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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California

Healthcare Inspection | **23-01602-147** | **April 23, 2024**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection following the OIG's data analytics team identifying that the VA Loma Linda Healthcare System (system) had the highest utilization of community care for new primary care services among all Veterans Health Administration (VHA) facilities during fiscal year 2022.[1] The inspection was conducted to review the factors that contributed to high usage of community care services for primary care, the impact of that use, and system leaders' oversight of VA outpatient clinics (clinics).[2]

In fiscal year 2022, the system provided over 160,000 outpatient primary care appointments to over 40,000 unique patients assigned to both the VHA-operated clinics near Loma Linda in Redlands and Blythe, and non-VHA-operated clinics in Corona, Murrieta, Rancho Cucamonga, Victorville, and Palm Desert, California.[3]

In April 2021, VHA awarded a contract to a new company to manage all five non-VHA-operated clinics beginning on October 1, 2021. The OIG found that a change in the company responsible for managing the non-VHA-operated clinics, and insufficient staffing at the non-VHA-operated clinics, contributed to the system's increased use of community care for primary care.[4]

The company managing the non-VHA-operated clinics was responsible for meeting VHA's patient aligned care team (PACT) staffing requirements and selecting and hiring all necessary clinic staff to deliver patient care.[5]

Patients "may be eligible to receive care from a community provider when VHA cannot provide the care needed" or is unable to do so timely. After the transition to the new company, the number of community care consults for primary care entered from the non-VHA-operated clinics increased from a total of 183 in fiscal year 2021 to a total of 1,626 in fiscal year 2022.

The OIG found that as of September 30, 2023, while the system continued to refer patients to the community for primary care, the total number of patients referred to the community and the

[1] 49 C.F.R. § 1511.3 Definitions (2023). The federal government defines a fiscal year as October 1 of a calendar year through September 30 of the next year. Fiscal year 2022 started on October 1, 2021, and ended September 30, 2022; The system consists of the Jerry L. Pettis Memorial Veterans' Hospital in Loma Linda, California, along with two VHA-operated clinics and five non-VHA-operated clinics.

[2] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[3] The system provides the majority of outpatient primary care at the two VHA-operated clinics and five non-VHA-operated clinics. A very small number of patients, less than 25, are assigned to primary care at the Jerry L. Pettis Memorial Veterans' Hospital.

[4] For the purpose of this review, the OIG focused on the system's increased use of community care for primary care for patients assigned to the VHA-operated and non-VHA-operated clinics.

[5] Contract No. 36C26221D0002, issued by VA on October 7, 2020. Standard Form 1449, Solicitation/Contract/Order for Commercial Items.

average time to process those referrals decreased from September 30, 2022. Decreases were also noted in the number of patients assigned to each of the providers at the non-VHA-operated clinics. However, due to ongoing staffing shortages, the enrollment of new patients remains variable at the non-VHA-operated clinics.

Factors Contributing to the Increased Use of Community Care Services

The OIG learned that in November 2021, six weeks into the management transition, the new company had 63 percent of the staff required to operate the five non-VHA-operated clinics.[6] Three months later, in February 2022, a Veterans Integrated Service Network (VISN) business office staff member submitted a "formal request for an update" to the company, noting that at four months into the company's role as clinic managers, the company had 73 percent of the staff required to operate the clinics. In interviews with the OIG, system leaders reported that staffing the non-VHA-operated clinics had been an ongoing problem since the new company assumed responsibility.

To receive continuous primary care services, patients are assigned to a specific primary care provider's panel after their first primary care appointment.[7] The OIG determined that because of limited staffing, the number of patients assigned to the panels of PACT providers at the non-VHA-operated clinics exceeded VHA's recommended maximum.[8]

At the end of December 2021, three months into the new company's operational period, all five non-VHA-operated clinics had providers with panels greater than 100 percent of the recommended maximum panel size.[9] In March 2022, panels remained greater than 100 percent of the maximum panel size at four of the five non-VHA-operated clinics. While primary care providers' panels at the VHA-operated clinics were not over capacity, the OIG learned from the

[6] Per the documents provided by the system, identified staffing deficiencies at the non-VHA-operated clinics were based off staffing data current as of November 10, 2021. Staffing targets for PACT vary according to the number of providers hired to support the total volume of patients assigned to clinic panels. For example, the total number of nursing and administrative support staff needed for a clinic depends on the number of full-time equivalent providers assigned to the clinic.

[7] VHA Directive 1406, *Primary Care Management Module (PCMM) for Primary Care*, June 20, 2017.

[8] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. The maximum panel size is determined locally by the Chief of Staff or other designee and is dependent on such factors as the number of support staff, number of clinic rooms, and the time a provider has available for direct patient care. Panel sizes for VHA primary care providers, if adjusted, typically fall in the range of 1,000 to 1,400.

[9] "Patient Aligned Care Teams Compass - Data Definitions," PACT Compass Dashboard Pyramid Analytics, accessed December 27, 2023, https://pyramid.cdw.va.gov/direct/?id=92c5f3b6-c855-49ed-9d7e-24583efa6f96. (This website is not publicly accessible.) Percentage of maximum PACT panel size, or panel fullness, is defined as "the total number of active patient assignments in PCMM to a Team as of the last day of each time frame (not unique patients) divided by the total, unadjusted team capacity."

system's Assistant Director that the VHA-operated clinic panels were unable to absorb the volume of additional patients from the non-VHA-operated clinics.

As a result of the staffing shortages and full panels, system leaders paused enrollment of new patients at all five non-VHA-operated clinics in May 2022. This pause prompted system staff to refer new patients that would otherwise be seen at a non-VHA-operated clinic to primary care providers in the community.

Delays in Processing Community Care Consults

The OIG interviewed a VISN and a system community care leader to understand the system's process for managing community care consults for primary care in order to gain further insight into impacts from the overall increase in consults after the closure of the PACT panels.

The OIG determined the system did not meet VHA's expectations for the timely processing and scheduling of appointments for care in the community despite community care department staffing levels being deemed adequate according to VHA's staffing tool.

The system's community care department receives incoming consults for care, confirms eligibility, authorizes service, and schedules appointments for patients in need of care in the community.[10] VHA measures consult timeliness from the date the consult for care is entered to the date an appointment is made.[11] As of the end of September 2021, VHA staff were expected to process consults and make patient appointments within 21 days of the consult entry. VHA later shifted the target to 7 days by the end of March 2022.[12]

The OIG reviewed system data for consult timeliness and found that in fiscal year 2021, the average number of days for patients assigned to four of the non-VHA-operated clinics to make a patient appointment for primary care in the community was in the range of 22.3 to 39 days, exceeding the VHA target of 21 days for the period. In May 2022, after the pause in enrollment at the same non-VHA-operated clinics, the average number of days increased in the range of 28 to 53.5, exceeding the updated VHA target of 7 days.

The OIG determined that the system did not meet VHA expectations for timely processing of consults and scheduling of care in the community appointments. While the VA Community Care Staffing Tool indicated the community care department was adequately staffed, OIG had

[10] "Request and Coordinate Care," VA Community Care, accessed November 21,2023, https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination.asp#RFS.

[11] "VHA Support Service Center (VSSC)" (web page), VHA Support Service Center, accessed August 16, 2023, https://vssc.med.va.gov/VSSCMainApp/. (This website is not publicly accessible.) The average days from file entry day (consult creation) to date of first appointment made displays the average number of days for the date that the consult was created to the date the first appointment was made for the referral.

[12] Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022. VHA monitors the consult scheduling process to ensure timeliness expectations.

concerns about the tool's sensitivity based on the increase in consult processing times and prior OIG reports that identified concerns with the reliability of the VA Community Care Staffing Tool.[13] The OIG is concerned that other factors, such as consult workflow or staff productivity, may have affected the ability of the system's community care staff to process consults timely.

VA Preference for Patients Receiving Primary Care

While there was an increase in patients receiving primary care in the community and delays in processing and scheduling community care consults, the OIG did not identify patients who experienced poor outcomes.

VISN and system leaders reported a preference to keep the care of veterans in the VA due to the clinical expertise and institutional knowledge regarding veteran needs and immediate access to veterans' electronic health records, which allows for timely care coordination.

VISN and system leaders informed the OIG that they want patients who are receiving primary care in the community to return to the system and that they are focused on creating access to care within the system to accommodate these patients at a future date.

System Leaders' Oversight of Clinic Transition

The OIG found that prior to the transition to the new management company, the system lacked an organizational structure to provide oversight of the system's clinics.

System leaders have a responsibility to ensure patients receive quality care at non-VHA-operated contracted facilities.[14] VA contracting staff also have a responsibility to oversee and enforce contractual compliance with quality metrics.[15] As such, having a structure in place to coordinate these efforts is critical.

During interviews, the OIG learned that the system lacked a formal mechanism to communicate with clinic stakeholders and representatives of the new company, review clinic performance metrics, and provide oversight of clinic operations. Although the system selected the new company in April 2021, the system had no oversight mechanism until April 2022, more than six months after the clinic operational transition. The OIG reviewed community-based outpatient

[13] VA OIG, *Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff*, Report No. 21-03544-111, July 19, 2023. Prior OIG reports have identified concerns with the reliability of the VA Community Care Staffing Tool. The results of the staffing recommendations provided are dependent on the information entered by system community care leaders in the staffing tool. For the purposes of this report, the OIG did not independently verify for accuracy the information obtained in the staffing tool, which is self-reported by VA facilities.

[14] "What are our responsibilities related to services provided by our contracted organization," The Joint Commission, accessed June 12, 2023, https://www.jointcommission.org/standards/standard-faqs/laboratory/leadership-ld/000001470/.

[15] FAR 1.602-2 (2023). The Audit Division of the OIG is conducting a separate review.

clinic steering committee (clinic steering committee) meeting minutes beginning in April 2022 through the committee's first year of meetings and identified that the non-VHA-operated clinics consistently did not meet access and quality of care expectations from October 2022 through February 2023. Despite the performance gaps, committee meeting minutes failed to capture discussion of any decisions made to address the identified deficiencies.

The OIG learned of staff turnover at the system in the assistant director and chief of primary care positions, which were key to the oversight and management of primary care. These two roles lacked permanent staff during the six months prior to, and throughout the first year of the transition to the new company managing the system's non-VHA-operated clinics. In addition, documentation provided to the OIG by system staff showed turnover within the leadership team of the clinic management company, including three different program managers, a new medical director, and multiple changes in clinic managers at each non-VHA-operated clinic since the initiation of the new contract.

The OIG found that the lack of a formal structure to oversee and manage the system's network of clinics, coupled with the frequent changes of personnel in leadership positions at the system and the new company, created a vulnerability in the oversight of non-VHA-operated clinics. Had a clinic steering committee been in place before or at the time of the service transition, system leaders and company representatives may have identified problems, such as inadequate staffing, and developed solutions.

The OIG made three recommendations to the System Director related to monitoring primary care staffing and panel sizes, timeliness of community care consult processing, and oversight of all the system's clinics.

VA Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

EHR	electronic health record
FY	fiscal year
OIG	Office of Inspector General
PACT	patient aligned care team
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review the factors that contributed to the high usage of community care services for primary care by the VA Loma Linda Healthcare System (system), the impact of that use, and system leaders' oversight of VA outpatient clinics (clinic).[1]

Background

The system, part of Veterans Integrated Service Network (VISN) 22, provides services to over 76,000 patients. The system consists of the Jerry L. Pettis Memorial Veterans' Hospital, located in Loma Linda, California, a level 1a, high complexity medical center. The system provides both outpatient and inpatient care, with 162 acute care and 108 community living center beds serving patients needing medical, surgical, and behavioral health care.[2] The system has over 80 academic affiliations and partners with the Loma Linda University School of Medicine and Medical Center.

In addition to the care provided at Jerry L. Pettis Memorial Veterans' Hospital, the system provides outpatient care at two Veterans Health Administration (VHA)-operated clinics and five non-VHA-operated clinics.[3] The clinics, located throughout the rapidly growing Inland Empire region of California, vary in distance from the main medical center in Loma Linda. The region stretches across 27,000 square miles and covers an area nearly the size of South Carolina (see figure 1).[4]

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "Facility Complexity Model Fact Sheet," October 1, 2020. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

[3] The system provides the majority of outpatient primary care at the two VHA-operated clinics and five non-VHA-operated clinics. A very small number of patients, less than 25, are assigned to primary care at the Jerry L. Pettis Memorial Veterans' Hospital. For the purpose of this review, the OIG focused on the system's increased use of community care for primary care for patients assigned to the VHA-operated and non-VHA-operated clinics.

[4] Chad Shearer, Isha Shah, Marek Gootman, "Advancing Opportunity in California's Inland Empire," Metropolitan Policy Program at Brookings, February 2019, accessed December 15, 2023, https://www.brookings.edu/wp-content/uploads/2019/02/Full-Report_Opportunity-Industries_Inland-California_Final_Shearer-Shah-Gootman.pdf. Located east of Los Angeles and comprised of both San Bernardino and Riverside counties, the area is home to more than four million people. Most residents live in the valley between Los Angeles and the mountains that run north to south through the region or east of the mountains in communities located throughout the desert to the Nevada and Arizona State lines.

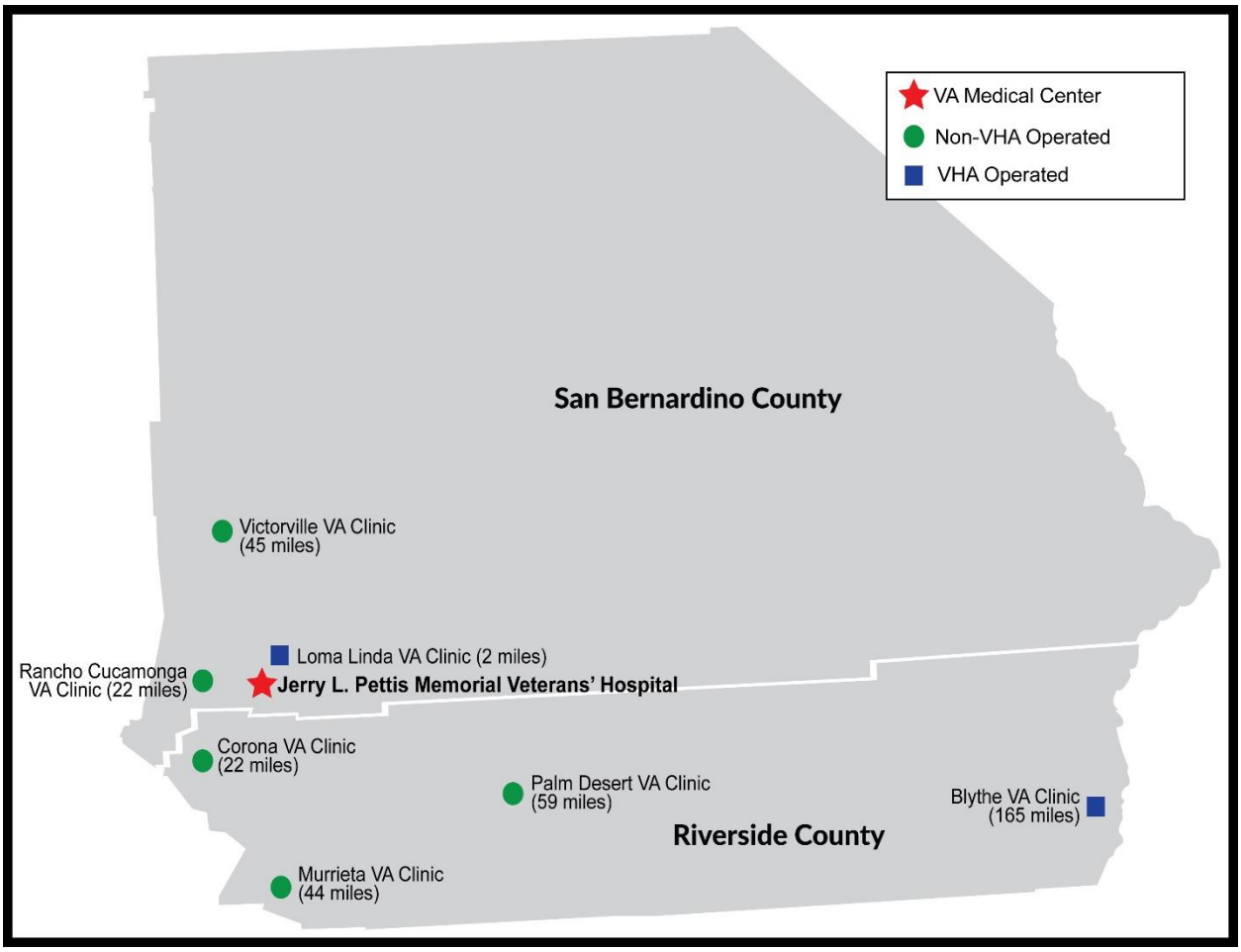

Figure 1. *Map of VA Loma Linda Healthcare System Clinic Locations.*
Source: OIG.

From October 1, 2021, through September 30, 2022, the system provided over 160,000 outpatient primary care appointments to over 40,000 unique patients assigned to VHA-operated clinics near Loma Linda in Redlands and Blythe, and non-VHA-operated clinics in Corona, Murrieta, Rancho Cucamonga, Victorville, and Palm Desert, California.

Primary Care in VHA

Primary care became the foundation of VHA's healthcare delivery system in the 1990s when VHA authorized the use of "team-based primary care," which focuses on veterans receiving "accessible, timely, coordinated, continuous, comprehensive, and compassionate" care.[5] In 2009, VHA adopted a patient-centered medical home model, called patient aligned care team (PACT)

[5] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

to further integrate team-based primary care principles and the delivery of patient-centered care.[6] By developing a patient partnership, primary care providers serve as a centralized source of patient care and play an important role in early disease prevention and chronic disease management.[7] Access to primary care improves patient outcomes, and patients with a designated primary care provider are more likely to receive important preventive services, such as vaccines and screenings for high blood pressure and cancer.[8]

After enrollment in VHA, veterans are assigned to a PACT that serves as the "primary access point to VHA's health care system."[9] The PACT is responsible for facilitating hospital admissions, discharges, and specialty care to ensure safe effective transitions occur without a lapse in care for the patient. PACT providers collaborate with other specialty care providers through the use of VA's electronic health record (EHR) consult referral package, or other informal communication methods, such as telephone calls or "just-in-time" interactions, to ensure safe, effective care delivery.[10] Patients receiving primary care within the VA system also have direct access to mental health care providers located within primary care clinics to assess and treat uncomplicated mental disorders, such as anxiety and depression.[11]

PACT staff are required to receive education and training to achieve competency on issues unique to post-deployed veteran concerns, such as deployment health risk, exposures, sleep issues, pain, traumatic brain injuries, mental health issues, and chronic multisystem illnesses.[12] VHA provides access to training and educational resources to ensure that VHA PACT providers are knowledgeable regarding healthcare needs specific to veterans.[13]

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[6] VHA Handbook 1101.10(1).

[7] "Healthy People 2030, Access to Primary Care," US Department of Health and Human Services Office of Disease Prevention and Health Promotion, accessed August 2, 2023, https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care#cit3.

[8] "Healthy People 2030, Access to Primary Care."

[9] VHA Handbook 1101.10(1).

[10] VHA Handbook 1101.10(1); VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. Clinical staff who are granted permission can access the EHR and view documentation from visits, medications, lab results, and consults for care.

[11] VHA Handbook 1101.10(1). Patients may access mental health providers assigned to primary care clinics through face-to-face appointments or virtually via video or phone.

[12] VHA Handbook 1101.10(1).

[13] "Post Deployment Care," Primary Care Educational Resources SharePoint, https://dvagov.sharepoint.com/sites/VHAOPCArchive/resources/pcedresourcesforPACT/postdeploymentcare/default.aspx. (This website is not publicly accessible.); "Public Health," accessed on December 15, 2023, https://www.publichealth.va.gov/index.asp. VA Primary Care provides free access to educational resources to support the professional development of clinicians.

Concerns

In February 2023, the OIG's data analytics team identified that the system had the highest utilization of community care for new primary care services among all VHA facilities from February 1, 2022, through February 3, 2023.[14]

As a result, the OIG initiated a healthcare inspection to determine

- factors contributing to the high utilization,
- the impact of the high utilization on the system, and
- the potential impact on patients when receiving community care for primary care services.

During the inspection, the OIG learned the system changed to a new company responsible for managing the non-VHA-operated clinics. The OIG assessed system leaders' oversight of the transition to a new company responsible for managing the clinics. The OIG also provided an update on the changes that have occurred since the time of this review.

Scope and Methodology

The OIG initiated the inspection on March 6, 2023, and conducted an on-site visit May 16–18, 2023. The OIG conducted additional virtual interviews from May through July 2023.

The OIG team interviewed VHA's Office of Primary Care Executive Director and the Medical Director for Primary Care Monitoring and Oversight; VISN and system leaders; former, acting, and current primary and ambulatory care leaders; primary care administrative staff; the chief of community care; a contracting officer and contracting officer's representative; a patient safety manager; the medical director and nurse quality manager for the non-VHA-operated clinics; and a sample of primary care providers from the system's VHA-operated clinics and non-VHA-operated clinics.

The OIG reviewed relevant VHA, VISN, and system policies and documents related to primary and community care during the time of the review. The review also included committee charters and minutes from April 2022 through March 2023; primary and community care metrics from October 2020 to February 2023; emails to the OIG from system leaders in April and October 2023; issue briefs and action plans from October 2021 to April 2023; quality and patient safety documents from October 2020 to September 2022; and organizational charts dated December 2021, October 2022, March 2023, and April 2023.

[14] 49 C.F.R. § 1511.3 Definitions (2023). The federal government defines a fiscal year as October 1 of a calendar year through September 30 of the next year. Fiscal year 2022 started on October 1, 2021, and ended September 30, 2022. Between February 1, 2022, and February 3, 2023, the system had 9,059 primary care consults out of 120,348 (8 percent) total primary care consults across VHA nationwide.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

1. Factors Contributing to the Increased Use of Community Care Services

As shown in figure 3, the OIG determined that a change in the company responsible for managing the non-VHA-operated clinics, insufficient staffing at the non-VHA-operated clinics, and VHA-operated clinics' inability to absorb the volume of additional patients contributed to a significant increase from fiscal year 2021 to fiscal year 2022 in the system's use of community care for primary care. The OIG found the lack of sufficient staffing led system leaders to pause enrollment of new patients at the non-VHA-operated clinics beginning in May 2022.

Change in Company Managing the Non-VHA-Operated Clinics

In April 2021, VHA awarded a contract to a new company to manage all five non-VHA-operated clinics beginning in October 2021 (see figure 2). A VISN and system leader told the OIG that the number of community care consults referring patients for primary care increased since the system transitioned to the new company.

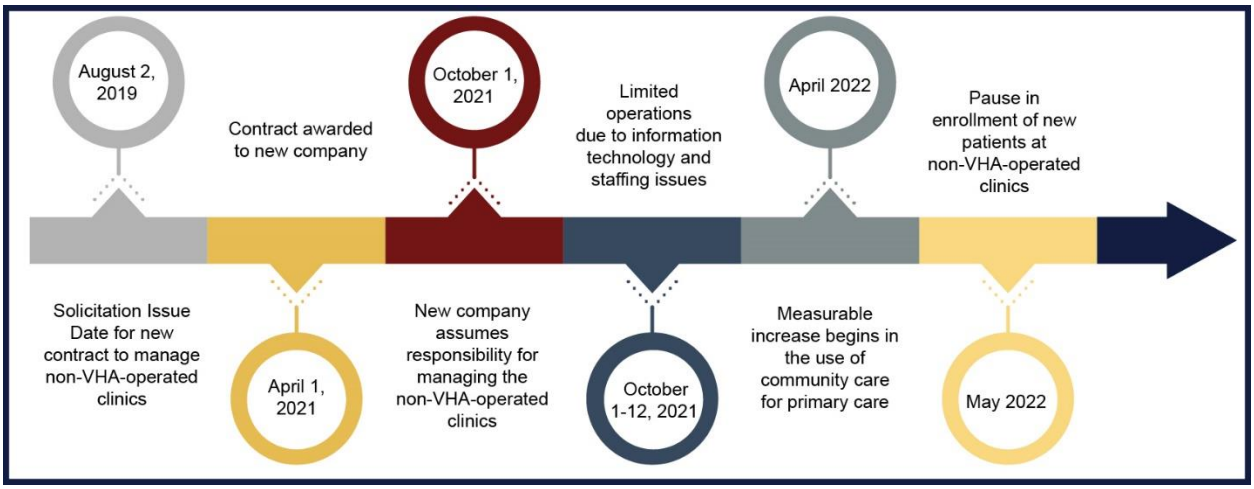

Figure 2. *Timeline of key events.*
Source: OIG analysis of system documents and information provided in interviews with system leaders and staff.

The OIG reviewed community care consult data and found the number of community care consults for primary care entered from the non-VHA-operated clinics increased from a total of 183 in fiscal year 2021 to a total of 1,626 in fiscal year 2022 (see figure 3).

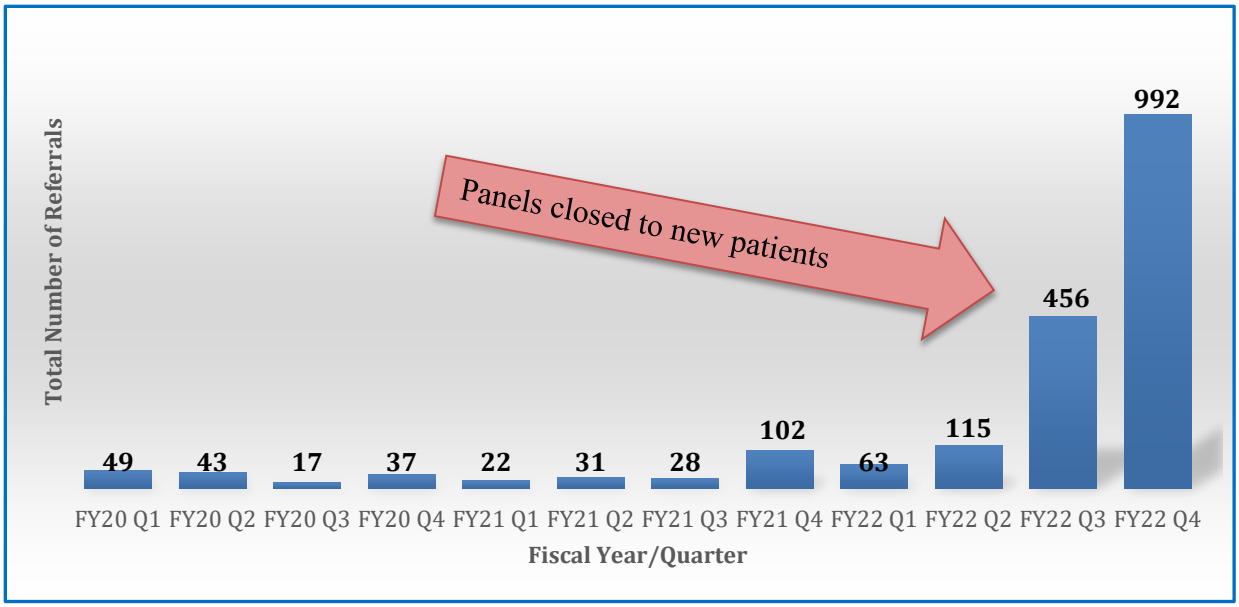

Figure 3. *Consults from non-VHA-operated clinics for primary care in the community.*
Note: "FY" denotes a fiscal year (FY); "Q" denotes the quarter of the fiscal year. Arrow indicates panel closure occurring during FY 22 Q3.
Source: OIG analysis of VHA Support Service Center (VSSC) community primary care consults from October 2021 through September 2022.

A justification for care outside of the system must be included with each community care consult.[15] The OIG reviewed community care consults entered for primary care from October 2021 through September 2022, and determined that the justification for non-VHA-operated clinics using community care was, in most cases, wait times in excess of 30 days. While the use of wait times as justification to send patients to the community began three months prior to the system's October 2021 transition to a new company (see FY 22 Q1 in figure 4), the OIG found wait time justification for community care consults for primary care from non-VHA-operated clinics rose considerably following the change in management (see figure 4).[16]

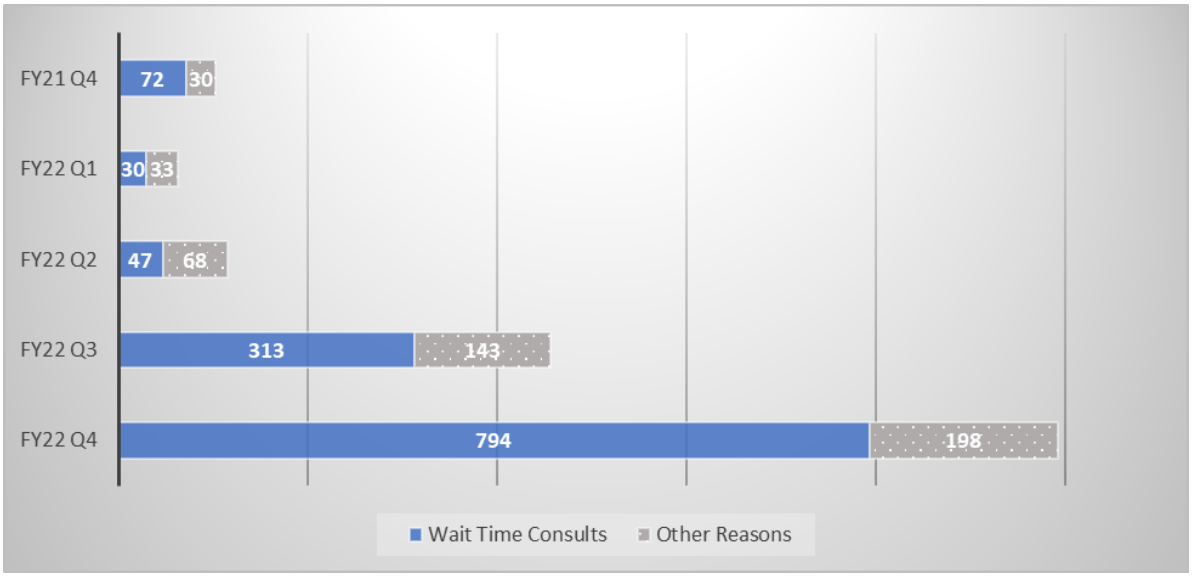

Figure 4. *Reason for community care consults for primary care from the non-VHA-operated clinics.*
Note: FY is used for fiscal year; Q denotes the quarter of the fiscal year.
Source: OIG analysis of VSSC community primary care consults from July 2021 through September 2022.

Insufficient Staffing at the Non-VHA-Operated Clinics

The OIG found that the change in the system's available resources for providing primary care services to patients coincided with the new company assuming responsibility for managing the system's five non-VHA-operated clinics.

The OIG learned that system leaders expected that non-VHA-operated clinics would be fully operational by October 1, 2021. However, the OIG found that after the new company assumed management of the clinics, services at the clinics were limited to only urgent or emergency care

[15] VHA Office of Community Care Field Guidebook, *Chapter 2, Eligibility, Referral, and Scheduling*, March 15, 2023. The Office of Community Care Field Guidebook "contains 'live' documents that are consistently updated with new and updated information."

[16] The OIG defined quarters of the fiscal year as Q1: October 1 – December 31; Q2: January 1 – March 31; Q3: April 1 – June 30; Q4: July 1 – September 30.

from September 27–October 8, 2021, and the new company experienced challenges staffing the clinics, which limited the system's capacity to provide primary care services.[17]

VHA requires both VHA operated and non-VHA-operated clinics to comply with all relevant VHA policies and procedures, including VHA's PACT policy, which outlines primary care staffing.[18] VHA also requires that PACT staffing be sufficient to ensure that all patients assigned to the PACT receive appropriate and desired health care.[19] While exact PACT staffing levels may vary by system, VHA recommends a PACT staffing ratio of at least three full-time equivalent staff for each full-time equivalent primary care provider assigned to a group or panel of patients receiving care.[20]

The company managing the non-VHA-operated clinics was responsible for meeting the PACT staffing requirements outlined by VHA and for selecting and hiring staff for the clinics. According to the agreement, the new company was required to have all PACT staff hired prior to the delivery of patient care.[21]

In early October 2021, system leaders became aware of operational issues at the Palm Desert clinic (a non-VHA-operated clinic), after receiving a media inquiry regarding a patient who described "access issues over the past two weeks."[22] On October 14, 2021, the system's Associate Director of Resources submitted an issue brief to VHA leaders explaining that "unforeseen challenges" delayed the full activation of the non-VHA-operated clinics scheduled for October 1, 2021. The issue brief noted that staffing challenges were reportedly exacerbated by providers choosing to leave the clinic when the previous company's contract ended in order to maintain their employment with that company. Additionally, the issue brief included challenges with the activation of the information technology network, caused by procurement and connectivity issues.

The OIG found that in November 2021, six weeks into the new company's role managing the clinics, the company's targeted number of staff positions was 143.6 and the company had 63

[17] The non-VHA-operated clinics opened to scheduled non-urgent or non-emergency care on October 12, 2021.

[18] VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019. Staffing outpatient sites to meet full patient demand is essential to providing quality care to a diverse patient population.

[19] VHA Handbook 1101.10(1).

[20] VHA Handbook 1101.10(1). A PACT generally consists of primary care providers, registered nurses, licensed practical or vocational nurses, and medical support assistants.

[21] Contract No. 36C26221D0002, issued by VA on October 7, 2020. Standard Form 1449, Solicitation/Contract/Order for Commercial Items.

[22] Issue Brief completed on October 14, 2021, Local News- Difficulty Scheduling Appointment and Obtaining Medication Refill.

percent of the staff required to operate the five non-VHA-operated clinics.[23] Three months later, in February 2022, the VISN business office staff member requested the company provide an update, noting that at four months into the company's role as clinic managers, the targeted staffing was 143.2 and the company had 73 percent of the staff required to operate the non-VHA-operated clinics (see table 1).

Table 1. Non-VHA-Operated Clinic Staffing

	Clinic Staffing November 2021	Clinic Staffing February 2022
Total Positions Filled	90	105.3
Total Positions with Offers and in the Hiring Process	38.6	26.5
Number of Staff Vacancies	11.6	11.4
Percentage Staffed*	63	73

Source: OIG review of non-VHA-operated clinic staffing numbers reported by system leaders in November 2021 and February 2022.
Note: The OIG did not independently verify system-provided data for accuracy or completeness.
**Total positions filled divided by targeted number of staff as reported in the body of the report.*

In interviews with the OIG, system leaders reported that staffing the non-VHA-operated clinics had been an ongoing problem since the new company assumed responsibility for managing the clinics. To gain further insight into primary care staffing at the clinics, the OIG interviewed a sample of VHA-operated and non-VHA-operated clinic primary care providers. When asked by the OIG if they were aware of staffing concerns, all non-VHA-operated clinic primary care providers reported staffing shortages at the clinics. One non-VHA-operated clinic provider told the OIG of shortages not only with primary care providers but also registered and licensed vocational nurses. Another non-VHA-operated clinic provider told the OIG that "there have been staffing issues all along since we started" and reported "grossly [*sic*] understaffing" of nurses and having only one registered nurse assigned to the clinic at the time of the OIG interview in June 2023.

Excess Panel Sizes Led to Pause In Enrollment

The OIG determined that because of limited staffing, the number of patients assigned to the panels of PACT providers at the non-VHA-operated clinics exceeded VHA's recommended maximum. To ensure quality of care and patient safety, the System Director paused enrollment

[23] Per the documents provided by the system, identified staffing deficiencies at the five non-VHA-operated clinics were based off staffing data current as of November 10, 2021. Staffing targets for PACT vary according to the number of providers hired to support the total volume of patients assigned to clinic panels. For example, the total number of nursing and administrative support staff needed for a clinic will depend on the number of full-time equivalent providers assigned to the clinic.

of new patients into all panels that were over 100 percent capacity at the five non-VHA-operated clinics in May 2022.

After a primary care appointment is created, a patient is assigned to a specific primary care provider's panel to receive continuous primary care services.[24] VHA has established guidelines for determining the recommended maximum number of patients assigned to a PACT provider's panel.[25] The maximum panel size is determined locally by the chief of staff or other designee and is dependent on such factors as the number of support staff, number of clinic rooms, and the time a provider has available for direct patient care.[26] A fully staffed PACT provider's panel, led by a full-time, primary care physician, typically has an expected panel size of 1,200 patients.[27] Primary care leaders within the system are responsible for the ongoing monitoring of provider patient assignments and overall panel size.[28]

The OIG found at the end of December 2021, three months into the new company's operational period, all five non-VHA-operated clinics had providers with panels greater than 100 percent of the maximum panel size. In March 2022, panels remained greater than 100 percent of the maximum panel size at four of the five non-VHA-operated clinics. The percentage of the maximum panel size at one of the system's VHA-operated clinic was in the lower 90 percent range over the same time frame (see table 2).[29]

Table 2. Percentage of Maximum PACT Panel Size

Clinic Name	Percentage of Maximum PACT Panel Size December 2021	Percentage of Maximum PACT Panel Size March 2022
Corona Clinic	108.59	96.73
Murrieta Clinic	162.54	224.80
Palm Desert Clinic	155.38	123.94
Rancho Cucamonga Clinic	148.57	120.90

[24] VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017.

[25] VHA Directive 1406. VHA utilizes a software system to monitor and track staff assigned to PACT panels and to determine the maximum recommended number of patients assigned.

[26] VHA Directive 1406.

[27] VHA Directive 1406. Panel sizes for VHA primary care providers, if adjusted, typically fall in the range of 1,000 to 1,400.

[28] VHA Directive 1406.

[29] "Patient Aligned Care Teams Compass -Data Definitions," PACT Compass Dashboard Pyramid Analytics, accessed December 27, 2023, https://pyramid.cdw.va.gov/direct/?id=92c5f3b6-c855-49ed-9d7e-24583efa6f96. (This website is not publicly accessible.) Percentage of maximum PACT panel size, or panel fullness, is defined as "the total number of active patient assignments in PCMM to a Team as of the last day of each timeframe (not unique patients) divided by the total, unadjusted team capacity. Higher panel fullness is correlated with longer wait times, larger EWL [electronic wait lists], and increased provider burn out."

Clinic Name	Percentage of Maximum PACT Panel Size December 2021	Percentage of Maximum PACT Panel Size March 2022
Victorville Clinic	124.37	120.62
Loma Linda VA Clinic*	91.13	94.16

Source: OIG review of VSSC system primary care service staffing data by fiscal year quarter.
**Designates VHA-operated clinic in Redlands, California.*

During interviews with the OIG, the System Director explained that upon learning that the non-VHA-operated clinic PACT provider panels exceeded 100 percent of the maximum panel size, the System Director made the decision to pause new patient enrollment for primary care at these clinics. While primary care providers' panels at the VHA-operated clinics were not over capacity, the OIG learned from the system's Assistant Director that the VHA-operated clinic panels were unable to absorb the volume of additional patients from the non-VHA-operated clinics. During an interview, the system's Assistant Director shared that during the pause in new enrollments, patients were provided with the option to either receive care in the community or to be seen by a VA provider at the ambulatory care clinic. However, the Assistant Director described the ambulatory care clinic as "incredibly impacted" by the clinic PACT panel closure and noted that there was "very little access at the ACC [ambulatory care clinic]."[30]

The OIG reviewed contractual documents and found that, per the agreement between the system and the new company managing the non-VHA-operated clinics, when the number of patients assigned to a provider's panel reaches 80 percent of the maximum panel size, the company is to submit a staffing plan to the system.[31] A May 2022 memorandum from the System Director to the company managing the clinics stated that "overcapacity panels remain[ed] a significant patient safety concern" and noted that the system had received an update from the company with a panel management plan to address over-capacity panels within primary care at the five non-VHA-operated clinics. The plan showed the maximum panel capacity and the number of active patients at each location (see figure 5).

[30] ACC refers to the Ambulatory Care Clinic located in Redlands, California. This VA clinic provides primary care.

[31] In May 2022, the system received a plan from the company to address over-capacity panels at the non-VHA-operated clinics.

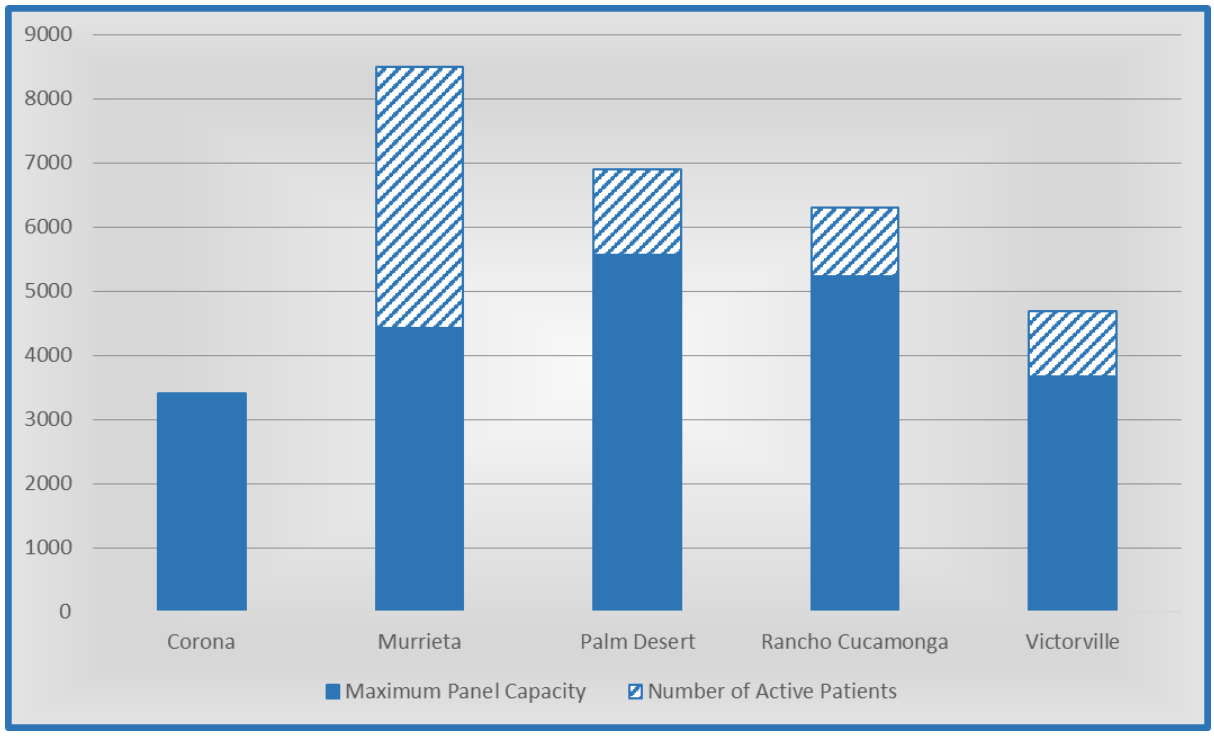

Figure 5. *Non-VHA-Operated Clinic PACT Panel Sizes May 2022. The Corona location had 37 active enrolled patients who are not visible in the figure due to the scale.*
Source: OIG review of system-provided non-VHA-operated clinic panel data.
Note: The OIG did not independently verify system-provided data for accuracy or completeness.

The OIG determined that inadequate staffing at the non-VHA-operated clinics led to panel sizes at those clinics that exceeded recommended maximums. As a result, system leaders paused enrollment of new patients at all five non-VHA-operated clinics in May 2022, thereby prompting system staff to refer new patients to primary care providers in the community.

2. Delays in Processing Community Care Consults

The OIG determined the system did not meet VHA's expectations for the timely processing and scheduling of appointments for care in the community despite community care department staffing levels being deemed adequate according to VHA's staffing tool.

Timeliness of Consult Processing and Scheduled Appointments

The OIG determined the system did not meet VHA's expectations for the timely processing of consults and scheduling appointments for care in the community.

Patients "may be eligible to receive care from a community provider when VA cannot provide the care needed" or is unable to do so timely.[32] VHA staff must authorize care in the community prior to the patient being seen by a community provider. [33] The system's community care department receives incoming consults for care, confirms eligibility, authorizes service, and schedules appointments for patients in need of care in the community.[34]

The OIG interviewed a VISN and a system community care leader to gain further insight into impacts from the overall increase in consults after the closure of the PACT panels at the non-VHA-operated clinics. They reported that pre-existing challenges with staffing in the system's community care department, combined with increased workload, resulted in delayed processing of community care consults and scheduling patients' community care appointments. When asked by the OIG about any challenges processing consults, the system's chief of community care reported that the department needed additional staffing due to increased consults, noting "the biggest challenge" is the timely processing of consults so that patient care is not delayed. The VISN Community Care Clinical Lead (VISN Lead) reported that system community care staff were "behind" in processing consults prior to the increase in primary care consults. VHA measures consult timeliness from the date a consult was entered to the date an appointment is made.[35] At the end of fiscal year 2021 (September 30, 2021), VHA staff were expected to process consults and make patient appointments within 21 days of the consult entry. VHA shifted the target to 14 days by the end of December 2021 with the final goal of 7 days by the end of March 2022.[36]

The OIG reviewed system data for the processing of consults at four of the non-VHA-operated clinics; in fiscal year 2021, the average number of days to make a patient appointment for primary care in the community was in the range of 22.3 to 39 days. In May 2022, after the pause in enrollment at the same four non-VHA-operated clinics, the average number of days increased in the range of 28 to 53.5 days.

[32] VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019; "Veteran Care Overview," (web page), VA Community Care, accessed June 8, 2023, https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp.

[33] "Veteran Care Overview," VA Community Care (web page).

[34] "Request and Coordinate Care," VA Community Care, accessed November 21, 2023, https://www.va.gov/COMMUNITYCARE/providers/Care-Coordination.asp#RFS.

[35] "Community Care Wait Times Report;" VHA Support Service Center (VSSC), accessed August 16, 2023, https://vssc.med.va.gov/VSSCMainApp/. (This website is not publicly accessible.) The average days from file entry day to date of first appointment made displays the average number of days for the date that the consult was created to the date the first appointment was made for the referral.

[36] Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022. VHA monitors the consult scheduling process to ensure timeliness expectations are met.

The OIG also reviewed data showing the time from consult entry date to the date of the actual appointment when the patient was to be seen by a community care provider. Patients were seen within an average of 21 days at the end of fiscal year 2021 with that number increasing to an average of 65 days by the end of fiscal year 2022.

Community Care Department Staffing

The OIG determined community care department staffing levels to be appropriate according to VHA's staffing tool.

VHA has established guidelines for community care department resources, including a VA Community Care Staffing Tool, to be done quarterly, and "designed to enable each site with a method for quantifying resource needs necessary to successfully operate and execute the operating model."[37]

The VISN Lead reported notifying the system's Assistant Director that the community care department was "definitely going to need more staff" to manage "potentially thousands" of consults. The system's chief of community care reported that system leaders had been "very supportive of staffing requests" and that staffing for the department was increased after the closure of the non-VHA-operated clinic PACT panels, from 93 full-time equivalents in October 2022 to 141 in May 2023.

The OIG reviewed VA Community Care Staffing Tool documents provided by the system to determine whether the community care department was adequately staffed at the time of the non-VHA-operated clinic enrollment pause. The OIG found that as of March 2022, the department was staffed adequately to meet workload demands, according to the staffing tool. Six months later, in September 2022, the community care department had adequate administrative staff but needed more clinical staff, according to the staffing tool. While the staffing tool indicated the community care department was adequately staffed, OIG had concerns about the tool's sensitivity based on the increase in consult processing times and prior OIG reports that identified concerns with the reliability of the VA Community Care Staffing Tool.[38] The OIG is concerned that other factors, such as consult workflow or staff productivity, may have affected the ability of the system's community care staff to process consults timely.

[37] VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook, *Chapter 6: How to Implement site Improvement Initiatives*, accessed August 16, 2023. The VA Community Care Operating Model is a standardized tool used to identify staffing resources (people, process, technology, and data) needed at the facility level.

[38] VA OIG, *Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff*, Report No. 21-03544-111, July 19, 2023. Prior OIG reports have identified concerns with the reliability of the VA Community Care Staffing Tool. The results of the staffing recommendations provided are dependent on the information entered by system community care leaders in the staffing tool. For the purposes of this report, the OIG did not independently verify for accuracy the information obtained in the staffing tool, which is self-reported by VA facilities.

The OIG concluded that the system did not meet VHA expectations for timely processing of consults and scheduling of community care appointments.

3. VA Preference for Patients Receiving Primary Care

While there was an increase in patients receiving primary care in the community and delays in processing and scheduling community care consults, the OIG did not identify patients who experienced poor outcomes.

To determine whether patients experienced poor outcomes while receiving primary care in the community, the OIG reviewed events entered in the Joint Patient Safety Reporting system and the Patient Advocate Tracking System from fiscal year 2021 through fiscal year 2022. Of the 118 Joint Patient Safety Reports and 591 Patient Advocate Tracking System reports reviewed, the OIG did not identify any reports of patients with poor outcomes related to care in the community or increased primary care consult processing or scheduling times.

Veterans may receive dual care from providers in the local community as well as VHA providers, making the process of care coordination a challenge.[39] During interviews with the OIG, the VHA Office of Primary Care, and VISN and system leaders reported a preference to keep the care of veterans in the VA due to the clinical expertise and institutional knowledge regarding veteran needs and immediate access to veterans' EHRs, which allows for timely care coordination. Staff from VHA's Office of Primary Care shared that some community care providers are better than others with getting medical records back to the VA timely, which could lead to harm if, for example, care coordination documentation related to medications and prosthetic equipment was delayed.

VISN and system leaders informed the OIG that they want patients who are receiving primary care in the community to return to the system and that they are focused on creating access to care within the system to accommodate these patients at a future date.

4. System Leaders' Oversight of Clinic Transition

The OIG found that prior to the transition to the new company managing the non-VHA-operated clinics, the system lacked an organizational structure to provide oversight of the VHA-operated and non-VHA-operated clinics. The OIG determined that this lack of structure, coupled with the need to take steps to improve clinic management, and a turnover of key leadership positions, created a vulnerability in the overall management and oversight of primary care services provided at the clinics.

[39] "Request and Coordinate Care," VA Community Care.

The Joint Commission specifically discusses the importance of leadership oversight of contracted services to ensure quality and safety of care noting that "leaders take steps to improve contracted services that do not meet expectations."[40]

System leaders have a responsibility to ensure patients receive quality care at non-VHA-operated contracted facilities.[41] VA contracting staff also have a responsibility to oversee and enforce contractual compliance with quality metrics.[42] As such, having a structure in place to coordinate these efforts is critical.

Delayed Oversight Structure

During interviews, the OIG learned that system leaders lacked a formal mechanism to: communicate with clinic stakeholders, including representatives of the new company; review clinic performance metrics; and provide oversight of clinic operations for the five non-VHA-operated clinics from the time the new company was selected in April 2021 until more than six months after the October 1, 2021, transition in clinic operations.

In April 2022, a community-based outpatient clinic steering committee (clinic steering committee), chaired by the system's Assistant Director, was chartered to work with clinic stakeholders and "define objectives, coordinate data-driven action plans, and continuously measure/monitor performance across all outlying clinics in terms of patient access to care, patient experience of care, and overall quality of care delivery." System leaders and staff informed the OIG that the committee facilitated a relationship between system primary care staff and representatives from the new company managing the non-VHA-operated clinics. Additionally, system leaders reported that the committee provided a method for structured review of overall performance and a platform for system leaders to address challenges or concerns. During an OIG interview, the clinic oversight nurse manager confirmed that once the clinic steering committee was created, information specific to clinic quality of care was tracked and presented monthly during the committee meetings.

The OIG reviewed the clinic steering committee meeting minutes from the committee's first year of meetings and identified that the non-VHA-operated clinics did not regularly meet access and quality of care expectations from October 2022 through February 2023. Several system staff and leaders reported to the OIG their understanding that providers at the non-VHA-operated clinics were not meeting performance requirements because of insufficient staffing. Despite the performance gaps, committee meeting minutes did not capture discussion of any decisions made based on the data to address identified deficiencies. For example, documentation from the

[40] The Joint Commission, *E-dition Standards Manual,* LD.04.03.09, July 2023. "Leaders take steps to improve contracted services that do not meet expectations."

[41] The Joint Commission, *E-dition Standards Manual,* LD.04.03.09, July 2023.

[42] FAR 1.602-2 (2023). The Audit Division of the OIG is conducting a separate review.

November 2022 meeting minutes noted that system staff identified possible inaccuracies in the data following the May 2022 pause in enrollment; the OIG found no further documentation regarding plans to address the discrepancy. Further, the OIG found that the panel management action plan that was first noted in May 2022 remained open in October 2022 with no updates or resolution documented in subsequent meeting minutes. The OIG requested information from system leaders to confirm the status of the panel management plan and determine whether this action item was still open or fully implemented. In written correspondence, the system's Assistant Director reported that, "the action plan remains in place" and noted it would remain active until the contract provider "has sufficient staffing to re-open panels at all" of the clinics.

In addition to creating a clinic steering committee, system leaders and staff took additional actions to address the management of primary care services across the system, which included

- during interviews, staff reported new positions were created at the system to improve primary care program processes and communication between system staff and representatives of the new company managing the non-VHA-operated clinics;
- providing in-person assistance to the non-VHA-operated clinic staff to assist with clinic staffing shortages for approximately 120 days;
- improving VHA-operated clinic appointment availability by increasing provider staffing through hiring incentives and increased salaries;
- inviting VISN 22 Primary Care Integrated Clinical Community staff to conduct a consultative site visit to review primary care operations and provide recommendations for improvements; and
- inviting National Improvement Office staff to conduct on-site improvement events to review primary care improvement strategies.

Turnover in Key Positions

The OIG learned of staff turnover in two roles key to the oversight and management of primary care during the six months prior to, and throughout the first year of the transition to a new company managing the system's non-VHA-operated clinics.

Hospital leaders play a central role in establishing organizational culture through their words, expectations, and behavior. According to The Governance Institute, "the greater the alignment among the leadership groups with respect to the hospital's mission, vision, and goals, the more likely they can effectively function as a team to achieve those goals."[43] Previous OIG reports

[43] A Governance Institute White Paper, "Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards," Winter 2009, accessed August 23, 2023, https://neltoolkit.rnao.ca/sites/default/files/Leadership%20in%20Healthcare%20Organizations_%20A%20Guide%20to%20Joint%20Commission%20Leadership%20Standards%202009.pdf.

have identified frequent turnover and vacancies in leadership positions as well as the long-term use of leaders in interim positions as a barrier to leaders' effectiveness at achieving organizational goals.[44]

As shown in table 3, the OIG learned from system leaders that from October 2021 through November 2022, the position of assistant director was held by two interim staff until a permanent selection was made in March 2023. Additionally, the OIG learned that the chief of primary care position was filled by four interim staff from May 2021 through May 2023.[45] In interviews with the OIG, VISN and primary care leaders identified the multi-year chief of primary care vacancy as a primary factor in the lack of oversight within the service. VISN and system leaders interviewed by the OIG recognized the changes in leadership at the system as a challenge and noted the need to review VHA clinic utilization and VHA primary care provider productivity to improve access to care. As a result, VISN leaders reported being detailed to help facilitate the transition of leaders and implement recommended improvement practices.

[44] VA OIG, *Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland*, Report No. 21-00239-180, July 14, 2022; VA OIG, *Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network*, Report No. 20-02899-22, November 16, 2021; VA OIG, *Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan*, Report No. 22-04099-153, July 18, 2023.

[45] The fourth interim chief of primary care was in the role for the month of May 2023 and became permanent in June 2023.

Table 3. Changes in System Leadership Positions

Loma Linda VAMC	2021	2022	2023
Executive Role			
Medical Center Director	Permanent 03/2019 to 02/2023		Interim 03/2023 through review period
Chief of Staff	Interim 04/2021 to 10/2021 *	Permanent 11/2021 through review period	
Assistant Director	Permanent 09/2019 to 10/2021	Interim 10/2021 to 03/2022; Interim 03/2022 to 09/2022 ‡	Interim 11/2022 to 03/2023; Permanent 03/2023 through review period
Chief of Primary Care	Interim 05/2021 to 01/2022	Interim 01/2022 to 04/2022; Interim 05/2022 to 04/2023 §	Permanent 06/2023 tthrough review period
Chief of Community Care	Interim 10/2021 to 10/2022		Permanent 10/2022 through review period

Source: OIG analysis of system documents and information provided in interviews with system leaders and staff demonstrating changes in system leadership positions from 2021 through 2023.
** Chief of Staff: Interim October to November 2021.*
‡ A different short-term, interim director was in place between September and November 2022, and the Assistant Director interim in November 2022 was selected for the permanent position effective March 2023.
§ Chief of Primary Care: Interim May 2023.

The OIG learned from leaders in the system and the new company managing the clinics that the company has a single medical director and program manager for all five non-VHA-operated clinics and a clinic manager at each location. Documentation provided to the OIG by system staff shows turnover within the company's leadership team, including three different program managers, a new medical director, and multiple changes in clinic managers at each non-VHA-operated clinic since the initiation of the new contract.

The OIG found that the lack of a formal structure to oversee and manage the system's network of clinics, coupled with the frequent changes of personnel in leadership positions, created a vulnerability in the oversight of non-VHA-operated clinics. Without a clinic steering committee in place before or at the time of the service transition, system leaders and company representatives lacked a venue to meet, identify, and resolve problems such as inadequate staffing and the delay in connecting information technology.

5. System Status Update

To determine whether changes in the use and processing of community care consults, staffing, or panel sizes have occurred since the data presented earlier in the report, the OIG compared the system's primary care metrics from September 30, 2022, to those since the initiation of this review.

The OIG found that as of September 30, 2023, while the system continued to refer patients to the community for primary care, the total number of patients referred decreased. The percentage of

maximum PACT panel size across the non-VHA-operated clinics, the average time from consult entry to first scheduled appointment, and the average time for a patient to be seen by a provider in the community have all decreased (see table 4).

Table 4. Comparison of System Data from FY 2022 to FY 2023

Metric	End of 4th quarter FY 2022 (September 30, 2022)	End of 4th quarter FY 2023 (September 30, 2023)
Number of Referrals to Care in the Community for Primary Care	992	84
Percentage of Maximum of PACT Panel Size	124	109
Average days from file entry to first scheduled	61	18
Average time to be seen by provider in community	65	17

Source: OIG analysis of VSSC community primary care consults from September 30, 2021, through September 30, 2023.

As of October 2023, the system's Assistant Director told the OIG that panel capacity at the non-VHA-operated clinics "remains variable." The Assistant Director reported that the system partially opened PACT panels at the Corona and Rancho Cucamonga VA Clinics (non-VHA-operated clinics) in May 2023 and August 2023 respectively, but later closed enrollment due to the new company managing the non-VHA-operated clinics having continued staffing shortages. The system signed another contract, with changes, effective October 1, 2023, to allow the new company to continue assisting the system in meeting their overall demand for primary care.

Conclusion

The OIG found that a change in the system's available resources for providing primary care services to patients and subsequent increased use of care in the community for primary care by non-VHA-operated clinics coincided with a new company assuming responsibility for managing the system's five non-VHA-operated clinics.

In April 2021, VHA awarded a contract to a new company to manage all five non-VHA-operated clinics with operations expected to commence on October 1, 2021. The new company had difficulty staffing the clinics. The OIG determined the inadequate staffing at the non-VHA-operated clinics led to panel sizes exceeding recommended maximums at all five non-VHA-operated clinics and that VHA-operated clinics lacked the ability to absorb the additional workload. In response, system leaders paused enrollment of new patients at the non-VHA-operated clinics beginning in May 2022.

This pause in enrollment resulted in the increased use of community care for veterans in need of primary care; however, the system did not meet VHA expectations for the timely processing of consults and scheduling of appointments for care in the community despite appropriate community care department staffing levels.

The lack of a clinic oversight structure for use by system leaders at the time the new company assumed responsibility for the non-VHA-operated clinics highlighted a vulnerability in the overall management of primary care services provided at the system's clinics. This vulnerability was further impacted by the lack of stable leadership due to a turnover of key leadership positions at the system and within the leadership team of the company managing the non-VHA-operated clinics. The system has addressed this concern, although opportunities to strengthen the processes remain.

The OIG found that as of September 30, 2023, while the system continued to refer patients to the community for primary care, the total number of patients referred decreased. The system had a decrease in the percentage of maximum PACT panel size across the non-VHA-operated clinics, the average time from consult entry to first scheduled appointment, and the average time for a patient to be seen by a provider in the community. However, due to ongoing staffing concerns, enrollment at the non-VHA-operated clinics remains variable.

Recommendations 1–3

1. The VA Loma Linda Healthcare System Director confirms that a mechanism is in place to monitor primary care patient aligned care team staffing and panel sizes at the non-VHA-operated clinics to ensure staff are available to care for enrolled patients.

2. The VA Loma Linda Healthcare System Director directs a review be done of VA Loma Linda Healthcare System adherence to Veterans Health Administration metrics for the processing and scheduling of community care consults and, if not met, determines the reasons for noncompliance, creates an action plan to address deficiencies, and monitors for compliance.

3. The VA Loma Linda Healthcare System Director conducts an assessment of the community-based outpatient clinic steering committee to ensure consistent oversight of quality of care and staffing levels for all of the VA Loma Linda Healthcare System's VA outpatient clinics.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 15, 2024

From: Network Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California

To: Director, Office of Healthcare Inspections (54HL05)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Healthcare Inspection—Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California
2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the findings, recommendations and submitted action plans by VA Loma Linda Healthcare System.
3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed by:*)

Steven E. Braverman, MD
VISN 22 Network Director

Appendix B: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 11, 2024

From: Director, VA Loma Linda Healthcare System (605)

Subj: Healthcare Inspection—Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California

To: Director, Desert Pacific Healthcare Network (10N22)

1. I have reviewed and concur with the OIG's report, Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California.
2. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care.
3. I would like to thank the Office of Inspector General for their thorough review and recommendations on process improvements. VA Loma Linda Healthcare System appreciates the opportunity to partner with the OIG on our high reliability journey. We remain steadfast in our commitment to zero harm.
4. If you have additional questions or need further information, please contact the Acting Chief, Quality and Patient Safety.

(*Original signed by*:)

Karandeep Sraon, MBBS, MBA, FACHE
Medical Center Director

System Director Response

Recommendation 1

The VA Loma Linda Healthcare System Director confirms that a mechanism is in place to monitor primary care patient aligned care team staffing and panel sizes at the non-VHA-operated clinics to ensure staff are available to care for enrolled patients.

_ X_Concur

____Nonconcur

Target date for completion: August 30, 2024

Director Comments

The VA Loma Linda Healthcare System Director confirms that a mechanism is in place to monitor primary care patient aligned care team staffing and panel sizes at the non-VHA-operated community-based outpatient clinics (CBOCs). The PACT staffing levels have been monitored weekly by the CBOC Administrative Team with reports being sent up through the Assistant Director to the Chief of Staff and Medical Center Director since November 2022. An Oversight Team to monitor and adjust panel sizes was established on January 17, 2024. This team meets recurrently every week to ensure staff are available to care for enrolled patients. This Team includes Primary Care subject matter experts and stakeholders (Chief of Primary Care, Business Manager, Patient Centered Management Module (PCMM), Contracting Officer Representative (COR), CBOC Administrative Specialist, CBOC Oversight Nurse Manager, and the contracting company leadership.

The primary purpose of the Oversight Team is to monitor panel size, capacity, and staffing. This allows for the identification of potential panel management issues before they become critical, ensuring quick resolution. This process ensures that access is not affected. The Oversight Team will be converted to a workgroup of the CBOC Steering Committee at the upcoming April 2024 meeting. The panel size and staffing updates are reported weekly through the chain of command, which includes the Medical Center Director and the Assistant Director. These updates will also be reported monthly to the CBOC Steering Committee in April 2024. Compliance will be reported at the Quality and Patient Safety Council through the governance structure. The report consists of:

- CBOC Clinic Site
- PACT Ratio Completion Status (y/n)
- Provider Title (MD/NP/PA)

- RNCM assigned to a provider (core team member)
- Clinical Associate assigned (LVN/MA) to a provider (core team member)
- Administrative Associate (MSA/MA) to a provider (core team member)
- Pharmacist
- Phlebotomist
- CBOC Clinic Manager
- Maximum Panel Capacity
- Total Veterans assigned to each team
- Percentage of Panel Fullness for each team

Recommendation 2

The VA Loma Linda Healthcare System Director directs a review be done of VA Loma Linda Healthcare System adherence to Veterans Health Administration metrics for the processing and scheduling of community care consults and, if not met, determines the reasons for noncompliance, creates an action plan to address deficiencies and monitors for compliance.

_ X_Concur

____Nonconcur

Target date for completion: August 30, 2024

Director Comments

The VA Loma Linda Healthcare System Director directed the Chief of Staff to review the system's adherence to Veterans Health Administration (VHA) metrics for the processing and scheduling of community care consults in May 2022 after the onsite VISN 22 Community Care Program Consultative Site Visit on May 24- 26, 2022. Noncompliance reasons were identified, an action plan was developed, and currently, sustainment is being monitored. The Community Care Oversight Committee which was established in 2021 was reinvigorated in June 2022 to work on the VISN 22 findings and corrective actions and this was reported to the Organizational Excellence Council (OEC) monthly until Fall 2023 when it transitioned to quarterly reporting. Moreover, the tiered huddles include reporting of community care metrics at the COS Daily Service Chief huddle and enterprise huddle.

The lack of Primary Care providers in outpatient clinics led to a significant increase in Primary Care Community Care consults: 5,077 consults in FY2022 and 11,332 consults in FY 2023. The Care in the Community Service lacked the manpower to process and schedule the influx of

consults and adhere to the new VHA expectation to process community care consults and make patient appointments within seven (7) days.

As part of the action plan, the Community Care Service was approved to add forty-nine new full-time employee (FTE) positions over two fiscal years (FY2023 and FY2024) to meet the growing demands of the program. Currently twenty-nine (29) positions are filled, and twenty (20) are pending onboarding. Clinical positions, such as Registered Nurse and Nurse Practitioner as well as administrative positions like Supervisory Medical Support Assistant (SMSA), Lead Advanced Medical Support Assistant (LAMSA), and Advanced Medical Support Assistant (AMSA) were restructured to create five teams. These teams process and schedule community care consults based on different categories of care and specialties.

All VHA Community Care matrix are monitored through the VISN 22 Community Care Operational Dashboard, created, and launched in April 2022, and through the daily VA Support Service Center (VSSC) – Clinic Practice Management (CMP) Dashboard. Additionally, the Chief of Community Care reports daily to the Chief of Staff huddle and Enterprise Huddle to Executive Leadership regarding the status of processing and scheduling of community care consults. The Chief of Community Care also attends and reports at the monthly Community Care Oversight Committee meeting and meets with the VISN 22 Community Care Leads biweekly. Compliance for timely processing and scheduling of primary care community care consults within 7 days will be monitored and reported at the Quality and Patient Safety Council through the governance structure.

Recommendation 3

The VA Loma Linda Healthcare System Director conducts an assessment of the community based outpatient clinic steering committee to ensure consistent oversight of quality of care and staffing levels for all of the VA Loma Linda Healthcare System's VA outpatient clinics.

_ X_Concur

____Nonconcur

Target date for completion: August 30, 2024

Director Comments

The Medical Center Director has requested the VISN 22 Primary Care Integrated Clinical Community (ICC) leadership, Quality and Patient Safety leadership, Group Practice Manager, and the Network Contracting Office to collaborate on a comprehensive assessment of the community-based outpatient clinic steering committee. This multidisciplinary team will ensure a thorough and systematic evaluation, taking into consideration the diverse aspects of healthcare delivery, quality of care, and operational efficiency. The scope of the assessment will include but

not be limited to the following: (1) Review of Current Steering Committee Structure, (2) Quality of Care Oversight, (3) Staffing Level Analysis, (4) Contractual Compliance and Performance, (5) Communication and Reporting, and (6) Recommendations for Improvement. The VISN 22 leaders are committed to conducting this assessment in a timely and thorough manner. Upon completion of the assessment, they will provide a summary report of findings, conclusions, and recommendations for improvement. VA Loma Linda Healthcare System will then establish a plan for implementing recommended changes.

Glossary

To go back, press "alt" and "left arrow" keys.

care coordination. An "administrative process that facilitates integration of health care services and navigation through complex health care systems." This includes but is not limited to working across settings to exchange information, access providers, and services when needed without duplication or avoidable inconveniences. [1]

full-time equivalent. "The hours worked by one employee on a full-time basis in a normal 80 hour pay period. The value usually ranges from 0.0 to 1.0. For example, a 1.0 FTE [full-time equivalent] would work 80 hours in a pay period, while a 0.5 FTE would work 40 hours per pay period."[2]

Joint Patient Safety Reporting system. The VHA event reporting system and database. As a user-based reporting system, the system captures real time incident reporting data from all VHA care sites.[3]

panel management. "The administrative process of using the Patient-Centered Management Module application to assign and un-assign patients to a team, and to calculate, adjust, and monitor Patient Aligned Care Team panel capacity and size."[4]

panel size. "A field in Patient-Centered Management Module that displays the total number of currently assigned patients. For all Patient Aligned Care Teams, panel size is the total number of pending and active Patient-Centered Management Module Patient Aligned Care Team assignments. For non-primary care and community (non-VA) populations, panel size is the total number of active assignments."[5]

Patient Advocate Tracking System. "A VHA-wide computer application that tracks patient complaints, compliments and other key program data at each VA medical facility."[6]

patient aligned care team. "A team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care."[7]

[1] VHA Handbook 1101.10(1).
[2] VHA Directive 1406.
[3] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2022.
[4] VHA Directive 1406.
[5] VHA Directive 1406.
[6] VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018.
[7] VHA Directive 1406.

patient-centered care. "Personalized, proactive, and patient-driven health care. Patient-centered care focuses on discovering the veteran's vision of living life fully and his or her goals for health."[8]

patient-centered medical home model. "VHA adopted and customized the patient-centered medical home model of care, and branded VHA's patient-centered medical home model as the Patient Aligned Care Team"[9]

primary care. The "provision of integrated, accessible health care services," including the "diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education."[10]

primary care providers. Include physicians, advanced practice registered nurses, and physician assistants who provide care to an assigned group, or panel, of patients.[11]

team-based primary care. "Emphasizes provision of care that is accessible, timely, coordinated, continuous, comprehensive, and compassionate"[12]

[8] VHA Handbook 1101.10(1).
[9] VHA Handbook 1101.10(1).
[10] VHA Handbook 1101.10(1).
[11] VHA Handbook 1101.10(1).
[12] VHA Handbook 1101.10(1).

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