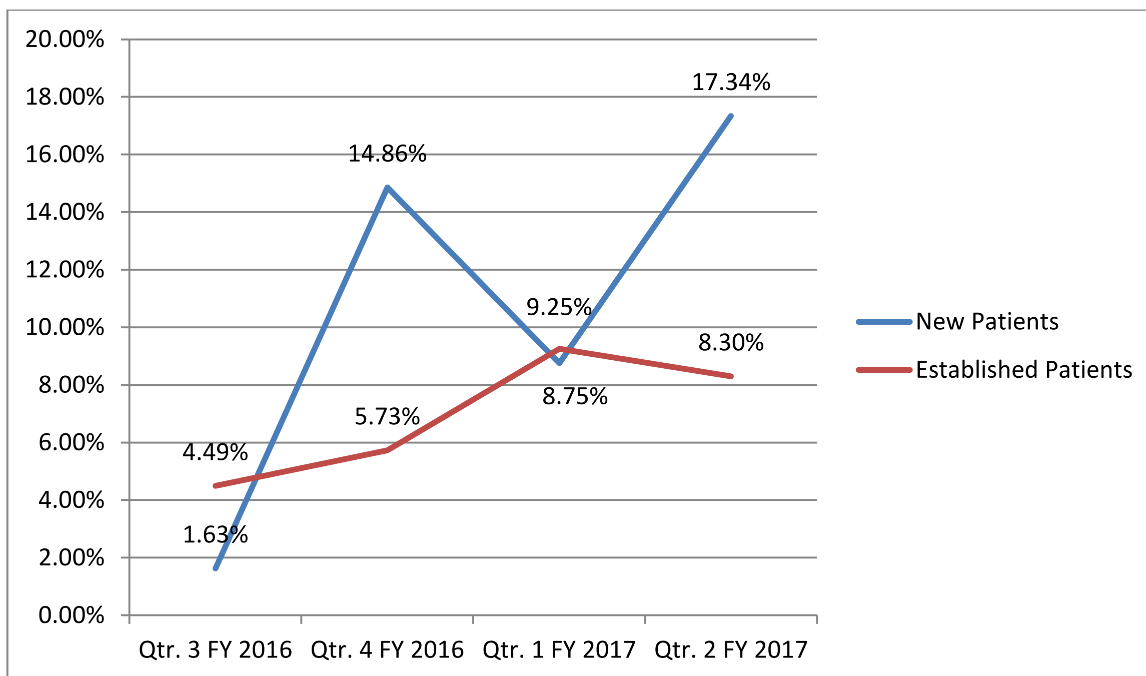
Time Period	New Patient	Established Patient
FY 2016 Qtr 3	7.1	7
FY 2016 Qtr 4	10.6	7.2
FY 2017 Qtr 1	9.4	8.5
FY 2017 Qtr 2	11.6	8.5

Source: VSSC

Despite the low average number of days between the preferred date and the appointment date, the data indicated the percentage of new patients experiencing a wait time of more than 30 days increased from 1.63 percent in FY 2016, Qtr 3, to 17.34 percent in FY 2017, Qtr 2. Although the percentage of established patients waiting more than 30 days was less than 10 percent, the data showed an increase from 4.49 percent in FY 2016, Qtr 3 to 8.30 percent in FY 2017, Qtr 2. The Figure below shows the increase in the percentage of both new and established patients waiting more than 30 days for a primary care appointment.

[15] VHA Directive 2010-027 was rescinded and replaced in July 2016 by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016. With the change of Directives, the term desired date was replaced with the term preferred date to indicate when the patient wants to be seen or the date the provider wants the patient to be seen.

Figure. Percentage of Patient Wait Times Greater Than 30 Days From Preferred Date FY 2016 Qtr 3 Through FY 2017 Qtr 2



Source: OIG analysis of VSSC data

A. Factors Impacting Wait Times

We identified several factors that contributed to the increase in the percentage of patients waiting greater than 30 days for a clinic primary care appointment.

PACT Physician Vacancies. We found PACT physician vacancies in the clinic from FY 2016, Qtr 3 through FY 2017, Qtr 2. Two physician assistants and a locum tenens[16] covered the patient panels for the vacant and absent physician positions. In April 2017, a fee for service or fee basis physician[17] started at the clinic to help provide coverage.

System leaders told us that delays in recruitment and selection of clinic PACT physicians occurred partially due to human resources (HR) processing issues. The Associate Chief of Staff for Ambulatory Care reported that system leaders were aware of the HR issues and implemented process improvements in October 2016.

When clinic vacancies occurred around that time, HR representatives were not notified until January 5, 2017. The positions were subsequently posted on the federal

[16] Locum tenens is defined as one filling an office for a time or temporarily taking the place of another.
[17] According to VA Handbook 5011/27, *Hours of Duty and Leave*, October 21, 2014, Intermittent and Fee Basis Employment are persons employed on an intermittent basis, per annum fee basis, or lump-sum fee basis, who under [the] authority of 38 U.S.C. 7405 are paid for actual service rendered and therefore their duty schedules shall be determined by procedural requirements issued by the Under Secretary for Health.

government website on January 27, 2017 and closed on April 28, 2017. As of August 25, 2017, all clinic PACT physician positions had been filled.

PACT Physician Schedules. Clinic PACT physician schedules varied depending on employment status and collateral duties. We reviewed the clinic's PACT schedules and found an FTE PACT physician schedule aimed to have 63 bookable 20-minute appointment slots per 40-hour work week. The appointment slots included new, established, and same day patient appointments. Traditionally, staff scheduled established and same day patient appointments in 20-minute increments. New patient appointments were 40 minutes in length, allowing more time for the patient and physician to exchange information at the initial visit. Physicians may have fewer new patient appointments per week depending on their current panel size.

Clinic staff told us a discrepancy in the scheduling practices of different PACT physicians resulted in a lack of appointment availability. Some physicians preferred to schedule established patient appointments in 40-minute increments as opposed to 20 minute. PACT physicians determined the appointment length and informed the MSA who scheduled the appointment according to physician instructions. Neither justification nor approval was required to schedule 40-minute established patient appointments.

We reviewed the scheduled clinic PACT patient appointments by physician for FY 2017, Qtr 2. We compared the schedules of the two FTE physicians who did not have scheduled clinic cancellations within the timeframe. We found a discrepancy in the number of patients a physician was able to see related to the amount of established patients staff scheduled into 40-minute appointment slots, as shown in Table 2.

Table 2. FTE PACT Physician Scheduled Appointments, FY 2017, Qtr 2

Patient Status	Physician 1	Physician 2
New Patients (40 minutes)	24	15
Established Patients (<40 minutes)[18]	373	100
Established Patients (40 minutes)	47	155
Total Patients	444	270
Weekly Average of all Patient Appointments	34.31	22.58

Source: OIG analysis of Corporate Data Warehouse data

The physician who scheduled more 40-minute established patient follow-up appointments saw 174 fewer patients that quarter. In addition, the difference in the average weekly number of patients seen was greater than 11.

[18] Data indicated that two established patient appointments were for 30 minutes during the timeframe reviewed. All other established patient appointments in this category were 20 minutes.

The clinic Medical Director informed us that as of June 7, 2017, physicians were no longer permitted to schedule established patients into 40-minute appointment slots.

Preparation for the Opening of the New Clinic. In preparation for the opening of the new clinic, PACT staff participated in "3P (Production Preparation Process)" planning workshops.[19] In interviews, system staff informed us that the 5-day process improvement workshops allowed teams to design a process for breakthrough ideas that challenged the status quo. Clinic staff participated in several 3P workshops, which focused on the "new patient centered model of care." These workshops took place during regular PACT clinic hours, resulting in patient appointment cancellations, and delayed next available appointment dates for both new and established patients. From April 2016 through April 2017, 52 provider PACT clinic days were blocked due to participation in 3P workshops.

B. Other Findings

Other PACT Staff Shortages. At the time of our May 2017 site visit, 3 of 16 PACT MSA positions were vacant including a supervisory and lead MSA position. While onsite, clinic leaders informed us all but one PACT MSA position had been filled, and the newly hired MSAs were in the hiring process. In addition, system leaders created a continuously open MSA job announcement to maintain a pool of qualified candidates due to high turnover of this position.

We did not find a shortage of PACT registered nurses (RN) or licensed vocational nurses at the clinic. In addition, we were told that leaders hired four new nursing assistants with the earliest new hire reporting in May. We were told that the other two nursing assistant candidates did not have a start date.

Panel Size Maintenance. As of June 2, 2017, FTE PACT physicians maintained patient panel sizes at 84–96 percent capacity. No physician panel was above 1,200 patients; however, 2 of the 3 part-time physicians were above capacity for their adjusted panel size.[20] Physicians who were less than 1.0 FTE had patient panels between 99–118 percent capacity, adjusted for the physician's hours. VHA has the expectation that a panel size is set to allow a patient to be seen 1.2 to 1.6 times per year. If a physician has a panel size over the recommended capacity, enough appointments may not be available to meet this expectation.

Walk-In Patients. System leaders, clinic leaders, and clinic staff, told us that the clinic had a large number of walk-in patients who presented on a daily basis. Clinic leaders provided data regarding the number of walk-in patients, showing a total average of five

[19] "3P workshops" are 5-day workshops that allow teams to design a new product or process for breakthrough ideas that challenge the status quo. 3P team membership includes key stakeholders, leadership, front line staff, internal and external customers. Team size varies from 10 to 25 team members depending on the scope of the workshop. The final deliverable of a 3P workshop is a proof of concept and a 3P action bulletin that serves as an implementation plan of steps required to operationalize the concept model developed during the 3P workshop.

[20] Providers who are not FTE have a panel size proportionately adjusted to their percentage of employment status.

unscheduled patients per day for all provider clinics.[21] The clinic standard operating procedure stipulated that when a patient presents to the clinic as a walk-in and requests to be seen by a provider, the MSA alerts the PACT team. When the RN has completed scheduled appointments for the day, the RN will conduct an assessment of the patient and consult with the provider to determine if a provider same day appointment is needed. Clinic staff reported they do not turn away walk-in patients. During interviews, system leaders stated clinic patients and staff have a “family culture,” which can encourage patients to walk-in for services.

Oversight at the Clinic. In April 2016, system leaders created and filled an onsite clinic Medical Director position to provide onsite management of the PACT providers and oversight of care. The clinic’s Medical Director, Nurse Manager, and Administrative Lead formed an onsite management team to oversee clinical and administrative operations as well as to ensure alignment of clinic goals with system goals. Prior to the creation of the onsite position, the Associate Chief of Staff for Ambulatory Care, located at the system, provided oversight to all system community based outpatient clinics.

Potential Effects of Delayed Access to Care

During interviews, staff were unaware of adverse patient outcomes as a result of lengthy wait times for appointments. We requested system incident reports, peer reviews, patient complaints, and patient advocate data; however, system leaders found no reported incidents from FY 2016, Qtr 3 to FY 2017, Qtr 2. Although no specific adverse patient events were identified, the lengthy wait times could have negatively impacted patient outcomes.

New patient appointments allow providers to assess a patient’s current condition, provide a baseline for treatment, prevent future ailments, and address patient concerns. Managing chronic illness often requires more frequent appointments and follow-up care. Difficulty accessing care could exacerbate unmanaged symptoms, resulting in potentially permanent or fatal outcomes.

Despite extended wait times for both new and established patients, clinic staff offered other services to meet patients’ immediate needs via the Telephone Care Program[22], same day access appointments, and nursing clinics. Walk-in patients were seen by available alternate providers, in lieu of their assigned provider. However, although effective, this practice also had disadvantages, potentially leading to inconsistencies in treatment plans and accountability for follow-up. Clinic staff addressed acute patient needs without a scheduled appointment; however, this type of scheduling process can increase the risk of adverse outcomes.

[21] We could not independently verify the data the facility presented because the data are not tracked nationally.
[22] Telephone Care Program (TCP) is a call center for the system available from 8:00 a.m. to 4:00 p.m. MSA agents screen and manages calls appropriate to the need. All medical symptom calls are entered into an RN queue for callback, unless the symptoms meet the criteria list for urgency. All urgent symptom calls are communicated directly to the TCP Advice Nurse.

Although staff were unable to specify adverse patient outcomes, clinic staff told us that patients often complained about difficulties obtaining an appointment. Clinic staff also stated that instead of attempting to make an appointment, many patients preferred to walk-in for services. Large numbers of clinic walk-in patients can increase daily clinic congestion, leading to patient dissatisfaction and poor customer service.

Issue 2: Clinic Funding

We did not substantiate the misuse of clinic funding, which was intended to maintain or improve PACT at the clinic. We analyzed the direct[23] and indirect[24] costs for the clinic for FY 2014 through May 31, 2017, and found that funding had not substantially changed throughout this timeframe. We found no evidence that the system misused PACT funding designated for the current clinic or the new clinic.

We evaluated additional funding for the new clinic and found that only partial FY 2017 activation funds were requested due to a delay in the opening of the new clinic. The main factor that led to the delay was the incorporation of the PACT model of care into the design of the new clinic. As of January 2017, the VA accepted the new clinic as substantially completed per the terms of the developer lease contract.

The Office of Capital Management determined the required activation funds, which included both recurring and non-recurring staffing costs. Activation funds are requested from VHA in January or February of each year. The funds are received, and available for staffing at the beginning of the following FY. Due to delays in completing construction of the new clinic, only minimal recurring activation funds ($500,000) for staffing salaries were requested for FY 2017. System leaders could use the funds for any new staff starting work prior to the end of FY 2017. We were informed that $2.8 million dollars in activation funds were requested for FY 2018.

Conclusions

We substantiated that patients experienced extended wait times for clinic primary care appointments. We found the number of new and established clinic primary care appointments taking 30 days or more to schedule had increased from FY 2016, Qtr 3 to FY 2017, Qtr 2. VSSC data indicated the percentage of new patients experiencing a wait time of more than 30 days increased from 1.63 percent in FY 2016, Qtr 3, to 17.34 percent in FY 2017, Qtr 2. Although the percentage of established patients waiting more than 30 days was less than 10 percent, the data showed an increase from 4.49 percent in FY 2016, Qtr 3 to 8.30 percent in FY 2017, Qtr 2.

[23] Direct cost is the cost of direct patient care. Examples include medical equipment, salaries of administrative positions in clinical areas, salaries of providers, and the cost of medical supplies.
[24] Indirect cost is not directly related to patient care and cannot be specifically traced to or identified with an individual patient or group of patients. Examples of indirect costs are financial, human resources and environmental services.

We determined that clinic wait times for primary care appointments were negatively impacted by PACT physician shortages, PACT scheduling processes, and PACT clinic appointments that were blocked to allow providers to participate in workshops. The workshops were held in preparation for opening the new clinic that would serve active duty military members and veterans.

We found a shortage of PACT physicians in the clinic from FY 2016 Qtr 3 through FY 2017 Qtr 2. When clinic vacancies occurred around that time, HR representatives were not notified until January 5, 2017. The positions were subsequently posted on the federal government website on January 27, 2017 and closed on April 28, 2017. As of August 25, 2017, all clinic PACT physician positions had been filled.

We found a disparity in the scheduling process related to the amount of time clinic PACT providers allotted for follow-up appointments, which impacted wait times. Some PACT providers routinely scheduled established patients for 40-minute follow-up appointments instead of the expected 20-minute appointments, thereby limiting the number of patients they were able to see each day. Other PACT providers scheduled 40-minute follow-up appointments more sparingly. We compared the schedule of two full-time PACT physicians in FY 2017, Qtr 2, who were not impacted by scheduled clinic cancellations. The physician who scheduled fewer 40-minute follow-up appointments saw 174 more patients that quarter and an average of 11 more patients on a weekly basis. The clinic Medical Director informed us that as of June 7, 2017, physicians were no longer permitted to schedule established patients into 40-minute appointment slots.

In addition, we found PACT staff participated in planning workshops for the new clinic, which opened on August 14, 2017. Due to the workshops scheduled in preparation for the opening of the new clinic, clinic staff blocked and rescheduled patient appointments (52 provider PACT clinic days), which delayed next available appointment dates for both new and established patients.

Within the clinic we also found MSA shortages, physician patient panel sizes over the recommended capacity, a reported large number of walk-in patients, and a history of minimal oversight. At the time of our site visit in May 2017, 3 of 16 MSA positions were vacant. Part-time physicians had patient panel sizes ranging between 99–118 percent of the recommended maximum. When a provider has a panel size over recommended capacity, enough appointments may not be available to provide timely care. Additionally, system leaders did not take into account the large number of walk-in patients being seen on a daily basis within the PACT clinic. Although the system website stated that the clinic has “no emergency services” and does not “have walk-in appointments available,” the clinic developed a process for the management of unscheduled walk-in patients. In April 2016, system leaders created and filled a clinic Medical Director position to provide on-site management.

System and clinic leaders and PACT staff were unaware of adverse patient outcomes that occurred as a result of lengthy wait times for appointments. However, although no specific adverse patient events were identified, the lengthy wait times could have negatively impacted patient outcomes and patient satisfaction.

We did not substantiate the misuse of clinic funding which was intended to maintain or improve PACT at the clinic. We analyzed the direct and indirect costs for the clinic from FY 2014 through May 31, 2017, and found that funding had not substantially changed throughout this timeframe. We found no evidence that the system misused PACT funding designated for the current clinic or the new clinic.

Recommendations

1. We recommended that the System Director review human resources and clinic hiring processes for Patient Aligned Care Team staff and take action to minimize delays in filling vacancies**.**

2. We recommended that the System Director assess and ensure patient panel sizes for Patient Aligned Care Team providers are in compliance with Veterans Health Administration policy.

3. We recommended that the System Director ensure that Patient Aligned Care Team process improvement projects do not negatively affect clinic patient appointments.

Appendix A

Prior OIG Reports

System Reports

Audit of VHA's Patient Advocacy Program
3/31/2017 | 15-05379-146

Review of Alleged Data Sharing Violations at VA's Palo Alto Health Care System
9/28/2015 | 14-04945-413

Healthcare Inspection – Alleged Dental Service Scheduling and Other Administrative Issues, VA Palo Alto Health Care System, Palo Alto, CA
7/9/2015 | 14-04755-428

Healthcare Inspection – Alleged Colorectal Cancer Screening and Administrative Issues, VA Palo Alto Health Care System, Palo Alto, California
7/9/2015 | 14-04754-407

Healthcare Inspection - Alleged Dental Service Scheduling and Other Administrative Issues VA Palo Alto Healthcare System Palo Alto, California
7/9/2015 | 14-04755-428

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Palo Alto Health Care System, Palo Alto, California
5/5/2015 | 15-00110-228

Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, California
4/30/2015 | 15-00032-226

Topic Related Reports

Healthcare Inspection – Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska
3/9/2017 | 15-05249-162

Healthcare Inspection – Nurse Staffing and Patient Safety Reporting Concerns, VA Roseburg Healthcare System, Roseburg, Oregon
10/12/2016 | 15-00506-420

Appendix A

Prior OIG Reports

Healthcare Inspection – Reported Primary Care Staffing at St. Cloud VA Health Care System, Veterans Integrated Service Network 23, Eagan, Minnesota
8/11/2016 | 15-05490-367

Healthcare Inspection – Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, AK
7/7/2015 | 14-04077-405

Healthcare Inspection – Staffing and Patient Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
2/12/2015 | 14-01708-123

Healthcare Inspection – Alleged Insufficient Staffing and Consult Management Issues, Carl Vinson VA Medical Center, Dublin, Georgia
1/7/2015 | 14-04702-60

An Analysis of Mental Health, Primary Care, and Specialty Care Productivity and Related Issues, El Paso VA Health Care System El Paso, Texas
12/2/2014 | 14-05128-51

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Bay Pines VA Healthcare System, Bay Pines, Florida
8/8/2014 | 14-00904-226

Healthcare Inspection - Quality of Care and Staffing Concerns, Salem VA Medical Center, Salem, Virginia
6/23/2014 | 13-03604-198

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Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 2, 2018

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection— Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic, VA Palo Alto Health Care System, Palo Alto, California

To: Director, San Diego Office of Healthcare Inspections (54SD)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review the draft report. Leadership at the VA Palo Alto Health Care System has reviewed the report and concurred with your findings. I have reviewed and agree with their corrective action plan.

2. Should you have any questions, please contact the VISN 21 Deputy Quality Manager at (707) 562-8350.

(original signed by Peter Bregenzer, Acting Deputy Network Director)

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: December 29, 2017

From: Director, VA Palo Alto Health Care System (640/00)

Subj: Healthcare Inspection— Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic, VA Palo Alto Health Care System, Palo Alto, California

To: Director, Sierra Pacific Network (10N21)

1. On behalf of VA Palo Alto Health Care System (VAPAHCS), I would like to express my appreciation to the Office of the Inspector General (01G) for their review of Alleged Patient Aligned Care Team Wait Time and Funding Issues at the Monterey Community Based Outpatient Clinic conducted May 1-5, 2017.

2. I have reviewed the findings from the report, and concur with each of the three recommendations. We have completed, or are in the process of completing, action to resolve these issues.

3. I appreciate the opportunity to participate in the review as a continuing process to improve the care to our Veterans.

Thomas J. Fitzgerald III

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director review human resources and clinic hiring processes for Patient Aligned Care Team staff and take action to minimize delays in filling vacancies.

Concur

Facility response: **Action 1:** Noted in the inspection results was the finding that PACT team physician vacancies occurring in July and October 2016 were not communicated to Human Resources until January 5, 2017. Also noted in the results is that the position vacancies were posted on January 27, 2017 and closed on April 27, 2017.

To close this communication gap, training was provided to service administrative officers regarding preparation and submission of USA Staffing requests. This has resulted in improved communication between the requesting service and human resources, evidenced by a reduction in the time fill a position to less than four months between a position being vacated and a firm offer being made to selectees.

Target date for completion: Completed

Action 2: A high rate of position turnover within the Human Resources department led to inefficiencies, owing to the need to recruit, onboard, and train replacements. Since June 2017 most vacant positions have been filled and staff trained to their positions, resulting in a stabilized workforce. A selection for the vacant Medical Resource office position has been made and the selectee will assume the duties on January 1, 2018. Filling this vacancy will eliminate delays in onboarding selectees.

Target date for completion: January 1, 2018

Recommendation 2. We recommended that the System Director assess and ensure patient panel sizes for Patient Aligned Care Team providers are in compliance with Veterans Health Administration policy.

Concur

Facility response:

Monterey PACT Teams	Active	Pending	Total	Target Panel	Available Capacity	% Target	PCMM FTE	COMMENT
MONT-PC-*WH*-TEAM 1	**919**	**15**	**934**	**960**	**26**	**97%**	**0.8**	**.1 MD PACT Lead, .1 PA Supervisor**
MONT-PC-TEAM 2	936	7	943	1200	257	79%	1	
MONT-PC-*WH*-TEAM 11	417	5	422	600	178	70%	1	.5 Panel. Start 7/10/17
MONT-PC-TEAM 3	1040	16	1056	1200	144	88%	1	
MONT-PC-TEAM 4	332	3	335	240	-95	140%	0.2	.2 GMC, .8 Hematology
MONT-PC-*WH*-TEAM 5	1040	7	1047	1200	153	87%	1	
MONT-PC-*WH*-TEAM 6	105	2	107	450	343	24%	0.5	.75 Start date 12/2016
MONT-PC-*WH*-TEAM 10	224	3	227	450	223	50%	0.5	.75 Start date 12/2016
MONT-PC-*WH*-TEAM 12	572	50	622	900	278	69%	1	Start date 5/1/17
MONT-PC-TEAM 7	1141	17	1158	1200	42	97%	1	
MONT-PC-*WH*-TEAM 8	**618**	**1**	**619**	**600**	**-19**	**103%**	**0.5**	**.4 Medical Director (.5 PC, .1 PA Supervisor)**
MONT-PC-*WH*-TEAM 9	672	3	675	600	-75	113%	1	Start 8/6/17 FTE .5
FEE BASIS PROVIDER			0	0	0		0	covering SD
MONT TOTALS			8145	9600	1455	85%	9.50	

Source: PCMM panel report Nov 2017–does not reflect model capacity

Action 1: Two providers exceed the allowable capacity, MONT-PC-Team 4 and MONT-PC-Team 9. MONT-PC-Team 4 provider's time allocation will be adjusted to increase from the current 0.2 GMC to adjust the target panel up, or reassign patients to another PACT, which will bring this provider assignment into compliance.

Target date for completion: February 16, 2018

Action 2: MONT-PC-Team 9 provider's target panel will be increased to 900, which will put this provider at 75% of target. The workload is consistent with PCMM handbook Appendix E-1:

> *f. Newly-hired providers who are building a panel of new patients may take 12 to 15 months to achieve a full panel equal to that of an established provider. For the purposes of pro-rating capacity, maximum panel capacity for such providers may be set at 50 percent of a fully-established provider for the first 6 months, at 75 percent for the second 6 months, and then at 100 percent at 12 months. Specific panel capacity recommendations for new providers are customized for each facility as appropriate by the Chief of Staff or designee.*

Target date for completion: February 6, 2018

Recommendation 3. We recommended that the System Director ensure that Patient Aligned Care Team process improvement projects do not negatively affect clinic patient appointments.

Concur

Target date for completion: Completed

Facility response: VA Palo Alto Healthcare System has completed the activations improvement initiatives for the Monterey CBOC. The clinic was activated on August 14, 2017 and there has been no additional impact to PACT provider schedules related to activations improvement workshops since that time. For future PACT process improvement initiatives, leadership will review initiatives to ensure that patients do not have scheduled appointments cancelled, and to verify that the next available appointment is not being negatively impacted.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Jennifer Tinsley, LMSW-C, Team Leader Lindsay Gold, LCSW Dannette Johnson, DO Judy Montano, MS
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Appendix E

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