Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-01708-340

Healthcare Inspection

Review of Primary Care Ghost Panels Veterans Integrated Service Network 23 Eagan, Minnesota

August 11, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to a concern raised by Congressman Timothy J. Walz regarding whether some primary care (PC) panels at facilities within Veterans Integrated Service Network (VISN) 23 are "ghost panels." The media has used the term "ghost panel" to describe patients assigned to PC providers who were not actively providing care, such as a provider who retired or resigned. Patients who need care and who are assigned to ghost panels would need to be seen by active facility PC providers, by temporary providers, or through a combination of efforts. Each PC provider has a limited amount of time available to see patients, and seeing additional patients would limit the time available to care for PC patients, which could be a barrier for patients assigned to either the PC or ghost panels to receive timely health care.

We found that 4 of 674 (0.6 percent) PC panels in VISN 23 were ghost panels. In total, 2,301 of 287,095 (0.8 percent) of active PC patients in VISN 23 were assigned to 1 of those panels. The Iowa City VA Health Care System and VA Black Hills Health Care System each had two ghost panels. We did not identify PC ghost panels at the other VISN 23 facilities.

The existence of PC ghost panels in VISN 23 is inconsistent with Veterans Health Administration policy, which requires patients to be reassigned or redistributed to other PC teams when PC providers discontinue employment. However, we did not identify a negative impact on patients since the facilities had enacted efforts to ensure ongoing patient care for patients assigned to the PC ghost panels.

We recommended that the VISN Acting Director ensure that Facility Directors reassign or redistribute PC patients to other PC teams as required by Veterans Health Administration policy and monitor compliance.

Comments

The Veterans Integrated Service Network Acting Director concurred with our recommendation and provided an acceptable action plan. (See Appendix A, pages 7–8 for the Acting Director comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to a concern raised by Congressman Timothy J. Walz regarding whether some primary care (PC) panels at facilities within Veterans Integrated Service Network (VISN) 23 are "ghost panels."

Background

VISN 23 serves over 300,000 veterans in the Upper Midwest Region, including Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and parts of Illinois, Kansas, Missouri, Wisconsin, and Wyoming.

VISN 23 includes the following eight health care systems (HCSs) and medical center.

- Fargo VA HCS
- Iowa City VA HCS
- Minneapolis VA HCS
- Royal C. Johnson Veterans Memorial Medical Center (Sioux Falls, SD)
- St. Cloud VA HCS
- VA Black Hills HCS
- VA Central Iowa HCS
- VA Nebraska-Western Iowa HCS

PC Management.[1] The Veterans Health Administration's (VHA) Primary Care Management Module (PCMM) software allows facility staff to track patients and data for their assigned PC providers (PCPs). The PCMM software allows users to set up and define a PC team, assign staff to positions within the team, and assign patients to providers.

Facility staff who are accountable for oversight of PC teams are required to establish and implement contingency plans for ensuring that patients receive continuity of and access to appropriate PC during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events (for example, extreme weather conditions or natural disasters).[2] Contingency plans must include the reassignment or redistribution of patients to other PC teams when the:

- PCP discontinues employment with the clinical service or program accountable for the PC team;

[1] VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. This VHA Handbook was scheduled for recertification on or before March 30, 2014, but has not yet been recertified.
[2] VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

- PCP is not permitted by state or federal law or VHA or local policy to provide health care to patients; or
- PCP's absence is expected to last longer than 6 months.

VHA collects data regarding patients assigned to PCPs in PCMM software and publishes selected information on the Active Panel List report.[3] The Active Panel List documents the number of active PC patients assigned to PC teams and providers, teams' capacity, and teams' PCP full-time employee equivalent by facility. This report is useful for PCMM and facility staff required to maintain the currency of information in PCMM software and to reassign or redistribute patients to PC teams when PCPs discontinue employment.

Ghost Panels. The media has used the term "ghost panel" to describe patients assigned to PCPs who were not actively providing care, such as a provider who retired or resigned. In this scenario, patients who need care and who are assigned to ghost panels would need to have been seen by active facility PCPs, by temporary providers, or through a combination of efforts. As a result, the active facility PCPs' panel size could seem artificially low since these patients would not be included in the active PCPs' panel totals. Further, each PCP has a limited amount of time available to see patients, and seeing additional patients would limit the time available to care for PC patients, which could be a barrier for patients assigned to either the PC or ghost panels to receive timely health care.

Allegation. On November 16, 2015, Congressman Timothy J. Walz contacted VA OIG to request a review of whether the practice of using "ghost panels" in PC care was taking place within the VA system. Subsequent to that request, Congressman Walz revised the request to determine whether this practice was occurring in VISN 23.

Scope and Methodology

We conducted our work from December 29, 2015, through February 11, 2016. The period of review was from December 29, 2015, through February 11, 2016.

We reviewed PCMM data and Active Panel List reports available through VHA Support Service Center. We also reviewed selected electronic health record data in the VA Corporate Data Warehouse and employment data available through the VA Personnel and Accounting Integrated Data (PAID) system.[4]

[3] *Active Panel List Data Definitions* (Last Updated January 14, 2016), VSSC (http://vssc.med.va.gov/), accessed February 11, 2016.

[4] The PAID package records payroll data including time and attendance records and a continuously updated employee master record database. Available PAID data was current through pay period 22 (ending November 14, 2015). See *Department of Veterans Affairs Personnel and Accounting Integrated Data (PAID) User Manual*, Version 4.0, May 2012.

We identified PC ghost panels using the following three steps:

- We identified PCPs on the Active Panel List reports as of January 4, 2016, who did not appear to be clinically active.[5] We concluded that PCPs might not be clinically active if they did not enter any progress notes in the electronic health record during the previous month (December 2015).
- For PCPs who did not appear to be clinically active, we reviewed PAID to determine if the PCPs were employed by the facilities.
- For PCPs who did not appear to be clinically active and were not employed by the facilities, we interviewed selected facility staff with knowledge of PC staffing at the respective facilities. We asked those staff for alternate explanations for what appeared to be the presence of ghost panels. We also asked about the steps taken, if any, to ensure patients assigned to the ghost panels received ongoing patient care.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

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.

[5] We did not flag associate provider panels, such as panels assigned to medical residents, if the supervising PCP was clinically active.

Inspection Results

We found that 4 of 674 (0.6 percent) PC panels in VISN 23 were ghost panels. In total, 2,301 of 287,095 (0.8 percent) active PC patients in VISN 23 were assigned to 1 of those panels. The Iowa City VA HCS and VA Black Hills HCS each had two ghost panels. We did not identify PC ghost panels at the other VISN 23 facilities. (See Table.)

Table. Number of PC Panels and Active PC Patients in VISN 23, by Facility

	PC Panels		Active PC Patients	
Facility	**Total**	**PC Ghost Panels**	**Total**	**Assigned to Ghost Panels**
Fargo VA HCS	34	0	28,872	0
Iowa City VA HCS	100	2	42,954	1,245
Minneapolis VA HCS	193	0	69,921	0
Royal C. Johnson Veterans Memorial Medical Center	40	0	24,754	0
St. Cloud VA HCS	37	0	32,607	0
VA Black Hills HCS	35	2	16,523	1,056
VA Central Iowa HCS	52	0	26,969	0
VA Nebraska-Western Iowa HCS	183	0	44,495	0
Total	**674**	**4**	**287,095**	**2,301**

Source: OIG analysis of VHA Support Service Center, VA Corporate Data Warehouse, and PAID data, and interviews with knowledgeable staff

Iowa City VA HCS

The two Iowa City VA HCS PC ghost panels represented 2 percent of PC panels at the HCS. As of January 4, 2016, 609 and 636 (1,245 total) active PC patients were assigned to the affected panels, representing 2.9 percent of the system's active PC patients.

Staff we interviewed from Iowa City VA HCS confirmed that the panels were from two PCPs who accepted positions at other VA facilities (one in August 2015 and the other in November 2015) and were not employed at Iowa City VA HCS. Recruitment efforts to fill these vacancies were not expected to exceed 6 months.

Staff told us that they employed several different strategies to meet ongoing patient care needs for patients assigned to those PC panels. Efforts included reassigning acutely ill patients to other PCPs with panel capacity, assigning surrogate providers to receive and manage electronic health record alerts on a weekly basis, and using a pool of providers to see patients assigned to these PC panels. A locum tenens provider[6] and a newly recruited provider were scheduled to begin employment and fill these vacancies on February 18 and 21, 2016, respectively. Staff also stated that the PC panels assigned

[6] A locum tenens provider is a provider hired to temporarily fill in or substitute for another provider.

to providers no longer employed at the respective facilities were maintained in order to facilitate the assignment of these patients to replacement providers.

VA Black Hills HCS

The two VA Black Hills HCS PC ghost panels represented 6 percent of PC panels at the HCS. As of January 4, 2016, 337 and 719 (1,056 total) active PC patients were assigned to the affected panels, representing 6.4 percent of the system's active PC patients.

Staff we interviewed from VA Black Hills HCS confirmed that the panels were from two PCPs who were no longer employed at VA Black Hills HCS (one left in September and the other in October 2015). Since September 2015, the HCS has used fee-basis, intermittent, and/or existing HCS providers to assist in managing patients assigned to these panels.

One newly hired provider was scheduled to begin employment on February 1, 2016, while a second provider was undergoing credentialing and privileging and was expected to begin employment in early March 2016. Staff we interviewed also stated that the PC panels assigned to providers no longer employed at the respective facilities were maintained in order to facilitate the assignment of these patients to replacement providers.

We did not identify a negative impact on patients since the facilities had enacted efforts to ensure ongoing patient care for patients assigned to the PC ghost panels.

Conclusions

We found PC ghost panels in VISN 23; however, we did not find evidence that the use of ghost panels was pervasive across VISN 23.

We determined that 4 of 674 (0.6 percent) PC panels and 2,301 of 287,095 (0.8 percent) active PC patients were assigned to PCPs who were no longer employed at the respective facilities, as of January 4, 2016.

At Iowa City VA HCS, 2 percent of PC panels were ghost panels and 2.9 percent of active PC patients at the HCS were assigned to those panels. At VA Black Hills HCS, 6 percent of PC panels were ghost panels and 6.4 percent of active PC patients at that HCS were assigned to those panels. No PC ghost panels were found among the remaining 539 PC panels at the other VISN 23 HCS.

Although we found that the facilities had employed efforts to ensure ongoing patient care for patients assigned to the affected PC panels, VHA requires patients to be reassigned or redistributed to other PC teams when PCPs discontinue employment.

Recommendation

1. We recommended that the Veterans Integrated Service Network Acting Director ensure that Facility Directors reassign or redistribute primary care patients to other primary care teams as required by the Veterans Health Administration and monitor compliance.

Appendix A

VISN Acting Director Comments

Department of Veterans Affairs

Memorandum

Date: March 30, 2016

From: Acting Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Inspection—Review of Primary Care Ghost Panels, Veterans Integrated Service Network 23, Eagan, Minnesota

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

VISN 23 concurs there were four primary care panels in which the Primary Care Provider (PCP) had discontinued employment with the VA. All panels have had a coverage provider assigned or the patients have been reassigned to other PCP panels as per PACT Handbook 1101.10.

On 11 January 2016 Primary and Specialty Medicine Service Line (PSMSL) leadership and on 8 February 2016 Primary Care Management Module (PCMM) coordinators at all Facilities in VISN 23 were instructed to remove primary care providers from PCMM graphical user interface that have discontinued employment with the VA. PSMSL leaders and PCMM coordinators were given the option to assign a coverage PCP to the panel or reassign patients to other PCP panels.

VISN 23 will monitor compliance by two mechanisms:

1) On a monthly basis Facility PCMM coordinators will submit a PCP Time Allocation spreadsheet to the VISN 23 PCMM Coordinator. The spreadsheet includes a list of all PCPs and their separation effective date. The list of PCPs listed in PCMM graphical user interface who have separated from the VA.

2) On a quarterly basis, each Facility Director will be asked to certify that all PCMM data is accurate, up-to-date and does not include PCPs that have discontinued employment with the VA.

Patrick J. Kelly, FACHE
Acting Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Acting Director ensure that Facility Directors reassign or redistribute primary care patients to other primary care teams as required by the Veterans Health Administration and monitor compliance.

Concur

Target date for completion: August 31, 2016

VISN response:

VISN 23 concurs there were four primary care panels at the VA Black Hills Health Care System and the Iowa City VA Health Care System in which the Primary Care Provider (PCP) had discontinued employment with the VA. The panels of these providers have had a coverage provider assigned or the patients have been reassigned to other PCP panels as per PACT Handbook 1101.10.

In addition, beginning April 1, 2016, the VISN 23 Primary Care Management Module (PCMM) Coordinator will ensure that each VISN 23 facility Director reassigns or redistributes primary care patients to other primary care teams (VHA PACT Handbook 1101.10) by monitoring compliance on a monthly basis with the following:

1) Name and separation date for all PCPs that have discontinued employment with the VA;

2) A timely "position inactivation date" for the PCP was entered into PCMM Graphic User Interface (GUI) or PCMM Web (new PCMM software to be implemented in VISN 23 in May 2016);

3) The name of the coverage PCP and date that he/she was assigned to the panel or the names of the PCPs to whom the patients were reassigned.

When a facility demonstrates 100% compliance with all of the audit criteria (above), it will continue to be monitored until it demonstrates 100% compliance for 3 consecutive months or 90 days.

Appendix B

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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