THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 21, 2020

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-19-0865

Dear Mr. Kerner:

I am responding to your April 16, 2019, letter regarding whistleblower allegations that the Department of Veterans Affairs (VA) Central Alabama Veterans Health Care System, engaged in conduct that may constitute a violation of law, rule, or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health.

The Executive in Charge, Office of the Under Secretary for Health, directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. We investigated this matter from June 18-20, 2019, and substantiated two of the whistleblower's allegations and partially substantiated one allegation. We make 12 recommendations to the Central Alabama Veterans Health Care System and one recommendation to Veterans Integrated Service Network 7.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File No. DI-19-0865

Department of Veterans Affairs (VA)
Central Alabama Veterans Health Care System
Montgomery and Tuskegee, Alabama

Report Date: December 13, 2019

TRIM 2019-C-19

Executive Summary

The Executive in Charge, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations reported to the Office of Special Counsel (OSC) concerning the Central Alabama Veterans Health Care System (Montgomery) located in Montgomery and Tuskegee, Alabama. The whistleblower, [redacted] who consented to the release of his name, alleged that Montgomery presently has at least three "ghost panels" which have compromised patient access to care, and that employees are engaging in conduct that may constitute a violation of law, rule, or regulation; engaged in gross mismanagement, or created a substantial and specific danger to public health. We conducted a site visit to Montgomery on June 18–20, 2019.

Specific Allegations of the Whistleblower

1. *CAVHCS grossly mismanaged the closure of the Dothan Community Based Outpatient Clinic (CBOC) by failing to plan for the influx of patients;*

2. *As a result of the Dothan CBOC closure, and employee departures, ghost panels are used at the Ft. Benning, Wiregrass, and Tuskegee clinics; and*

3. *The absence of an adequate number of providers impedes patient access to care.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **unable to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, we make the following conclusions and recommendations.

Conclusion(s) for Allegation 1

- We **substantiate** that Montgomery grossly mismanaged the closure of the Dothan CBOC by failing to plan for the transfer of patients.

- There was a delay in notifying the Montgomery patients and staff impacted by the move.

- There was mismanagement in transferring the Montgomery patients to other sites of care.

- Montgomery leadership did not ensure that the proper human and capital resources were available to support the move; including a delay in recruiting and hiring

providers needed to support the Patient Aligned Care Team (PACT) and the Patient Centered Management Module (PCMM) Web.

- There was a staffing plan to hire additional staff that would accommodate 4 PACTs, but only 15 of 38 positions were posted, and only 10 were filled, which did not include providers.

- Montgomery Human Resources Officer or Human Resources staffing specialists were not a part of the work planning group.

- There was a delay in developing a Community Care Consult for Primary Care, thus a lack of options such as community care to absorb any of the displaced patients who required Primary Care management and continuity.

- The ongoing temporary acting leadership roles of the Chief of Staff (CoS), the ACoS for Primary Care, and the Associate Director (AD), contributed to poor communication and the delays in planning for the Dothan contract clinic closure and subsequent transition of the Montgomery patients into other VA clinics.

- We are concerned that requiring the ACoS for Primary Care to prescribe controlled substances for patients that the ACoS does not personally examine and may violate generally accepted standards of medical practice. It may also pose a safety risk to the subject patients.

Recommendation(s) to Central Alabama

1. In the future, for major projects, utilize the Office of Systems Redesign and Improvement, or a Facility/Project Manager as lead, ensuring that all invested parties are at the table.

2. Initiate recruitment actions to hire the CoS, AD, and ACoS for Primary Care positions as soon as possible, as well as all other staffing vacancies.

3. Immediately initiate recruitment actions to fill all physician positions at Dothan 2.

4. Ensure all prescriptions for controlled substances are issued in full compliance with applicable law, VA and VHA policies, and generally accepted standards of medical practice.

5. Perform a quality of care review of the records of the patients from the panels of the two Dothan 2 Nurse Practitioners to ensure the controlled substances they were prescribed by the ACoS for Primary Care were clinically appropriate and necessary, and issued consistent with generally accepted standards of medical practice.

Recommendation(s) to VISN 7

1. Identify and correct any Montgomery leadership failures in the planning and management of the Dothan contract clinic closure, including the proper transition of Montgomery patients to available clinics, and take the appropriate administrative, educational or disciplinary action.

Conclusion(s) for Allegation 2

- We **partially substantiate** that as a result of the Dothan contract CBOC closure, and employee departures, ghost panels are used at the Fort Benning, Wiregrass, and Tuskegee clinics.

- There was one "ghost panel" at the Wiregrass clinic.

- There was no evidence of "ghost panels" at the Fort Benning or the Tuskegee clinics.

- There were irregularities in PCMM Web designation at both the Wiregrass and Tuskegee clinics. Wiregrass PACT 10, which provides care for approximately 700 patients, established in December 2018 after closure of the Dothan contract clinic and disbanded June 10, 2019, does not meet the definition of a teamlet or primary care panel as defined in VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, and constitutes a violation of this policy.

- The Tuskegee Medical Officer of the Day (MOD), who also served as a Primary Care Provider (PCP), had an incorrect clinic profile, which can negatively impact access to care, continuity, and patient safety.

Recommendation(s) to Central Alabama

6. Assess all PACTs to ensure that there are no current or future clinics without assigned providers.

7. Ensure compliance with VHA Directive 1406.

8. Ensure that all pending View Alerts are addressed as soon as possible.

9. Develop a process to ensure that all clinic profiles are reviewed in accordance with VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, that clinics are at maximum efficiency, and that the clinic schedule/profile reflect the providers' capacity to see patients, ensuring that there is adequate supply to meet the demand for patient care.

10. Immediately correct the PCMM Web and labor mapping issues regarding the Tuskegee MOD.

Conclusion(s) for Allegation 3

- We **substantiate** that the absence of an adequate number of providers impedes patient access to care.

- There are delays in access to care at multiple Montgomery clinic sites including Fort Benning, Wiregrass, and Tuskegee.

- Panel sizes at Wiregrass and Dothan are over capacity.

Recommendation(s) to Central Alabama

11. Primary Care leadership and the PCMM Coordinator should review clinic wait times and panel capacity on a monthly basis. In response to these findings, develop a plan to improve wait times through improved access to care and develop contingency plans for unplanned absences of both providers and multidisciplinary team members.

12. Conduct a deep dive of all PACTs to include staffing, space, panel sizes, clinic utilization, data validation, and labor mapping to ensure appropriate resourcing.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Montgomery may have engaged in conduct that may constitute a violation of law, rule, or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health. VHA Human Resources has examined personnel issues to establish accountability and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy and a potential risk of danger to public health at Montgomery.

Table of Contents

I. Introduction

The Executive in Charge, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations reported to the Office of Special Counsel (OSC) concerning the Central Alabama Veterans Health Care System (Montgomery) located in Montgomery and Tuskegee, Alabama. The whistleblower, a staff physician and the [redacted] who consented to the release of his name, alleged that Montgomery presently has at least three "ghost panels" which have compromised patient access to care, and that employees are engaging in conduct that may constitute a violation of law, rule or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health. We conducted a site visit to Montgomery on June 18–20, 2019.

II. Facility Profile

Central Alabama is a member of Veterans Integrated Services Network (VISN) 7 and is a VHA level 1c health care facility that was formed by the merger of the Montgomery and Tuskegee VA medical centers on January 1, 1997. Community Based Outpatient Clinics (CBOC) are located in Alabama (Dothan, Monroeville, Montgomery, and Tuskegee) and on the Fort Rucker Army Post (Wiregrass). There are two Georgia CBOCs in Fort Benning and Columbus. The Dothan CBOC described in the OSC letter refers to a Primary Care contract clinic, located in Dothan, which closed on November 30, 2018. A second Dothan clinic, Dothan 2, was previously known as the Dothan Mental Health Clinic. Dothan 2 provides both Mental Health and Primary Care services to Veterans. All other CBOCs also offer Primary Care and Mental Health services. Central Alabama serves more than 134,000 Veterans in 43 counties in the central and southeastern portions of Alabama and western Georgia.

III. Specific Allegations of the Whistleblower

1. *CAVHCS grossly mismanaged the closure of the Dothan Community Based Outpatient Clinic (CBOC) by failing to plan for the influx of patients;*

2. *As a result of the Dothan CBOC closure, and employee departures, ghost panels are used at the Ft. Benning, Wiregrass, and Tuskegee clinics; and*

3. *The absence of an adequate number of providers impedes patient access to care.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of two Senior Medical Investigators, and a Clinical Program Manager, all from OMI; the Acting Deputy Director, VHA Primary Care; the National Patient Centered Management Module (PCMM) Coordinator, VHA Office of Primary Care; a Health Systems Specialist, VHA Field Support, Office of Veterans Access to Care (OVAC); and a VISN 8 Human Resources (HR) Employee Relations/Labor Relations (ER/LR) Specialist. We reviewed

relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Montgomery VA Clinic, specifically Primary Care and the Specialty Care Clinics, and conducted entrance and exit briefings with Central Alabama leadership.

Our team initially interviewed the whistleblower via teleconference on May 17, 2019, and in person at the Montgomery CBOC on June 18, 2019. We held entrance and exit briefings with the following Central Alabama and VISN 7 leadership:

- Network Director, VISN 7
- Group Practice Manager (GPM), VISN 7
- Quality Management Officer, VISN 7
- Medical Center Director (MCD)
- Acting Chief of Staff (CoS)
- Associate Director of Patient Care Services (ADPCS)
- Associate Director, Tuscaloosa (Acting MCD, Montgomery)
- Deputy Director
- Acting Associate Director
- Chief of Quality Management

We interviewed the following staff:

- Chief Medical Officer, VISN 7/Former Acting CoS, Montgomery
- GPM, VISN 7
- PCMM Coordinator, VISN 7
- MCD
- Former Acting CoS
- Acting CoS
- Deputy CoS
- Former Associate Director
- ADPCS
- HR Officer
- Employee/Labor Relations Specialist
- Former Acting Chief of Quality Management
- Risk Manager
- GPM
- Former GPM
- Chief, Health Administration Service (HAS)
- Chief of Dental Service
- Acting ACoS, Primary Care
- Three Staff Physicians, Primary Care
- Two Nurse Practitioners (NP), Primary Care
- Associate Chief Nurse, Primary Care
- Nurse Manager, Primary Care, Monroeville and Wiregrass CBOCs

- Nurse Manager, Primary Care, Columbus and Ft. Benning CBOCs
- PCMM Coordinator, Primary Care
- Former PCMM Coordinator
- Two Staff Nurses, Primary Care
- Licensed Practical Nurse (LPN), Primary Care
- Former CBOC Administrative Officer (AO)
- AO, Columbus and Ft. Benning
- Program Support Assistant, Primary Care
- Lead Medical Service Assistant

V. Background, Conclusions, and Recommendations

Allegation 1.

CAVHCS grossly mismanaged the closure of the Dothan Community Based Outpatient Clinic (CBOC) by failing to plan for the influx of patients.

Background

VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, establishes the guidelines and business rules for use of the PCMM Web, an Internet-based enterprise application that was developed to ensure that the data entered is reliable and consistent across VA.[1] PCMM Web enables users to (1) set up and define health care teams, (2) assign staff and their associated full-time equivalent employee staff to positions within each team, (3) assign patients to the team, and (4) assign patients to specific team members. For Primary Care, PCMM Web enhances the ability of the Patient Aligned Care Team (PACT) to optimally manage health care for patients assigned to PACTs, including all VHA Primary Care clinical sites of care, VHA owned, leased and contracted locations.

VHA Directive 1406 defines a PACT as 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. A PACT teamlet consists of a Primary Care Provider (PCP), a registered nurse (RN) Care Manager, a Clinical Associate, and an Administrative Associate who provides patient care, either in-person or through telehealth, to one entire panel of patients as assigned in PCMM Web. Generally, teamlet members are designated in PCMM Web to the following positions: PCP, RN, LPN (or, alternately, a licensed vocational nurse, a health technician, or medical assistant), and a scheduling clerk. PCPs are physicians, NPs and physician assistants (PA) who provide primary care to an assigned panel of patients in accordance with licensure, privileges, scope of practice, or functional statement.

[1] VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2019.

Findings

Montgomery contracted with a non-VA contractor on December 1, 2017, to provide Primary Care services within a Dothan contract clinic to serve Montgomery Veterans. The term of the Dothan contract agreement was from December 1, 2017, through May 21, 2018. During the contract, Montgomery found that there were many issues with the contracted services, and that the contracted staff did not consistently follow the PCMM Web directives or VHA policies with generally accepted standards of care provided to Montgomery Veterans who received primary care services at the Dothan contract clinic. Based on continued conflicts, Montgomery did not renew the contract, and services at the Dothan contract clinic were discontinued after the contract period was completed. As the initial May 21, 2018, contract closure date approached, Montgomery was not prepared to transition the approximately 4,500 patients to VHA clinics, thus they worked with the outside contractor to extend the contract for an additional 6 months, with a new closure date of November 30, 2018.

Our team found that communication was fragmented between Montgomery and the Dothan contract clinic, and meetings were inconsistent and ineffective in planning and preparing for this clinic's closure. Various work groups were formed, led by different individuals, causing inconsistency and multiple delays in planning for the closure, the transition, and the disposition of the Montgomery patients from the Dothan contract clinic to other Montgomery clinics.

There were approximately 4,500 Montgomery patients, representing four PACT panels, using the Dothan contract clinic. These patients were to be initially triaged at the Wiregrass CBOC. Two thousand of the 4,500 would then be assigned to two contract NPs who Montgomery hired to provide Primary Care services at Dothan 2. The other 2,500 patients were to be dispersed between the other CBOCs, including Wiregrass, Fort Benning, and Tuskegee.

We did not find a written strategic or operational plan outlining the closure or transition plan, instead finding a "*Montgomery, [Wiregrass], and Dothan Consolidation*" document outlining an incomplete action plan for closure of the contract clinic and transitioning patients to other Montgomery clinics. This document was not initiated until mid-August 2018, and it had a target completion date of September 7, 2018, to communicate the closure information to the appropriate stakeholders and patients. This plan did not have identifying action items and did not identify persons responsible for follow-up on the action items or target dates for their completion. Additionally, planning meeting minutes were not consistently recorded and distributed to the members of the clinic closure work group. The work group did not include the Montgomery Human Resources (HR) Officer or any HR staffing specialists, which further impeded the ability to anticipate and meet staffing requirements. They failed to ensure a successful transition process by not including other stakeholders such as a patient advocate, Systems Redesign and Improvement Expert, Project Manager, or Primary Care clinicians and staff who would ultimately be impacted by the Dothan clinic closure and redistribution of patients.

We reviewed an October 4, 2018, Montgomery staffing plan, developed during the time of the closure, with plans to hire 38 additional staff members to support the expansion of the Wiregrass clinic staffing to cover the 4 PACTs that were being affected by the Dothan clinic closure, including 4 PCPs, 2 psychiatrists, 3 clinical pharmacists, 2 social workers, 7 nurses (3 RNs and 4 LPNs), 4 medical technicians, and 16 additional clinical and administrative staff. Of the 38 projected positions, only 16 positions were posted, and 10 staff members hired, including 4 LPNs, 4 medical technicians, and 2 social workers. None of the additional providers projected in the expansion staffing plan were hired. Currently, Montgomery continues to have challenges recruiting, hiring, and retaining providers.

At the time of the Dothan contract clinic closure, Community Care was not an option because of a local delay in Montgomery implementing the Primary Care Community Care consult process. Montgomery did not start using this consult process until December 24, 2018, almost a month after the contract clinic closure.

During the transition and continuing to date, there has been instability in executive and supervisory management positions. There are currently an Acting CoS and an Acting ACoS for Primary Care. The AD contributed to inconsistency in the planning process, as well as poor and fragmented communication and an inadequate hand-off essential to providing information to key leaders regarding the contract clinic closure and subsequent transition of the Montgomery Dothan contract clinic patients to other VA clinics.

Currently, the two NPs hired to lead two PACTs at Dothan 2 do not have Drug Enforcement Agency (DEA) licenses. This prohibits them from writing prescriptions for controlled substances such as narcotics. The ACoS for Primary Care who works at the Montgomery medical center, is assigned to write prescription orders for controlled substances for the two NPs until they obtain their DEA licenses, or until a DEA licensed provider is assigned to the Dothan 2 clinic. The process of physicians writing controlled substance prescription orders for patients without seeing them or actively examining them is a potential patient safety risk and a potential licensure issue for the covering physicians.

The provisions of 21 Code of Federal Regulations (CFR) § 1306.03(a) provide that a prescription for a controlled substance may be issued only by an individual practitioner who is authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and either registered or exempted from registration pursuant to 21 CFR §1301.22(c) and 1301.23.

In addition, a prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. See 21 CFR 1306.04(a), first sentence. What constitutes a legitimate medical purpose, or the usual course of professional practice is understood to refer to generally accepted standards of medical care. Writing prescriptions for controlled substances based only on chart reviews without seeing or physically

examining the subject patients may not be consistent with generally accepted standards of medical care.

Conclusion(s) for Allegation 1

- We **substantiate** that Montgomery grossly mismanaged the closure of the Dothan CBOC by failing to plan for the transfer of patients.

- There was a delay in notifying the Montgomery patients and staff impacted by the move.

- There was mismanagement in transferring the Montgomery patients to other sites of care.

- Montgomery leadership did not ensure that the proper human and capital resources were available to support the move; including a delay in recruiting and hiring providers needed to support the PACT and PCMM Web.

- There was a staffing plan to hire additional staff that would accommodate 4 PACTs, but only 16 of 38 positions were posted, and only 10 were filled which did not include providers.

- Montgomery Human Resources Officer or HR staffing specialists were not a part of the work planning group.

- There was a delay in developing a Community Care Consult for Primary Care, thus a lack of options such as community care to absorb any of the displaced patients who required Primary Care management and continuity.

- The ongoing temporary acting leadership roles of the CoS, the ACoS for Primary Care, and the AD, contributed to poor communication and the delays in planning for the Dothan contract clinic closure and subsequent transition of the Montgomery patients into other VA clinics.

- We are concerned that requiring the ACoS for Primary Care to prescribe controlled substances for patients that the ACoS does not personally examine, may violate generally accepted standards of medical practice. It may also pose a safety risk to the subject patients.

Recommendation(s) to Central Alabama

1. In the future, for major projects, utilize the Office of Systems Redesign and Improvement, or a Facility/Project Manager as lead, ensuring that all invested parties are at the table.

2. Initiate recruitment actions to hire CoS, AD, and ACoS for Primary Care positions as soon as possible, as well as all other staffing vacancies.

3. Immediately initiate recruitment actions to fill all physician positions at Dothan 2.

4. Ensure all prescriptions for controlled substances are issued in full compliance with applicable law, VA and VHA policies, and generally accepted standards of medical practice.

5. Perform a quality of care review of the records of the patients from the panels of the two Dothan 2 NPs to ensure the controlled substances they were prescribed by the ACoS for Primary Care were clinically appropriate and necessary and issued consistent with generally accepted standards of medical practice.

Recommendation(s) to VISN 7

1. Identify and correct any Montgomery leadership failures in the planning and management of the Dothan contract clinic closure, including the proper transition of Montgomery patients to available clinics, and take the appropriate administrative, educational or disciplinary action.

Allegation 2.

As a result of the Dothan CBOC closure, and employee departures, ghost panels are used at the Ft. Benning, Wiregrass, and Tuskegee clinics.

Background

VHA Handbook 1101.10, *Patient Aligned Care Team (PACT),* Section 7 directs that PACT members and staffing at a facility reassign or redistribute patients to another PACT when: 1) the PCP has discontinued employment with the clinical service or program accountable for the PACT, 2) the PCP is not permitted by state or Federal law, or VHA or local policy, to provide health care to patients, or 3) the PCP's absence is expected to extend longer than 6 months.[2] If reassignment or redistribution is not available and lack of capacity and/or access to care exists, patients must be offered care in the community. Accordingly, a patient panel may not remain assigned to a provider who meets the above criteria as cited in Handbook 1101.10.

VHA Directive 1406: Appendix B – Sections A and F, identifies PACT teamlets as staff that are in the same Primary Care clinic, or collaborating through telehealth, and are responsible for the same assigned panel of patients. Staff must not be entered in PCMM Web for PACT teamlet roles if they are not consistently assigned to the same PACT or do not have regular engagement with other team members or patients on the panel.

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

Findings

The term "ghost panel" currently does not exist in any VHA handbook or directive. According to the OSC complaint letter, a "ghost panel" is defined as rosters of patients in a clinic who have not been assigned to an active VA provider.

Wiregrass

We found evidence of a "ghost panel" at the Wiregrass site. An Interim Staffing Program provider left Montgomery on May 4, 2019, and the providers name was left on the panel until May 22, 2019, at which time another provider was placed in PCMM Web. This constitutes a "ghost panel" of 18 days duration.

Dothan

While not meeting the definition of a "ghost panel," following the closure of the Dothan contract clinic, we found that a new PACT, designated as PACT 10 with approximately 700 patients, had been established at the Wiregrass clinic in December 2018, and was disbanded on June 10, 2019. Although a designated Montgomery PCP was assigned to cover this panel of patients, the provider was not physically assigned to work at the Wiregrass clinic, but rather physically worked at the Montgomery medical center, over 1.5 hours away. The PCP did not provide care through telehealth and did not have a designated teamlet assigned in the PCMM Web. In addition, the PACT did not have a clinic grid, limiting the ability to schedule patients to the appropriate team for follow-up care, disrupting the continuity of care for those 700 patients assigned to Wiregrass who previously received their care at the Dothan contract clinic. In summary, this does not meet the VHA Directive 1406 definition of a teamlet or a primary care panel and is a violation of VHA policy.

Our team also reviewed evidence that while the PCPs assigned to Wiregrass PACT 10 did receive Computerized Patient Record System (CPRS) View Alerts for these patients, in addition to their own alerts, one of these PCPs had over 2,000 pending View Alerts. Others also confirmed that they received excessive number of alerts daily. View Alerts are CPRS based notifications to communicate potentially important and actionable clinical information to providers in an "inbox-like" format. Many of these notifications are related to test results while others are related to referral responses, medication refill requests, and messages from other clinicians. Several types of notifications to clinicians are important. For instance, VHA Directive 1088, notes that all test results must be communicated by the diagnostic provider to the ordering provider, or designee within a time-frame that allows for prompt attention and appropriate action to be taken. Lack of timely follow-up of abnormal test results can contribute to poor outcomes and a potential patient safety risk.

Tuskegee

At the Tuskegee clinic, we found evidence of incorrect PCMM Web data and clinic grids involving the Tuskegee Medical Officer of the Day (MOD). At the Tuskegee location the MOD is currently assigned as a full-time PCP to PACT Team 6 in the PCMM Web, with a panel of 732 active patients. This provider only works Monday through Wednesday each week; however, the clinic grid for PACT Team 6 is built for appointments Monday-Friday. This situation necessitates that this provider's assigned patients on PACT Team 6 are covered by other providers every Thursday and Friday.

VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, requires facilities to ensure that clinic profiles are kept current and are reviewed annually.[3] The "Clinic Profile Management Guide 2.0" dated February 2018, provides additional guidance and recommendations for establishing accurate clinic profiles. This provider is also expected to cover urgent issues in his role as the MOD on the Tuskegee campus. We heard evidence that patients with scheduled appointments had to wait for his return when he is called away to attend to MOD duties. The incorrect PCMM Web data and clinic grids, along with this provider's duties as MOD, may negatively impact patient access to care, continuity of care, and patient safety.

Conclusion(s) for Allegation 2

- We **partially substantiate** that as of result of the Dothan contract CBOC closure, and employee departures, ghost panels are used at the Fort Benning, Wiregrass, and Tuskegee clinics.

- There was one "ghost panel" at the Wiregrass clinic.

- There was no evidence of "ghost panels" at the Fort Benning or the Tuskegee clinics.

- There were irregularities in PCMM Web designation at both the Wiregrass and Tuskegee clinics.

- Wiregrass PACT 10, which provides care for approximately 700 patients, established in December 2018, after closure of the Dothan contract clinic and disbanded June 10, 2019, does not meet the definition of a teamlet or primary care panel as defined in VHA Directive 1406, and constitutes a violation of this policy.

- The Tuskegee MOD, who also served as a PCP, had an incorrect clinic profile, which can negatively impact access to care, continuity, and patient safety.

[3] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

Recommendation(s) to Central Alabama

6. Assess all PACTs to ensure that there are no current or future clinics without assigned providers.

7. Ensure compliance with the VHA Directive 1406.

8. Ensure that all pending View Alerts are addressed as soon as possible.

9. Develop a process to ensure that all clinic profiles are reviewed in accordance with VHA Directive 1230, that clinics are at maximum efficiency, and that the clinic schedule/profile reflect the providers' capacity to see patients, ensuring that there is adequate supply to meet the demand for patient care.

10. Immediately correct the PCMM Web and labor mapping issues regarding the Tuskegee MOD.

Allegation 3.

The absence of an adequate number of providers impedes patient access to care.

Background

According to VHA Handbook 1101.10, Section 7, *PACT Members and Staffing*, PACT staffing must be sufficient to ensure that all patients assigned to the panel receive appropriate and desired health care. There must be contingency planning for inadequate PACT resources and extended staff absences. Therefore, local service-level officials accountable for PACTs must establish and implement contingency plans for ensuring patients receive continuity of and access to appropriate Primary Care during periods of inadequate resources, extended staff absences, staff turnover, and understaffing.

According to VHA Directive 1406, Appendix E, the baseline capacity for a full-time PACT is 1,200 patients. Panel capacity for general PACTs will vary from facility to facility depending on patient characteristics and the level of support systems. For PACTs with a patient population reflecting average VHA disease severity and reliance on health care, the average panel would be 1,200 patients, with a recommended teamlet support staff of 3 and at least 2 exam rooms per full-time direct care PCP. The average panel size can peak at 1,320 patients provided that there is an appropriate ratio of clinical pharmacists, which is one Clinical Pharmacy Specialist per 3 PACT panels, or 3,600 patients. After adjustment for the factors identified, panels for PACT providers largely fall in the range of 1,000 to 1,400 patients. Adjustments to panel capacities are also permitted for the number of women Veterans assigned and provider type. Provider type adjustments provide non-physician PCPs sufficient time to manage a panel of patients. A non-physician PCP panel capacity may be adjusted to 75 percent of a physician's unadjusted capacity. For 4,500 patients, the number of PACT teamlets

needed is a minimum of 3.8 if staffed by full-time physicians at a capacity of 1,200 to 1,320, depending on the clinical support staff. Patient and panel characteristics are specific to each teamlet and may require panel reductions or increases to exceed the recommended panels for non-physician and physician PCPs, which are respectively 900 and 1,200. As such, the number of teamlets could range from 3.3, if staffed by full-time physicians with sufficient support staff and 2.6 exam rooms, to 6.3 if there are no physician PCPs, fewer support staff, and fewer than 2 assigned exam rooms per non-physician PCP. Suboptimal PACT staffing levels will lead to decreased capacity and decreased productivity of individual PCPs. A teamlet support staff ratio greater than 3:1 may lead to further improvements in productivity and is encouraged. Further increases in capacity are gained by optimizing exam rooms, which increases access to VA health care and decreases the number of Veterans required to seek care in the community.

Findings

We found evidence of delayed wait times and over-paneled providers, based on the Corporate Data Warehouse (CDW). (See Tables 1, 2, and 3 below.)

Wait time data below shows that there continues to be delayed (extended) wait times at the Wiregrass, Fort Benning, and Tuskegee clinics and an overall panel fullness at 140 percent in Dothan; 129 percent in Wiregrass; 104 percent in Fort Benning; and 86 percent in Tuskegee.

Wiregrass	OCT-FY19	NOV-FY19	DEC-FY19	JAN-FY19	FEB-FY19	MAR-FY19	APR-FY19	MAY-FY19
New Pt Appts	48	47	57	54	61	76	59	31
Average New Patient Wait from Create Date	34.3	38.2	38.1	39.7	61	47.9	48.7	52.4
Average Established Patient Wait from Preferred Date	4.5	5.4	3.3	7.5	4.9	9.1	11.7	15.2
Established Pt Appts	775	725	694	835	819	986	993	819

Table 1. Wiregrass clinic wait times. *(Source: CDW)*

Ft. Benning	OCT-FY19	NOV-FY19	DEC-FY19	JAN-FY19	FEB-FY19	MAR-FY19	APR-FY19	MAY-FY19
New Pt Appts	60	67	60	68	81	80	106	73
Average New Patient Wait from Create Date	36.4	33.2	45.8	66.4	62.6	46.1	44.6	40.4
Average Established Patient Wait from Preferred Date	4.7	4.3	5.5	9.3	14	13	6.8	6.5
Established Pt Appts	1,949	1,615	1,365	1,609	1,513	1,412	1,426	1,378

Table 2. Fort Benning clinic wait times. *(Source: CDW)*

Tuskegee	OCT-FY19	NOV-FY19	DEC-FY19	JAN-FY19	FEB-FY19	MAR-FY19	APR-FY19	MAY-FY19
New Pt Appts	26	16	19	45	43	52	81	58
Average New Patient Wait from Create Date	57	55.1	46.4	51.4	53	36.8	24	35.2
Average Established Patient Wait from Preferred Date	2.6	2.7	3.1	15.8	23.9	15.9	13.6	8
Established Pt Appts	1,128	1,098	1,026	1,353	1,166	1,270	1,326	1,125

Table 3. Tuskegee clinic wait times. *(Source: CDW)*

Patient Aligned Care Teams Compass
Division Performance Summary
Panel Fullness

Location	Metrics	OCT-FY19	NOV-FY19	DEC-FY19	JAN-FY19	FEB-FY19	MAR-FY19	APR-FY19	MAY-FY19
(2V07) (619) Central Alabama HCS	Panel Fullness	111.90 %	98.39 %	105.13 %	107.42 %	101.53 %	101.12 %	101.60 %	102.76 %
	Numerator for Panel Fullness	38,605	38,459	38,208	37,913	37,801	37,441	38,156	38,221
	Denominator for Panel	34,501	39,088	36,342	35,295	37,233	37,027	37,554	37,193
(2V07) (619) Montgomery, AL (Central Alabama)	Panel Fullness	65.00 %	65.00 %	65.83 %	64.17 %	63.33 %	61.25 %	59.58 %	59.17 %
	Numerator for Panel Fullness	156	156	158	154	152	147	143	142
	Denominator for Panel	240	240	240	240	240	240	240	240
(2V07) (619A4) Tuskegee, AL (Central Alabama)	Panel Fullness	151.63 %	91.15 %	90.37 %	91.48 %	75.36 %	84.14 %	84.98 %	84.74 %
	Numerator for Panel Fullness	5,401	5,363	5,318	5,275	5,249	5,188	5,240	5,226
	Denominator for Panel	3,562	5,884	5,885	5,766	6,965	6,166	6,166	6,167
(2V07) (619GA) Columbus, GA	Panel Fullness	89.57 %	90.93 %	86.97 %	107.42 %	119.87 %	118.17 %	111.34 %	113.27 %
	Numerator for Panel Fullness	2,036	2,026	2,016	3,098	3,450	3,402	4,861	4,891
	Denominator for Panel	2,273	2,228	2,318	2,884	2,878	2,879	4,366	4,318
(2V07) (619GB) Dothan 1, AL	Panel Fullness	107.27 %	106.45 %						
	Numerator for Panel Fullness	4,206	4,173						
	Denominator for Panel	3,921	3,920						
(2V07) (619GD) Wiregrass, AL	Panel Fullness	175.83 %	82.23 %	119.97 %	118.98 %	118.25 %	102.55 %	99.94 %	129.17 %
	Numerator for Panel Fullness	3,033	3,032	4,999	4,959	4,930	4,834	4,844	4,814
	Denominator for Panel	1,725	3,687	4,167	4,168	4,169	4,714	4,847	3,727
(2V07) (619GE) Monroe County, AL	Panel Fullness	52.39 %	52.20 %	51.96 %	56.05 %	55.84 %	55.16 %	55.61 %	54.12 %
	Numerator for Panel Fullness	1,084	1,080	1,075	1,060	1,056	1,043	1,051	1,052
	Denominator for Panel	2,069	2,069	2,069	1,891	1,891	1,891	1,890	1,944
(2V07) (619GF) Central Alabama Montgomery, AL	Panel Fullness	118.58 %	108.22 %	107.79 %	107.15 %	106.57 %	107.17 %	109.64 %	103.13 %
	Numerator for Panel Fullness	12,399	12,374	12,327	12,251	12,188	12,112	12,477	12,511
	Denominator for Panel	10,456	11,434	11,436	11,434	11,437	11,302	11,380	12,131
(2V07) (619QA) Dothan 2, AL	Panel Fullness			7063.33 %	7013.33 %	139.93 %	139.87 %	140.33 %	140.20 %
	Numerator for Panel Fullness			2,119	2,104	2,113	2,112	2,119	2,117
	Denominator for Panel			30	30	1,510	1,510	1,510	1,510
(2V07) (619QB) Fort Benning, GA	Panel Fullness	100.34 %	106.53 %	99.99 %	101.46 %	106.39 %	103.34 %	103.72 %	104.36 %
	Numerator for Panel Fullness	10,290	10,255	10,196	9,012	8,663	8,603	7,421	7,468
	Denominator for Panel	10,255	9,626	10,197	8,882	8,143	8,325	7,155	7,156

Table 4. Panel Sizes, by percentage.

Currently, providers at Dothan and Wiregrass are significantly above the recommended panel sizes. (See Table 4 above.) In addition, during our interviews, we found limited evidence of written contingency plans for provider shortages, to include the availability of "float" providers, locum tenens contracts, telehealth, or availability of the VISN 7 Clinical Resource Hub for Primary Care Telemedicine to leverage capacity for access to care across all divisions.

Conclusion(s) for Allegation 3

- We **substantiate** that the absence of an adequate number of providers impedes patient access to care.

- There are delays in access to care at multiple Montgomery clinic sites including Fort Benning, Wiregrass, and Tuskegee.

- Panel sizes at Wiregrass and Dothan are over capacity.

Recommendation(s) to Central Alabama

11. Primary Care leadership and the PCMM Coordinator should review clinic wait times and panel capacity on a monthly basis. In response to these findings, develop a plan to improve wait times through improved access to care and develop contingency plans for unplanned absences of both providers and multidisciplinary team members.

12. Conduct a deep dive of all PACTs to include staffing, space, panel sizes, clinic utilization, data validation, and labor mapping to ensure appropriate resourcing.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Montgomery may have engaged in conduct that constitute a violation of law, rule, or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health. VHA HR has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy and a potential risk to public health at Montgomery.

Attachment A

Documents reviewed:

The DEA Practitioner's Manual:
https://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf.

Title 21 CFR 1306.03, § 1306.03 Persons entitled to issue prescriptions, (a) (1) and (2).

VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2019.

VHA Directive 1406 Appendix B, *PACT Team and Staff Roles In PCMM*, June 20, 2019.

VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

VHA Handbook 1101.10 (1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

VA DoD Clinical Practice Guideline, *Management of Opioid Therapy for Chronic Pain*, 2017.

VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

Alabama NP Collaborative Practice agreement, 2019.

Montgomery Organizational Chart, Fiscal Year (FY) 2018.

Montgomery and CRA Contract for Dothan Clinic, December 7, 2019.

Memorandum from Director to VISN 7 Network Director, Compliance with Panel Reassignment/Redistribution Requirement to Resolve "Ghost Panel" under PACT, August 18, 2016.

PACT Steering Committee meeting minutes, FY 2017-Present.

Patient Advocate Tracking System (PATS) complaints, October 1, 2018, to Present.

PCMM panel size reports FY 2017-Present.

Position Description GPM Health System Specialist, GS-0671.

Position Description Health Systems Specialist, GS-071-12.

Position Description Management and Program Analyst, GS-343-11.

Numerous emails from Montgomery Employees.

Current PCMM providers with assigned PACT members at Montgomery Medical Center and all CBOCs.

Current PACT panel sizes, Fiscal Year 2019.

New and Established patient wait times for all Primary Care clinics, FY 2018-current.

Memorandums, emails, or plans that outlined the closure of the Dothan contract CBOC.

Issue Briefs, Congressional Inquires, Patient Safety reports, Peer Reviews, and Torts related to Dothan, Fort Benning, Wiregrass and Tuskegee clinics FY 2018 to present.