



Department of Veterans Affairs  
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05490-367

## Healthcare Inspection

# Reported Primary Care Staffing at St. Cloud VA Health Care System 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 to assess the merit of allegations made regarding information contained in a September 14, 2015 letter from Veterans Integrated Service Network (VISN) 23 to Congressman Timothy J. Walz concerning primary care at the St. Cloud VA Health Care System (facility), St. Cloud, MN. The specific allegations were:

- VISN 23 staff did not accurately represent gains and losses of physicians and mid-level providers at the facility.
- VISN 23 staff did not accurately represent primary care provider panel sizes at the facility.

While we substantiated that part of the VISN 23 Acting Director's September 2015 response to Congressman Walz outlining the status of improvement actions taken to address OIG's query about alleged management issues, primary care staffing, and primary care panel sizes (*VISN 23 Response 2*) did not accurately represent gains and losses of physicians and mid-level providers at the facility, it appeared to be an inadvertent error. We were generally able to validate the staffing gains reported for fiscal years 2014 and 2015; however, upon requesting supporting documentation for the gains and losses reported, facility staff acknowledged inaccurately representing the number of mid-level providers who were hired in fiscal years 2014 and 2015.

We substantiated that *VISN 23 Response 2* inaccurately represented primary care provider panel sizes at the facility. VISN and facility leadership acknowledged that no data validation steps were taken prior to submitting *VISN Response 2* to Congressman Walz.

We found the reported facility average primary care panel size was based upon a simple average of panel sizes across all facility providers. The calculation did not include adjustment for factors such as whether the provider was a part-time employee. The adjusted panel sizes were consistently higher than the panel sizes reported to Congressman Walz, which generally under-represented true primary care workload and staffing availability. Further, we found that most primary care providers had panel sizes outside the Veterans Health Administration expected panel sizes range, which affects the timeliness of patients seeing a provider. Staff reported that patients are redirected to urgent care when a primary care provider is not available to see them on the same day. However, we did not observe evidence of "ghost panels" or patients assigned to primary care providers who were not actively providing care.

During our review, we found that facility staff distributed a news release with data reporting similar errors to those found in *VISN 23 Response 2* related to reported primary care average panel sizes for physicians and mid-level providers.

We also reviewed the accuracy of data provided in a response from the VISN to the VA Office of Inspector General Hotline Case at issue. We found that the facility-reported average panel size of 1,417 for November 2013 was generally accurate

compared to the historical facility Primary Care Management Module data of 1,453 for November 2013.

We recommended that the Acting Veterans Integrated Service Network 23 Director ensure that the St. Cloud VA Health Care System Director reviews Primary Care Management Module data and reports and takes steps to follow Veterans Health Administration guidance for primary care provider panel sizes across the system.

## **Comments**

The Acting Veterans Integrated Service Network 23 and St. Cloud VA Health Care System Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 12–14 for the Directors' 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 to assess the merit of allegations made regarding information contained in a September 14, 2015, letter from Veterans Integrated Service Network (VISN) 23 to Congressman Timothy J. Walz (*VISN 23 Response 2*) and the accuracy of data submitted to stakeholders and the VA OIG concerning primary care (PC) at the St. Cloud VA Health Care System (facility), St. Cloud, MN.

## Background

The facility is a secondary, low-complexity system and is a part of VISN 23. The facility serves over 30,000 veterans and is located in the upper Midwest region. The facility has 388 authorized beds to support acute psychiatry, the Mental Health Residential Rehabilitation Treatment Program, and the Community Living Center. The facility operates three community based outpatient clinics located in Brainerd, Alexandria, and Montevideo, MN.

In this report, we used the term “facility” to mean only the parent facility in St. Cloud, MN. We used the term “system” to include the St. Cloud, MN facility and all other locations providing primary care that report to the St. Cloud VA Health Care System.

**PC Management.** 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).<sup>1</sup> The PCMM software allows users to set up and define a primary care team, assign staff to positions within the team, and assign patients to practitioners.

All patients receiving PC in a VA medical center or community based outpatient clinic must be assigned as active patients in PCMM at the time they present for their first PC appointment.

Primary Care Direct Patient Care (PCDPC) time is defined as the time providers use to prepare for, provide, and follow up on the clinical care needs of outpatient PC patients. PCDPC data is entered for each PCP in PCMM as a portion of a full-time employee (FTE). Full-time mid-level providers’ (nurse practitioners and physician assistants) time is defined as 0.75 of a physician FTE. This adjustment allows for comparisons between full-time physicians, part-time physicians, and full- or part-time mid-level providers. Table 1, on the following page, illustrates the importance of using PCDPC time when calculating facility average panel sizes. Using calculations based on factors other than PCDPC time may significantly underestimate average panel sizes.

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<sup>1</sup> VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. This VHA Handbook was scheduled for recertification on or before April 30, 2014 but has not yet been recertified.

**Table 1: Potential Variation in Average Panel Size Determination Based on Number of PCPs, FTE, and PCDPC Time**

Provider	Panel Size	FTE	PCDPC Time	Average Panel Size		
				Based on Total Number of Providers	Based on Total FTE	Based on Total PCDPC Time
Physician 1	1,500	1.0	0.95 <sup>†</sup>	(2,000 patients ÷ 2 providers)	(2,000 patients ÷ 1.5 FTE)	(2,000 patients ÷ 1.29 PCDPC)
Mid-Level Provider 2	500	0.5	0.34 <sup>‡</sup>			
<b>TOTAL (N=2)</b>	<b>2,000</b>	<b>1.5</b>	<b>1.29</b>	<b>1,000</b>	<b>1,333</b>	<b>1,550</b>

Source: OIG

<sup>†</sup> Example PCDPC based upon 0.95 FTE for clinical care and a 0.05 FTE adjustment for non-clinical duties.

<sup>‡</sup> Example PCDPC calculation based upon (0.5 FTE) x (0.75 mid-level provider adjustment) and no adjustment for non-clinical duties.

The maximum PCP panel size is determined locally by the Chief of Staff, or designee, as it is dependent on such factors as disease burden, number of support staff, number of clinic rooms, and time available for direct patient care. Panel sizes are expected to be adjusted based on deviations in these factors. After adjustments, expected patient panel sizes for VHA PCPs largely fall in the range of 1,000–1,400.

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).<sup>2</sup> Contingency plans must include the reassignment or redistribution of patients to other PC teams when PCPs discontinue employment or a PCP’s absence is expected to last longer than 6 months.

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, one of the active facility PCPs would need to see any patients assigned to a ghost panel who needed care. As a result, the active facility PCPs’ panels would seem artificially low since these patients would not be included in the active PCPs’ panel totals.

**PCMM Data Availability.** VHA collects and maintains a multitude of PCMM data to allow for detailed analysis (such as monitoring, benchmarking or identification of opportunities) at national, VISN, facility, division, and provider levels since fiscal year (FY) 2014.<sup>3</sup> One of VHA’s monitors—Monitor 1—is the ratio of the adjusted physician

<sup>2</sup> VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

<sup>3</sup> *PCP Panel Cube Data Definitions* (Last Update August 17, 2015), VSSC (<http://vssc.med.va.gov/>), accessed October 30, 2015.

equivalent observed panel size to the adjusted physician equivalent capacity ratio.<sup>4</sup> The targeted ratio range is between 90–105 percent. If the ratio is below 90 percent, the cause may be excess availability on the PCP's panel or an overestimated capacity. If the ratio is above 105 percent, the cause may be over assignment on the panel or an underestimation of the panel's capacity.

A second VHA monitor—Monitor 2—is the ratio of the adjusted physician equivalent capacity to the modeled capacity.<sup>5</sup> This ratio compares the panel capacity as estimated by the facility to the capacity modeled for the clinic location, which takes into account the number of rooms, support FTE, direct FTE, and visit intensity. The targeted ratio range is between 80–120 percent. If the ratio is below 80 percent, the cause may be underestimated capacity. If the ratio is above 120 percent, the cause may be an overestimation of the panel's capacity.

VHA also collects data regarding patients assigned to PCPs in PCMM software and those considered unassigned to PCPs who have had a qualifying encounter and publishes selected information on the Active Panel List and Unassigned Patient List reports:<sup>6, 7, 8</sup>

- The Active Panel List documents the number of active PC patients assigned to PC teams and providers, teams' capacity, and teams' PCP FTE by facility.
- The Unassigned Patient List documents selected patient demographic data, dates patients visited facility PC clinics, and other information to assist PCMM Coordinators in managing unassigned patients and PCP panels.<sup>9</sup>

In combination, these reports are useful tools 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. A high number of unassigned patients or patients not reassigned or redistributed would underestimate a facility's "true" average PCP panel size.

**Timeline of Events and Allegations.** The following represents the timeline of events related to the VA OIG Hotline Case (Hotline Case) at issue:

- September 27, 2013: VA OIG Office of Healthcare Inspections received multiple allegations related to management issues, PC staffing, and PC panel sizes as part of the Hotline Case.

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<sup>4</sup> VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009.

<sup>5</sup> Ibid.

<sup>6</sup> *Active Panel List* Data Definitions (Last Updated January 6, 2015), VSSC (<http://vssc.med.va.gov/>), accessed November 11, 2015.

<sup>7</sup> *Unassigned Patient Report* Data Definitions (Last Updated January 7, 2015), VSSC (<http://vssc.med.va.gov/>), accessed November 11, 2015.

<sup>8</sup> Both reports are accessible for approved users through the VSSC intranet site, <http://vssc.med.va.gov/>.

<sup>9</sup> Within the Unassigned Patient List report, a link to a 12 Month Lookback Unassigned Patient Report is also available.

- November 1, 2013: VA OIG referred allegations to VISN 23 staff for review and determination of merit.<sup>10</sup> For substantiated allegations, VA OIG requested corrective actions initiated, taken, or completed as well as contact information for subsequent follow up, if needed.
- January 17, 2014: VISN 23 staff provided the results of its investigation into each allegation, including substantiated findings related to PCP staffing and panel sizes to VA OIG (*VISN 23 Response 1*).
- April 14, 2014: After processing and considering *VISN 23 Response 1*, VA OIG closed the Hotline Case.
- August 11, 2015: Congressman Walz requested a copy of *VISN 23 Response 1* related to the Hotline Case through the Deputy Inspector General.
- August 14, 2015: The VA OIG Deputy Inspector General provided Congressman Walz with a redacted copy of *VISN 23 Response 1*.
- September 2, 2015: Congressman Walz requested an update from the VISN 23 Acting Director on the status of improvement actions taken in response to the Hotline Case.
- September 8, 2015: A complainant contacted Congressman Walz alleging that staff had previously provided inaccurate information in the *VISN 23 Response 1* to the Hotline Case.
- September 14, 2015: The VISN 23 Acting Director provided Congressman Walz with a response letter, *VISN 23 Response 2*, outlining the status of improvement actions taken in response to the Hotline Case.
- October 2, 2015: Congressmen Waltz and Emmer visited the facility to speak with staff after receiving *VISN 23 Response 2*.
- October 14, 2015: The facility issued a news release to various news and media sources, Veterans Service Organizations, and the Minnesota Congressional Delegation. The news release was intended as an update to the Hotline Case as well as to present additional data that was collected after *VISN 23 Response 2*.

The complainant's allegations raised concerns with Congressman Walz with respect to *VISN 23 Response 2*. Specifically, we reviewed concerns that:

- VISN 23 staff did not accurately represent gains and losses of physicians and mid-level providers at the facility.
- VISN 23 staff did not accurately represent PCP panel sizes at the facility.

We also reviewed the accuracy of data presented in the:

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<sup>10</sup> In accordance with VA Directive 0701 *Office of Inspector General Hotline Complaint Referrals*, January 15, 2009, VA OIG refers some allegations to VHA for review. In such instances, OIG reviews the adequacy of VHA's response, including any planned or completed corrective actions. If responses are deemed adequate, the case is closed. If responses are determined to be inadequate, additional information may be requested or a healthcare inspection may be opened.

- October 14, 2015, facility-issued news release to various news and media sources, Veterans Service Organizations, and Minnesota Congressional Delegation.
- January 17, 2014, *VISN 23 Response 1* to VA OIG related to the Hotline Case.

## Scope and Methodology

The period of review was from October 1, 2014, through December 29, 2015. We conducted site visits to VISN 23 and the facility on November 16–18, 2015.

We reviewed statements in *VISN 23 Response 2* to Congressman Walz and corresponding facility-provided supporting data. We reviewed various related historical<sup>11</sup> and current<sup>12</sup> PCMM data and reports available through the VHA Support Service Center (VSSC), including the Unassigned Patient List, 12 Month Lookback Unassigned Patient List, and Active Panel List reports. We also reviewed selected PCMM data in the VA Corporate Data Warehouse (CDW).

We did not assess individual factors affecting maximum panel sizes (for example, disease severity, number of support staff per provider, and the number of clinic rooms per provider). We did not review *VISN 23 Response 2* issues related to management, canceled appointments, death rates, or progress on implemented improvement actions.

We also reviewed the October 14, 2015, facility news release and evaluated selected statements and data related to PCP panel sizes during FYs 2014–2015 specific to physician and mid-level provider average panel sizes; facility-provided supporting documentation; and historical facility PCMM data<sup>13</sup> and reports available through VSSC. VHA does not maintain PCMM data reports prior to FY 2014; therefore, we could not readily validate other data reported to VA OIG.

Despite our attempts, we were unable to reach the complainant who contacted Congressman Walz. We interviewed facility staff who generated data or participated in the preparation of *VISN 23 Response 2*. We also interviewed selected facility staff, including facility PCPs.

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

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<sup>11</sup> Patient Aligned Care Team Compass Cube, VSSC (<http://vssc.med.va.gov/>), accessed on October 27–December 2, 2015.

<sup>12</sup> PCMM Cube, VSSC (<http://vssc.med.va.gov/>), accessed on October 30–December 2, 2015.

<sup>13</sup> Patient Aligned Care Team Compass Cube, VSSC (<http://vssc.med.va.gov/>), accessed on December 1–2, 2015.

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

## Inspection Results

### Issue 1: Facility Physician and Mid-Level Provider Gains and Losses

While we substantiated that part of *VISN 23 Response 2* did not accurately represent gains and losses of physicians and mid-level providers at the facility, it appeared to be an inadvertent error.

*VISN 23 Response 2* stated, “The growth in the number of full time provider equivalents (FTE) engaged in panel management in primary care settings has positively impacted Veteran care and reduced panel sizes.” *VISN 23 Response 2* also included a graphic reflecting FTE in October 2013, July 2014, and September 2015. We found that, when comparing facility-reported FTE and historical PCMM data, the data from these two sources were similar, as shown in Table 2 below.

**Table 2: Comparison of Facility-Reported FTE to Historical PCMM Data**

Month	Facility-Reported FTE	Historical FTE
October 2013	14.1	14.0
July 2014	17.1	17.8
September 2015	20.7	20.4

*Source: OIG analysis of facility-provided and historical VSSC PCMM data*

However, *VISN 23 Response 2* also stated:

- “In FY 14 these efforts [referring to a provider recruitment workgroup] resulted in the hiring of eight physicians and 14 mid-level providers.”
- “In FY 15 St. Cloud has added eight physicians and six mid-level providers across the organization, and is in the process of hiring more.”

Upon requesting supporting documentation for the above statements, facility staff who participated in drafting *VISN 23 Response 2* acknowledged that the supporting documentation did not match the information included in the letter. Table 3 on the following page shows a comparison between the number and type of providers included in *VISN Response 2* and supporting documentation provided on November 3, 2015. Given that the facility reported FTE numbers that were generally accurate in comparison to historical PCMM data, we determined that the information provided was not intentionally inaccurate.

**Table 3: Comparison of Gains Reported in VISN 23 Response 2 to Facility-Provided Supporting Documentation**

Staff Type	VISN 23 Response 2		Supporting Documentation	
	FY 2014	FY 2015	FY 2014	FY 2015
Physician	8	8	8	8
Mid-Level Providers	14	6	7	13
<b>Total</b>	<b>22</b>	<b>14</b>	<b>15</b>	<b>21</b>

Source: OIG comparison of facility-provided documentation

After VISN 23 Response 2 was provided to Congressman Walz, but prior to our site visit in November 2015, facility staff recognized vulnerabilities in the data sources and took steps to increase the reliability of gains and losses reports by developing a “Provider Dashboard” report. The report allows staff to track the authorized FTE, current FTE, and gains and losses for physicians and mid-level providers in Primary & Specialty Medicine, Mental Health, Surgical & Specialty Care, other services, and overall. Gains and losses by employee name, title, service, FTE, and start/separation date are tracked as well.

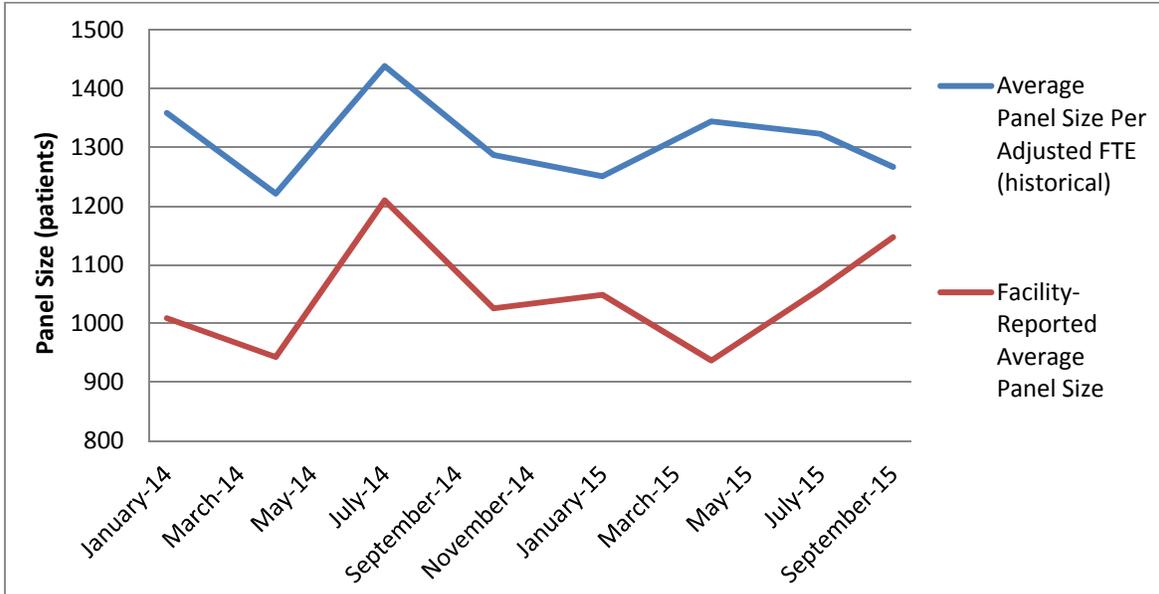
**Issue 2: PC Provider Panel Sizes**

We substantiated that VISN 23 Response 2 inaccurately represented PCP panel sizes at the facility.

We found that VISN 23 Response 2 reported the facility average PCP panel size per month based on a simple average of panel sizes across all facility providers. The calculation did not include adjustment for PCDPC time. The figure below shows the facility-reported average panel size and the adjusted average panel size at the facility by month from January 2014 through September 2015.<sup>14</sup> The adjusted panel sizes were higher than those reported to Congressman Walz. During our interviews, staff were not aware of calculation errors reported in VISN 23 Response 2; however, staff recognized the errors during our review and discussion of the data. Further, VISN and facility leadership acknowledged that no data validation steps were taken prior to submitting VISN Response 2 to Congressman Walz.

<sup>14</sup> Comparisons between the facility-reported average panel size and the adjusted average panel size in the figure were based upon facility-provided supporting data annotated as beginning of the month data compared to end-of-the-previous-month data available in the Patient Aligned Care Team Compass Cube in VSSC.

**Figure: St. Cloud PC Panel Sizes from January 2014 through September 2015**



Source: OIG analysis of facility-provided and historical VSSC PCMM data

We found that 21 of 32 providers (66 percent), as of October 28, 2015, had adjusted panel sizes outside the expected panel size range for VHA PC providers (1,000–1,400).<sup>15</sup> We observed panel sizes both above the maximum and below the minimum range values.

We found 21 of 32 providers (66 percent) as of October 28, 2015, had Monitor 1 ratios outside VHA targets of 90–105 percent. We found 7 of 32 providers (22 percent) had Monitor 2 ratios outside VHA targets of 80–120 percent. We observed ratios above the maximum and below the minimum range values for both monitors.

We did not observe evidence of ghost panels or patients assigned to PCPs who were not actively providing care on the Active Panel Report. The Active Panel Report as of November 9, 2015, documented 32,510 active PC patients across the system assigned to the current 34 PCPs with capacity for 28,029 patients.<sup>16</sup> Finally, we did not find a significant number of unassigned patients. We found that the Unassigned Patient List and 12 Month Lookback Unassigned Patient List reports as of November 10, 2015, documented 21 and 117 patients, respectively.

Staff reported that patients are redirected to urgent care when a primary care provider is not available to see them on the same day.

<sup>15</sup> One provider did not have PCDPC, adjusted capacity, or adjusted panel sizes entered in PCMM.

<sup>16</sup> Between October 28, 2015, and November 9, 2015, one PC provider left the facility and two others PC providers were assigned PC panels.

### **Issue 3: Facility News Release**

During our review, we found that facility staff distributed a news release to various news and media sources, Veterans Service Organizations, and offices of Minnesota Congressional Members.

We found that the facility-reported average panel sizes were generally calculated based upon panel sizes per providers' employment FTE rather than adjusted PCDDPC time. Although the facility-reported physician average panel size generally trended with historical PCMM data from November 2013 through September 2015, the facility-reported mid-level provider average panel sizes by month were lower than the historical facility PCMM data. The average monthly difference between facility-reported mid-level provider average panel sizes and historical PCMM data was 258 patients.<sup>17</sup>

### **Issue 4: VISN Response 1 to VA OIG**

We attempted to review the accuracy of data in *VISN 23 Response 1* to the Hotline Case at issue.

We found that the facility-reported average panel size of 1,417 for November 2013 was generally accurate compared to the historical facility PCMM data of 1,453 for November 2013. VHA does not maintain PCMM data reports prior to FY 2014; therefore, we could not readily validate other data reported to VA OIG.

## **Conclusions**

While we substantiated that part of *VISN 23 Response 2* did not accurately represent gains and losses of physicians and mid-level providers at the facility, it appeared to be an inadvertent error. Although we were able to generally validate the total FTE reported to Congressman Walz by reviewing historical PCMM data, upon requesting supporting documentation for the gains and losses reported, facility staff acknowledged that the supporting documentation did not match the information included in *VISN 23 Response 2*. Supporting documentation provided on November 3, 2015, indicated different gains across the system for mid-level providers than previously stated. However, after *VISN 23* staff provided *VISN 23 Response 2* to Congressman Walz, but prior to our site visit in November 2015, facility staff recognized vulnerabilities in the data sources and took steps to increase the reliability of gains and losses reports by developing a "Provider Dashboard" report.

We substantiated that *VISN 23 Response 2* inaccurately represented PCP panel sizes at the facility. We found that *VISN 23 Response 2* reported the average PCP panel size based upon a simple average of panel sizes across all facility providers. Calculations

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<sup>17</sup> Comparisons between the facility-reported average panel size and the adjusted average panel size were based upon facility-provided supporting data compared to end-of-the-previous-month data available in the Patient Aligned Care Team Compass Cube in VSSC to correspond to reporting differences noted previously. Monthly differences between facility-reported and historical average panel sizes ranged from 37 to 458 patients.

did not include adjustment for PCDPC time. The adjusted panel sizes were consistently higher than the panel sizes reported to Congressman Walz, which generally under-represented true PC workload and staffing availability. Further, we found that most PCPs had panel sizes outside the VHA expected panel sizes range, which affects the timeliness of patients seeing a provider. Staff reported to us that patients are redirected to urgent care when a primary care provider is not available to see them on the same day.

We also found deviation from VHA guidance for a significant number of PC panels for Monitors 1 and 2. These observations were supported by data in the Active Panel Report, which documented 32,510 active PC patients across the system with only capacity for 28,029 patients as of November 9, 2015. We did not observe ghost panels or patients assigned to PCPs who were not actively providing care on the Active Panel Report or a significant number of unassigned patients on either the Unassigned Patient List or 12 Month Lookback Unassigned Patient List Reports as of November 10, 2015.

We also found data reporting issues with the facility October 14, 2015 news release related to reported PC average panel sizes for physicians and mid-level providers. Calculations were based upon panel sizes per providers' employment FTE rather than PCDPC time.

We attempted to review the accuracy of data provided by *VISN 23 Response 1* to the Hotline Case at issue. We found that the facility-reported average panel size of 1,417 for November 2013 was generally accurate compared to the historical facility PCMM data of 1,453 for November 2013.

## Recommendation

1. We recommended that the Acting Veterans Integrated Service Network Director ensure that the Facility Director reviews Primary Care Management Module data and reports and takes steps to follow Veterans Health Administration guidance for primary care provider panel sizes across the system.

## Acting VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** April 7, 2016

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

**Subj:** Healthcare Inspection—Reported Primary Care Staffing at St. Cloud VA Health Care System, 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 with the OIG Draft Report “Healthcare Inspection - Reported Primary Care Staffing at St. Cloud VA Health Care System”. The VISN Director will ensure the St. Cloud HCS Director reviews Primary Care Management Module data and reports through the following activities:

1. Primary Care Management Module time allocations reports will be submitted to the VISN on a monthly basis with a signed attestation statement demonstrating the report was reviewed by the Facility Director. Provider time allocation reports provide the basis for establishing modeled and adjusted capacity. This VISN will monitor modeled and adjusted capacity in relation to the target score outlined in VHA Handbook 1101.02. The target score is 0.80 to 1.20.
2. VISN 23 Primary Specialty Medicine Service Line will prepare a monthly panel management report that includes current primary care management assignments in relation to capacity (panel saturation rates) and provider staffing levels. The report will include trends for the overall facility, and provider specific data. The VISN will monitor panel saturation rates in relation to capacity targets outlined in VHA Handbook 1101.02. The target score is 0.90 to 1.05.
3. The St. Cloud HCS Director will submit a monthly action plan to the VISN Director in response to variances identified in the VISN panel management reports. The report will contain sufficient detail to validate efforts to improve. This monitoring will continue until panel saturation rates are in alignment with targets for three consecutive months.

  
Patrick J. Kelly, FACHE  
Acting Director

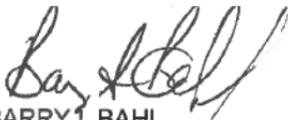
## Facility Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** March 30, 2016  
**From:** Director, St. Cloud VA Health Care System (656/00)  
**Subj:** Healthcare Inspection—Reported Primary Care Staffing at St. Cloud VA Health Care System, Veterans Integrated Service Network 23, Eagan, Minnesota  
**To:** Director, VA Midwest Health Care Network (10N23)

I have reviewed and concur with the OIG DRAFT Report “Healthcare Inspection – Reported Primary Care Staffing at the St. Cloud VA Health Care System”.



BARRY T. BAHL

## Comments to OIG's Report

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

### **OIG Recommendation**

**Recommendation 1.** We recommended that the Acting Veterans Integrated Service Network Director ensure that the Facility Director reviews Primary Care Management Module data and reports and takes steps to follow Veterans Health Administration guidance for primary care provider panel sizes across the system.

Concur

Target date for completion: December 31, 2016

VISN response: The VISN Director will ensure the St. Cloud HCS Director reviews Primary Care Management Module data and reports through the following activities:

1. Primary Care Management Module time allocations reports will be submitted to the VISN on a monthly basis with a signed attestation statement demonstrating the report was reviewed by the Facility Director. Provider time allocation reports provide the basis for establishing modeled and adjusted capacity. This VISN will monitor modeled and adjusted capacity in relation to the target score outlined in VHA Handbook 1101.02. The target score is 0.80 to 1.20.
2. VISN 23 Primary Specialty Medicine Service Line will prepare a monthly panel management report that includes current primary care management assignments in relation to capacity (panel saturation rates) and provider staffing levels. The report will include trends for the overall facility, and provider specific data. The VISN will monitor panel saturation rates in relation to capacity targets outlined in VHA Handbook 1101.02. The target score is 0.90 to 1.05.
3. The St. Cloud HCS Director will submit a monthly action plan to the VISN Director in response to variances identified in the VISN panel management reports. The report will contain sufficient detail to validate efforts to improve. This monitoring will continue until panel saturation rates are in alignment with targets for three consecutive months.

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
<b>Contributors</b>	Larry Ross, Jr., MS, Team Leader Cathleen King, MHA, CRRN Melanie Krause, PhD, RN Roneisha Charles, BS

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Director, St. Cloud VA Health Care System (656/00)

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