MEETING PATIENT CARE NEEDS: MEASURING THE VALUE OF VA PHYSICIAN STAFFING STANDARDS

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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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MEETING PATIENT CARE NEEDS: MEASURING THE VALUE OF VA PHYSICIAN STAFFING STANDARDS

Wednesday, March 13, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 340, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Huelskamp, Wenstrup, Brownley, Ruiz, Negrete McLeod.

OPENING STATEMENT OF CHAIRMAN BENISHEK

Mr. BENISHEK. The Subcommittee will come to order. Good morning. I want to begin by thanking all of those in attendance today for joining us at the first Subcommittee on Health oversight hearing of the 113th Congress.

I am honored to have been selected to serve as the Chairman of this important Subcommittee and am pleased that Julia Brownley of California has been selected to serve as the Ranking Member.

I look forward to working with her and the many new and returning Members of the Subcommittee individually and collectively to improve and protect the health of our honored veterans.

Having served on this Subcommittee before, I know that each of us shares an immense respect and deep admiration for the service and sacrifices of American's veterans.

My goal as chairman, in part, is to ensure that when a veteran accesses health care through the VA, he or she is met with timely, consistent, high-quality care and services, and is unburdened by lengthy wait times or unnecessary travel requirements, and to keep the dollars we spend on VA health care close to the bedsides of our veteran patients, that is to say, to prioritize patient care above administrative costs and bureaucratic overhead that serve the department more than it serves our veterans.

I was proud to serve for 20 years as a part-time physician at the Oscar G. Johnson VA Medical Center in my hometown of Iron Mountain, Michigan. In that capacity, I cared for my veteran neighbors almost every day. And in the course of that care, I got to know them, talk to them, and learn from them about the many challenges and frustrations they face in accessing health care through the VA.

Here in Washington, I have made it a priority to continue these conversations with my veteran constituents and I can tell you that

unfortunately their experiences at VA have not changed for the better.

There are many examples I could provide, through personal experience and from conversations, examples of veterans who see a different doctor every time they go to VA for an appointment and examples of veterans from my district told to travel hundreds of miles from our home in northern Michigan to the VA medical center in Milwaukee or Detroit because rules prevent local physicians from providing needed services in our community.

I am convinced that these problems are rooted at least partly in the issue that we are discussing today and that is the persistent lack of staffing standards at VA medical facilities.

On December 27th, 2012, the VA inspector general issued an audit of physician staffing levels for specialty care services. The IG found that the VA did not have effective staffing methodology to ensure that appropriate staff is in place to treat veteran patients at VA medical facilities across the country.

Since 1981, no less than eight audits and reports have been issued by either the VA inspector general or the Government Accountability Office that have recommended VA develop and implement productivity standards and staffing measures to more effectively meet patient demand.

Thirty-two years later, alarmingly, little progress has been made and our veterans are the ones who suffer for it. It is really unacceptable for those of us on this side of the dais and I believe it is just as unacceptable for you as well. Today I am not here to listen to excuses, but I want to hear some solutions.

I want to thank you all for joining us this morning.

I now yield to Ranking Member Brownley for any opening statement she may have.

Ms. Brownley.

[THE PREPARED STATEMENT OF HON. BENISHEK APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chair. And I would like to really thank you very much you holding today's hearing.

As the new Ranking Member of the Subcommittee on Health, I look forward to working with you, Mr. Chair, and the other Members of the Subcommittee and all of our stakeholders to ensure quality, timely, and accessible health care to all of our veterans. This must indeed be our mission.

We are here today to address the very important issue of physician staffing within the Veterans Health Administration. We know that access to health care is essential to veterans. It improves treatment outcomes and quality of life for those who have it. And we know that health care professionals are VHA's most important resource in delivering high-quality care and services to our Nation's veterans.

Since 1981, there have been several reports that have recommended that VA implement measures to assess provider productivity, staffing levels, and associated resources.

I understand that the wide range of specialties VHA offers varies in complexity and it is often difficult to quantify the work that specialists provide day in and day out.

However, in a system with over 152 medical centers and nearly 1,400 community-based outpatient clinics, it is vital that VHA is able to establish a staffing methodology to help evaluate productivity, identify best practices within the specialties, and develop staffing plans in order to properly manage resources.

Additionally, with recent veterans returning from war and becoming eligible for VA services in record numbers, VHA also needs to be looking toward the future to ensure that all patients' needs can be met.

I thank all of the panelists for being here today. I am looking forward to hearing from all of you on how to proceed to ensure that VA staffing levels are adequate and productivity levels are sufficient in meeting the needs of all of our veterans for today and in the future.

Thank you, Mr. Chair, and I yield back.

[THE PREPARED STATEMENT OF HON. BROWNLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Ms. Brownley.

I would like to welcome our first and only panel to the witness table.

With us today is Linda Halliday, the Assistant Inspector General for Audits and Evaluations from the VA Office of the Inspector General. Ms. Halliday is accompanied by Larry Reinkemeyer, the Director of the Kansas City Audit Operations Division for the VA Office of the Inspector General.

They are joined by Mr. Larry Conway, the Director of Communications for the National Association of VA Physicians and Dentists.

And finally representing the Department of Veterans Affairs is Dr. Agarwal, the Deputy Under Secretary for Health for Policy and Services. She is accompanied at the witness table by Dr. Jeffrey Murawsky, the Director of the VA Great Lakes Healthcare System which is known as VISN 12, and by Dr. Carter Mecher, a Senior Medical Advisor for VA's Office of Public Health who is seated behind them.

Thank you all for being here this morning and agreeing to speak with us. It is my pleasure to have you here.

Ms. Halliday, why don't we start with you. Please proceed with your testimony.

STATEMENTS OF LINDA A. HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY LARRY REINKEMEYER, DIRECTOR, KANSAS CITY AUDIT OPERATIONS DIVISION, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS; LARRY H. CONWAY, DIRECTOR OF COMMUNICATIONS, NATIONAL ASSOCIATION OF VETERANS AFFAIRS PHYSICIANS AND DENTISTS; MADHULIKA AGARWAL, DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JEFFREY A. MURAWSKY, GREAT LAKES HEALTH CARE SYSTEM, (VISN 12), VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND CARTER MECHER, SENIOR MEDICAL ADVISOR, OFFICE OF PUBLIC HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF LINDA HALLIDAY

Ms. HALLIDAY. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss our audit of physician staffing levels for specialty services that we issued in December of 2012.

As you said, I have Larry Reinkemeyer here with me. He is the director of our Kansas City office that led this audit.

The need for VHA to develop a staffing methodology is not a recent issue. As early as 1981, GAO recommended VHA develop a methodology to measure physician productivity. Since then, several VA OIG and GAO reports have made similar recommendations.

To date, VHA has established productivity standards for two of its 33 specialties, ophthalmology and radiology.

In April 2012, VHA assigned a physician to lead the development of productivity standards and staffing plans for ten specialties.

Generally, our audit results found there is a consensus among VHA officials that VHA needs to develop a methodology to measure productivity. However, a lack of agreement exists within VHA on the methodology to actually use.

Some VHA officials believe the RVU productivity model is not a good measure as a stand-alone component for staffing and other VHA officials stated that based on data availability, the RVU model is the best model currently available.

VHA lacked the established productivity standards for specialty care services and as a result, it limits the medical centers' ability to determine the appropriate number of specialty physicians needed to meet patient care needs.

An RVU is a value assigned to a service such as a medical procedure that establishes work relative to the work assigned to another service. To determine the approximate measure of current physician specialty productivity, we established a rudimentary conservative standard by identifying VHA's RVU median for each specialty care service.

The national median is the middle value among each specialty care service. Using the median, we analyzed the collective group of

specialty physicians at all VA medical centers and determined that approximately 12 percent of the physician FTE did not perform up to the standard.

This translates to just over 800 physicians full-time equivalents (FTE) representing approximately $221 million in salaries during fiscal year 2011. Although we did not analyze the productivity of individual physicians, our results support the need for VHA to do an in-depth evaluation of staffing.

In addition, without staffing standards, VHA does not have the internal measure to benchmark productivity within a specialty. We compared the workload output per clinical FTE for each specialty care service and found significant differences in workload. None of the five medical centers we visited could provide an adequate staffing plan that addressed the facility's mission, structure, workforce, recruitment, and retention issues to meet current or projected patient outcomes to address clinical effectiveness or efficiency.

VHA has not established the productivity standards for all its specialties because of indecision on how to measure this productivity. Instead of focusing on the difficulties of measuring the productivity, the OIG position is VHA needs to focus on the benefits of discovering the medical facilities which might be using best practices and identify those practices that need to be changed or eliminated.

This information is vital to understanding resource management and making informed decisions. This would maximize the use of physician resources while increasing access and quality care to more veterans.

We made three recommendations to the Under Secretary for Health who agreed in principle with these recommendations. We expect VHA to establish productivity standards for five specialty care services by the end of this fiscal year and to approve a plan to ensure all services have standards within three years.

Mr. Chairman, this concludes my statement and we would be pleased to answer any questions you or the Members have.

[THE PREPARED STATEMENT OF LINDA A. HALLIDAY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Ms. Halliday. I appreciate it.

Mr. Conway, please go ahead.

STATEMENT OF LARRY H. CONWAY

Mr. CONWAY. Good morning, Mr. Chairman, Madam Ranking Member, and other Members of the Committee.

My name is Larry Conway and I am the Director of Communications for the National Association of Veterans Affairs Physicians and Dentists. I am honored to have the opportunity to represent NAVAPD in that role today.

I also currently serve as the Chief of Respiratory Therapy Subsection at the VA medical center here in Washington, D.C.

NAVAPD President Dr. Samuel Spagnolo regrets being unable to participate today. I am presenting NAVAPD's thoughts and suggestions on developing a viable system for determining VA specialty physician staffing needs and productivity.

NAVAPD's focus since its inception in 1975 has been promoting and supporting the highest quality care for our Nation's veterans and caring for those who provide care for them.

To that end, NAVAPD supports the development of an accurate and appropriately administered staffing and productivity system. This will help assure appropriate staffing levels to provide the excellent care due to our veterans without undue or inequitable stress upon the caregivers.

The lack of a unified VA-wide system and the flaws and the fragmented systems currently in use have led to productivity assessment models that are not accurate or balanced and which, in fact, mislead and are useless in determining staffing needs or performance levels.

NAVAPD became aware of these issues through concerns voiced by our members over the last two years. And having reviewed the OIG audit of physician staffing levels for specialty care services, NAVAPD found that this audit confirms many of the issues that have been brought to our attention.

The systems being used where any are used are fundamentally flawed. They are based upon the wrong measurement units. In some cases, they favor certain staff members while harming or diminishing others.

For example, these flaws can make one physician, in this particular case reported to us, a radiology physician for which there is a system, who performs procedures continually for their entire shift, appear less productive than a fellow physician who performs procedures only a few hours out of the shift. Whether this is accidental or intentional could not be ascertained.

Regardless, these concerns and the findings of the OIG culminated an article in the current NAVAPD newsletter. This article was planned and written before NAVAPD became aware of this hearing. The article details many of the problems discussed in NAVAPD's written testimony and the parallel—findings by the OIG.

Developing a comprehensive staffing and productivity system for the VA is appropriate and it presents challenges; however, it is not impossible and should not take a decade to accomplish. Developing such a system need not be over complex. It can be tedious, but the assumption of excessive complexity can be a barrier to progress in the design and implementation.

During my 38 years in management roles across the United States, I have devised, reviewed, developed, and refined multiple staffing and productivity systems. I am very familiar with design options and various methodologies for assessing health care staffing, needs and productivity.

Beyond selecting and defining the correct measurement units, the greatest difficulty will be gaining consensus on the assignment of these measurement units to various procedures.

NAVAPD understands the VA's difficulty in developing a system and does not seek controversy or confrontation with the VA; rather, NAVAPD offers its thoughts to the Subcommittee and its assistance and expertise to the VA in actualizing a useful and transparent system well within the timeframe that was recommended in the OIG audit.

Basically, the efforts until now have confused the relatively simple goal of assessing the number of needed staff with the factoring of the value of procedures. Determining required staff is purely a matter of time. Seeking to assess procedure value introduces many confusing unrelated factors.

The simple one-dimensional time-based relative value unit was supplanted with a multidisciplinary—I am sorry—multidimensional unit very much like the unit used by Medicare that sets dollar values for different services. This introduces extraneous factors unrelated to the primary goal and including these factors have been an attempt to assess the required skill mix of the staff, but it simply multiplies the complexity and confusion.

As NAVAPD views it, there are three fundamental errors causing the delays in progress: misconstruction and misunderstanding of the basic unit of measure, the relative value unit, which should be purely time-based; second, adding required skill set procedure difficulty and stress factors to the RVU; these relate to skill mix which differs from basic staffing determination; and, three, confusing and interchanging staffing needs, productivity, and benchmarking systems; each is distinct, though related to each other.

All of these points touched upon, briefly, in this statement are discussed more thoroughly in NAVAPD's submitted written testimony—again, NAVAPD stands ready to assist the VA in the development of this system.

Thank you for your kind attention. I will be happy to answer any questions from the Committee.

[THE PREPARED STATEMENT OF LARRY H. CONWAY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Conway.

I appreciate it.

Dr. Agarwal, please proceed with your testimony.

STATEMENT OF MADHULIKA AGARWAL

Ms. AGARWAL. Good morning, Mr. Chairman, Madam Ranking Member, and Members of the Subcommittee.

Thank you for the opportunity to testify, and I submit my written testimony for the record.

I am accompanied today by Dr. Carter Mecher, of the VHA's Office of Public Health and Dr. Jeffrey Murawsky, Network Director of Great Lakes Health Care System.

It is essential to ensure that VHA's physicians are able to work as effectively as possible to meet the needs of veterans. It is my privilege to inform the Subcommittee of the actions we are taking to ensure that our physician workforce is optimally deployed.

The foundation of our integrated health care delivery system is primary care; therefore, primary care physicians were our first priority for developing a staffing model. These providers constitute 34 percent of our physician workforce.

Our fully operational—operational primary care panel staffing model defines the number of active patients that may be assigned to each primary care provider and our model balances productivity with quality, access and patient needs, and permits VHA to meas-

ure the productivity of primary care providers and the capacity of our system.

Psychiatrists, the second largest component of our physician workforce, now account for 14 percent of VA physicians. We will be providing productivity and staffing guidance for mental health providers of spring this year.

Mr. Chairman, the contrast to a panel-based model, relative value units, or RVUs, are used by many academic and private institutions to track specialty care physician productivity. Work RVUs consider the time and intensity of physician services.

In academic and in private practices, work RVUs are used to determine the practice and physician compensation; therefore, these practices have a significant investment in capturing the workload and coding, including support staff as the RVUs, sir, to optimize billing.

We currently use RVUs to determine productivity standards for radiologists, the third largest component of the physician workforce. And by late spring, more than 54 percent of VHA's physician workforce will have standards to measure their productivity and efficiency.

VHA intends to expand the use of work RVUs as one of the measures to assess the productivity and efficiency of the specialty practice areas throughout the organizations. Productivity standards are an essential component, but require other contributing factors such as support staff, capital infrastructure, and patient needs to determine staffing levels.

VHA's Office of Productivity Efficiency and Staffing, also known as OPES, has created a Physician Productivity Cube to determine the productivity workload for physicians specialties by measuring the workload through work RVUs, number of encounters, and number of individual patients.

In June 2012, VHA established a specialty care physician productivity and staffing plan task force. The task force has focused on seven specialties: cardiology, gastroenterology, dermatology, neurology, orthopedics, urology and ophthalmology. Its recommendation was for an RVU-based approach that builds upon the extensive work that OPES has already done in this area. OPES is testing and refining new solutions for capturing workload that do not impose additional burdens on clinicians who are treating veterans and will take into account the unique characteristics of local facilities.

VHA is also integrating the physician productivity data and measure of access to care into a model to guide staffing decisions in specialty care. This approach, when coupled with measures of quality and amount of specialty contract care, will help VA medical centers' leadership make informed decisions regarding staffing.

We intend to establish productivity standards for five specialties by the end of this fiscal year and we will ensure a plan is in place to establish productivity standards for all specialty care services within three years. We are providing specific training to the leadership of our health care facilities on how to use the data from the Physician Productivity Cube and we will provide the medical facility leadership more specific guidance on how to develop staffing

plans so that management reviews them annually to ensure optimal efficiency.

Mr. Chairman, we appreciate the opportunity to appear before you today. My colleagues and I are prepared to answer your questions.

[THE PREPARED STATEMENT OF MADHULIKA AGARWAL APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you. I hope that we have a vigorous round of questions here. I'm going to start by yielding myself five minutes for questioning.

Speaking with physicians at various VHA medical centers, I've heard different reasons for, difficulty with productivity, and—in the IG report, on page 4, there was endocrinology clinics where an FTE produced 3,000 patient visits a year and another facility, that was twice as productive, for the same amount of time and within the same specialty.

So, as I understand it, Ms. Halliday, you didn't really look into the reasons for the productivity differences between different facilities that were supposed to be comparable. Do you know the reason why one unit is twice as productive as the other?

Mr. REINKEMEYER. We tried to stay away from looking at the individual inefficiencies or efficiencies of a physician. The point we tried to make is there could be lots of reasons why that is occurring.

As we talked the other day, it could be support staff. Maybe these physicians do not have the adequate support staff they need, and maybe they are checking patients in, or having to do a lot of the administrative tasks, which is decreasing their productivity.

There could be more negative reasons as well, but what this does is give the director that tool—and I would hope the director would want that tool—to identify best practices and efficiencies.

Mr. BENISHEK. Mr. Conway, do you have any input to that? It seems to me that there may be circumstances that make a physician less productive. You work with that group.

Mr. CONWAY. Yes, Mr. Chairman. There certainly are factors that make physicians more or less productive. We have heard from our members of scenarios where a clinic, for example, is operated where each physician has one exam room, no support staff. They have to go get the patient, register the patient, pull up the chart, do the vitals, do the physician review, remove the patient from the room, and finish their charting, and any other support documentation necessary; whereas, other particular facilities may have staff available to prep the patient for the physician, provide more than one exam room—as would happen in a private practice—and thereby increase the throughput by one physician.

So, we know those type of variables exist. I would also note that this section of the report speaks of encounters. We are not clear at NAVAPD of how an encounter is defined. An encounter could be something as simple as a quick review that might last four or five minutes. It could become something much more complex that lasts 20 or 30 minutes.

A term as broad as encounter——

Mr. BENISHEK. Right.

Mr. CONWAY. —without an attached timeframe is useless in determining either staffing needs or productivity.

Mr. BENISHEK. Dr. Agarwal, you know, these kind of questions, bother me. The reason I am doing this is that, people have told me that I go to the VHA for my congestive heart failure and I see a different physician every time, that concerns me that that patient is not getting the best of care because when you have congestive heart failure, you have to have a provider that recognizes how much edema you had in your legs last week and how short of breath you were. And when you have a different physician seeing you, they can't make that judgment. And I can't tell from what you are saying, what the IG is saying, and what the actual physicians are saying.

Do we have a standard way to run a clinic—where there are four exam rooms and—and a physician has adequate opportunity for example—or is it up to the individual medical center? Is there no standard way of running a clinic?

Ms. AGARWAL. Sir, thank you for that question.

Sir, let me answer it in two ways. First is that the VHA has adopted a model, which is sort of based on the patients at a medical home and we call it PACT, the Patient Aligned Care Teams, which is the initial entry for most patients with chronic illnesses, such as congestive heart failure.

And the idea is that they would be provided full comprehensive care with continuity of care in that PACT Team, and when they need a specialist they would then see a specialist. So, I am somewhat surprised that a patient who has been assigned to one of the PACT Teams is not seeing their team on a consistent basis—and I will certainly look into it—but that is—that is the goal. When it comes to referring to the specialist, I think most of the specialties are doing what they can do best, which is taking care of the patients for that particular episode.

So, it is likely that if for this patient that you are mentioning or the clinician who is not being able to see their own physician all the time is also perhaps going to different—other specialties, as well, and I cannot ascertain that right now.

Mr. BENISHEK. Well, that is disappointing. I don't like the fact that we don't have an answer. Apparently, right now, physicians are seeing patients slowly in one hospital and then maybe more effectively in another because of the staffing issues within their clinic. This is something I would like to further explore, but my time is up and I would like to give the Ranking Member an opportunity.

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you to the panel for your testimony. You know, as a new Member of Congress, which I am to have read this report and to see that we have been working on this for 30 years—and are still wrestling with it is just really astonishing to me—it's shocking—and it seems that this kind of thing is the thing that sort of underscores what the public feels in terms of Government being inefficient and perhaps wasteful.

And, certainly, for our veterans who have served our country, it is clear, the outcomes here are that our veterans are being served on a timely basis and have consistency with the same doctor to get the quality of care that he or she deserves.

I guess I wanted to ask Dr. Agarwal.

Ms. AGARWAL. Yes, ma'am.

Ms. BROWNLEY. Can you speak to how the VHA really compares with productivity of the private sector?

I know the private sector has got to have best practices established. I know that the private sector is generally for profit and the VA is not, but are there any comparisons that you can speak to?

Ms. AGARWAL. Madam, thank you for that question.

And you are absolutely right in pointing out that we have a different practice model. We, as compared to the private practice, we serve more as a capitated or HMO-like setting with salaried positions. So, our productivity levels are best measured by like specialties and like facilities with that appropriate staffing mix.

In the private sector, as I mentioned previously in my testimony, the RVUs, the work RVUs especially, are generated, which are also something that contributes strongly towards the compensation.

Now, that is not the case in VHA. Our goal is primarily to achieve the best health care outcomes for our veterans and that is where we focus, not in the volume of services, but in providing the right services at the right time in the right place.

So, I am just going to ask my colleague, Dr. Murawsky to expand, if he would.

Mr. MURAWSKY. So, in running the health systems and in evaluating how we—operational, as our clinics—we look at productivity as one component of a multifaceted decision-making process, to evaluate what we are doing so productivity drives the comparisons with—the private sector have the disadvantage for us in that their selection for what work to expand is based on what RVUs bring in the highest per time, where we look at the whole patient, and so we don't want to be ignoring one area because it is a low RVU generator for another. So, we use it internally to benchmark it against ourselves. Comparing for, as has been mentioned before, the practice setting, the support staff ratio, those things are critical, physical plant design also drives what you can generate.

Physician productivity is also linked to what a facility can accomplish. We see lower levels of productivity in pure RVUs. If you try to compare a very small facility to a very large facility, the opportunity for a physician to do high RVU work in a small rural hospital is less than in a large tertiary hospital because of the support systems needed to do cardiac bypass surgery. The high RVU specialties just are not going to be present.

Ms. BROWNLEY. Well, it seems to me that some of the challenges here, and it seems like the challenges are very clear, they are laid out—but one of the challenges is trying to find, in essence, sort of consistency and continuity over all of these different practices which may, indeed, be impossible to do. I mean, there are doctors on this dais that know more about this than I do. I agree with you that the goal should be the outcome of the patient, making sure that they have the timely and right services when they need them, but why are we not looking at that kind of measurement, as opposed to trying to measure all of these things?

At the end of the day, we can be as efficient and productive as possible, but if a patient remains sick or dies, we are not achieving what we want to accomplish here. So, I am just wondering why we are not looking at this a little differently.

Ms. AGARWAL. You are absolutely right.

You know, I think to compare each of them against each other—the specialties, I should say—would not be a good idea at all. In fact, one of the reasons why we set up this task force was to set up those standards for each of the specialties of its own. Because it is only fair to compare one specialty—let's take cardiology as an example to another cardiology—but then even cardiology between two facilities may not be the same if they are on different levels of expertise.

One facility may provide more interventional procedures, as opposed to another smaller, perhaps, rural facility that is only going to provide, likely, outpatient work.

So, the comparisons have to be fair and they have to be done within the like specialties and that is what the goal of the task force has been, to first identify that, you know, RVUs were whatever we may want to say that how imperfect or perfect they are, but they are currently one measure that is used as an outside benchmark, and be used to use—take that and start to compare and use our methodologies to create certain business rules, so that the workload capture is common and accurate, the present class designation in our systems is accurate for those specialties, and the support staff, which is a very important component of getting to the final idea of having a staffing plan, are all taken into account when we put forward a plan to do this.

Ms. BROWNLEY. I yield my time.

Mr. BENISHEK. Thank you, Ms. Brownley.

Next for questions, we have a Member from Ohio, Mr. Wenstrup. Thank you.

Mr. WENSTRUP. Thank you for your time. Thank you, Mr. Chairman. You know, as somebody who has served in the Army Reserve, I have been in DoD facilities. Virtually any doctor in America, who was trained in America, has been in VA facilities and received their training there; it is an important part of our medical system.

And I have also been in theater, but also in civilian practice, and my take is that the huge difference is in your own practice, you have to be efficient or you close your doors, and that is the difference. And my experience has been that you have doctors doing so much administrative work, that it cuts into the time that they can see patients and there is your backlog. Literally, in the time that I can see 45 patients in my civilian practice, in another facility, such as this, I could see about 15. And the doctor is doing work that a 16 year old could do at minimum wage, and this is part of the problem.

I applaud you for breaking it down by specialty, because it is different, and even within specialties, it can be different.

My question to you is: Are you looking at it that way? Are you breaking it down and saying how efficient are we making the provider of care and are we having them doing things that other people could do for virtually next to nothing?

And, you know, a lot of your doctors come from civilian practices and give a couple days a month or something like that—some of my partners in orthopedics have done that—and they will say where I do six surgeries in civilian practice, I can do two at the VA.

This is a fundamental problem. Maybe it is work ethic and maybe it is how the system is set up—maybe it is both—and I would like to hear where you are going with it from there, because the answers are fairly obvious to me.

Ms. AGARWAL. Sir, thank you, again, for that question—actually a very important question. And you are right and I am going to ask my colleague, Dr. Murawsky right after I finish, to add more to it.

So, our statutory mission is, of course, to provide direct patient care. But it is also to provide education and training for the medical students and the residents, as well as to provide cutting-edge research so that we can benefit the veterans, and the fourth role is emergency preparedness.

What is also critical is that we appropriately apply our labor mapping to distinguish on the role of a given position, and that is also very important. Suppose if someone is to give 100 percent direct patient care, then that is how it is mapped back into the system. If someone is going to be providing training to an education—to the residents or the medical students who are coming in—that they are given credit to that end as well.

So, those are some of the factors that we are working on and the task force that is currently in play with the four pilots and the four reasons that are going, are also looking at these contributing factors to the productivity and how do we optimize and bring them to their fullest efficiency that we are all seeking. So, the methodologies of how we do this are critically important.

I am going to ask Dr. Murawsky to sort of follow on that.

Mr. MURAWSKY. Thank you, and thank you for the question.

It is a complex system—and coming from private practice before I came into the Department as a medical educator, we need to make sure as we develop our pilots, and as the task force does that, we look at the inefficiencies gained by our training mission—which all attending physicians know, residents can slow you down—so, we need to capture that. And since we have such a high number of trainees, that is a unique part of our mission, so when we make our comparisons, we have to add that.

We started to look at support staff, and I know from experience within Network 12, we started to look at that component. When we looked at research requests, what is the support staff ratio? What should it be? Are there external benchmarks that we can compare to?

The task force is trying to bring that in through the pilot, so that when we take productivity and create the algorithm to develop staffing, it pulls those components in so we get that optimal level of efficiency.

We also trust our staff members to look at—are there things in the encounter that they are doing that are inefficient that we need to make better? So, we are trying to decrease that burden.

And one of the things I can speak to as a provider, is that I lost a lot of burden of my billing and coding when I came to the VA. The encounter is a much simpler method that we have internally than the time that I used to spend trying to capture that revenue before I came in. So, there is some switch. We just need to capture how much that is and then gather those inefficiencies and look at it across, not just the practice setting in the outpatient area, but

in our surgical area for our surgeons, can the ORs turn quickly enough? So, we have to capture all of that in the decision-making process.

Mr. WENSTRUP. And I appreciate that, and I would be the first to agree that when you are training, it takes more time than if you are just seeing the patient individually. I think you have got the right parameters, it is just how we implement them and how we get that done universally.

And I yield back.

Mr. BENISHEK. Thank you, Mr. Wenstrup.

I now yield to my colleague from California, Dr. Ruiz.

Mr. RUIZ. Thank you, Chairman Benishek and Ranking Member Brownley, for holding today's hearing.

I am looking forward to learning more and having more discussions about productivity within the Veterans Health Administration.

It is very important for me, coming as an emergency medicine physician both in the private sector, as well as the academic sector, being a Senior Associate Dean at one of the—California's newest medical schools, UC Riverside School of Medicine, I know the importance of RVUs for a physician. Often times, we practice medicine and a lot of our reputation lies on who has seen the sickest and the most complicated patients and for emergency medicine physicians, that is a source of pride.

But it is also a source for incentives on how you practice medicine, because, usually, productivity equates to compensation, and therefore, it is all too easy, sometimes, to add an extra box on the EMR or add an extra section on the social history in order to beef up your medical record to get paid more. And it is also, often times, too easy to add and be incentivized to order another test that you might not need to order because it adds to compensation.

And I think that Ranking Member Brownley mentioned the incentives that we want to change is not only to order more tests, but also to keep what you mentioned, patients healthy, so we don't have to order these expensive tests.

So, one of my questions to you is: In your productivity or compensation model, how are you incentivizing a healthy patient, keeping them from acquiring and getting sick for end-stage congestive heart failure?

Ms. AGARWAL. Again, an excellent question, Congressman. Our compensation is somewhat different from what it is in the private sector. Most physicians in the VA are salary positions and I, you know, I can talk about the three parts of the compensation package but they are largely not incentive-based in that sense.

But incentives really have to be that our goal and our mission, for those of us who come in to serve in the organization, is to be very proactive and offer personalized patient health care.

So, I will, again, emphasize the fact that as the others are doing so, in ABIM's Choosing Wisely campaign, that it is not how much that we are going to offer, but how well and how wisely we are going to choose the services that are going to keep our patients healthy going forward. And that is sort of the mantra and the principle that we have for ensuring that the right services are provided without any real financial motivators, I would say.

But, again, the third component of the physician's salary is the performance pay, and I can ask Dr. Murawsky as to how he goes about setting that up in his network.

Mr. MURAWSKY. Thank you. The two base components that make up the predominance of pay, up to 7.5 percent above that, is a performance pay, individually negotiated between each provider and their supervisor. There is some general guidance around performance pay. It is used to improve your practice.

In most cases, within our network—within the network that—that we have in Chicago and up to the Iron Mountain area, we look at quality metrics as what we use to drive that particular component of pay.

It might also be access metrics if there are issues we want to drive around access to care. It could be new service delivery; if we want to add a service or reduce a service, we will add that.

In some cases, we use productivity levels in a very broad sense if we believe that they might be low in an area. We use them in radiology, as an example, for the practice, but not for an individual. Can the practice maintain a certain level of productivity?

We find that if we have our physicians work together in those groups, those incentives that can be perverse tend to wash away because there is not an individual trying to get ahead of another one, so we tend to orient it that way.

Mr. RUIZ. Do you factor in the Press Ganey and patient satisfaction into that?

Mr. MURAWSKY. Yes, sir. There are a number of VA specific scores. We have a—in primary care there is a particular outpatient survey that is used. HCAHPS and CAHPS scores for the practice area can be—can be used in that area. Our physicians find that sometimes the data lags at such a point that it is not there.

So, I know that in areas where we receive veteran concern—I have one example in a network within the facilities of my network where we did a postcard program, where, basically, we said how many postcards said we did a great job; how many postcards said we did a poor job; let's see if that changes over the year. We incorporated that.

Mr. RUIZ. I know my time is up.

My final comments are essentially to see if we can move away from an incentive that fosters expensive tests and complicated uncoordinated management of patients and more towards incentivizing the prevention and the outcome so that our measure of success is not how many MRIs and cardiac caths we do, but it is how many heart attacks we prevent from happening. So, the longevity and the wellness of our veterans is first and foremost, above anything else.

And I thank you very much. I know it is a very difficult job and I appreciate all you do, and I yield back my time.

Mr. BENISHEK. Thank you, Doctor.

Next, we have the gentleman from Kansas, Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I appreciate the opportunity to be here today and to look a little more closely at this issue.

The first question would be directly to the VA, and given after 32 years of efforts, there seems to be a lot of inconsistency in deter-

mining staffing and those issues. So, what is unclear to me is how do you currently measure the productivity of your physicians to determine staffing levels?

Ms. AGARWAL. So, sir, for primary care, it has been something that has been in place regarding a panel model and that is about a third of our patient physician workforce.

We have done the same for radiology, on determining what their duties—standards should be.

We have guidance that is coming out for mental health very soon and that will constitute about 14 percent of the physician workforce—that covers about half.

What we are currently working on now is to set standards for five specialties by the end of this fiscal year, and to that end, there are pilots that have started in four networks, in VISNs 7, 12, 19, and 22.

And the purpose of——

Mr. HUELSKAMP. If I might interrupt on that.

Are you telling me that the primary care physicians, you have an adequate standard for determining proper staffing levels?

Ms. AGARWAL. Yes, sir, we do; for primary care, we do.

Mr. HUELSKAMP. That seems somewhat different than what I saw on the IG report. But one thing I will ask, pretty specific to my district, I do have a community-based outpatient clinic that has been without a physician for over two years. Can you tell me how do you determine what clinics do not need a physician at all or even a nurse practitioner, is there a basis for making that decision?

Ms. AGARWAL. Sir, I do not know of a primary care clinic that would not have either a physician or a nurse practitioner.

Mr. HUELSKAMP. There must have been some lost information. Again, December 20 of 2011—actually, it is a little over a year, I guess, a nurse practitioner for over two years or not a doctor since December of 2011 still has no—in a clinic in Liberal, Kansas.

We have asked the VA again and again, and I just didn't know how you determine that there will be no primary care physician or a nurse practitioner in this community-based outpatient clinic. So, I look forward to your response on that.

But other than that particular area, I am still struggling. After 32 years, the IG report would suggest that we have not solved this situation. But you believe that within how long it will be solved, out of the primary care into the specialty-physician level, that will be solved or be adequately addressed in what time period?

Ms. AGARWAL. Within three years, sir. We will have standards for all specialties in three years.

Mr. HUELSKAMP. Okay. A law passed in 2002, and so we are going to take 15 years to implement that law or do you think that you are currently implementing that requirement of the 2002 law?

Ms. AGARWAL. Sir, we have been working on it, sir.

The creation of the office of productivity and efficiency was in 2008 and that was mostly to sort of ensure that we have some strategy to manage this important resource. They have been developing certain tools for it, so it has been a work in progress.

Mr. HUELSKAMP. Do you think that 15 years is an adequate time period to—again, January of 2002 is when that law was passed, is my understanding.

Ms. AGARWAL. Sir, it has been longer than one would have anticipated, but we—at this time, what I can assure you is that it will be completed in three years.

Mr. HUELSKAMP. Mr. Chairman, that would be very helpful, but I think I would be quite foolish to anticipate that if you could not get it done in 11 years, 12 years, that three more years is going to make that happen.

And, again, I look forward to your response, specifically, to how an outpatient clinic that has no primary care staffing, and I don't know how you all made that determination.

And we have not had an answer back. I have been asking again and again from the VA and there has not been a good reason—just saying, hey, we are not doing that.

So, I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, Mr. Huelskamp.

And I will, of course, expect follow-up answers, after you get some information in.

Ms. AGARWAL. Yes, sir.

Mr. BENISHEK. —but I was interested by your questions, as well. Next, we have Ms. Negrete-McLeod from California.

Ms. NEGRETE-MCLEOD. Since I came in late, I don't want to ask questions that have already been asked.

Well, I guess I was going to ask the same thing that it has taken ten years to implement what has been mandated by law and I am just wondering—following up on the question of why it is taking so long.

Ms. AGARWAL. Madam Congresswoman, this is somewhat of a complex issue, as our testimony has indicated. It is not very simple.

And especially given the fact that we are a capitated model and not a fee-for-service, where, you know, much of this would have already taken place about capturing the workload and comparisons and so on and so forth. We have been working on it, but we also realized that to have appropriate staffing, we need to have certain standards in place and the work is underway to complete that.

We have done the staffing standards for roughly 54 percent of our physician workforce and the remainder is going to be completed within the next three years.

Ms. NEGRETE-MCLEOD. I guess, then, I would ask that, I understand that you have a very large organization, you know, overall, but I think that ten years is really a long time and I think, I am just wondering if you can assure us that you are going to do it soon, then we would take your word on that, that it would be implemented soon.

Ms. AGARWAL. Thank you.

Mr. BENISHEK. I would like to ask members of the IG staff to comment on the answer that VA gave to Mr. Huelskamp and Ms. McLeod.

Ms. HALLIDAY. I would be happy to.

The law that you are citing, talks to having to ensure that the medical facilities have adequate staff to provide high-quality care.

Right now, you constantly hear that there are waiting times and those type of issues that veterans cannot get to their appointments that are impacting their view of whether they can even get care.

In our report, we have a recommendation to the Under Secretary to provide specific guidance on how to develop the staffing plans and to ensure medical facilities actually review these annually to optimize their efficiency.

When our team went out, teams went out to the five facilities, we saw significant inconsistencies in the types of staffing plans that were maintained. That is the piece that, I believe, sir, you were talking about.

Mr. BENISHEK. Mr. Conway, do you have any comments?

Mr. CONWAY. Yes, Mr. Chairman.

A number of things have come forward in the last few answers, actually. There is continuing reference to high RVU work which means that for the same period of time it is valued higher. That is a model—that is a metric that is more consistent with a fee-basis or a for-profit type environment where you are saying that this 30 minutes of time during neurosurgery is more valuable than 30 minutes suturing a hand. It does not deal with the issue of how much staff it takes to do it. It is a different kind of metric that confuses the issue. And those kinds of—those kinds of disagreements are a part of what has pushed this development back so far.

There was also a reference to incentivizing and performance pay being part of the incentive package. But, again, if you have a productivity model that inappropriately makes certain staff members look less productive when they are not, that affects performance pay in a way that disincentivizes, rather than incentivizes.

Again, I think that—that maybe that underlying message is to keep the metrics simple so that you can truly assess what you need, which is the amount of staff it takes, and then, conversely, how much work is being produced with a given level of staffing, which is the definition of productivity, and we are introducing factors in the current system that—that simply cloud the issue.

Should it take ten years? Absolutely not. Are there for-profit organizations that has a system that does exactly this today? Yes. Would they share them with you? I doubt it. Should you apply them to the VA? No, because the VA model is different, the patients that we serve are different, and our goals are different.

That having been said, there certainly is no reason to not be able to develop a model that gives you adequate staffing assessments and adequate productivity assessments.

Mr. BENISHEK. All right. Thank you.

I think we are going to have time for another round and I have a couple of follow-up questions that I am going to start with.

Frankly, I am a little disappointed.

And I know, Dr. Agarwal, you have not been here this whole time in this position, but the fact of the matter is that, for 30 years, VA has been struggling with, not having an overall plan, with, issues such as the fact that there is no standard way of conducting a clinic, with different—with time requirements—with inadequate support staff, and, some of the reasons that you have given, really don't wash.

I have practiced in a rural VA hospital and I think Iron Mountain did it really well. We had four or five exam rooms. I was able to see patients. In the surgery clinic, when I was there, we could

see them very efficiently, just as efficiently, I thought, as it was in private practice.

And, frankly, I think we improved the efficiency in the OR by having the physicians comment on how it should be done and why we improved the efficiency of the OR a great deal.

I am just afraid that there is so much inconsistency, that there is no overrule all plan. My biggest concern is the fact that our veterans are suffering because there is inadequate staffing. I know in the upper peninsula, people have to travel some time because we don't staff Iron Mountain hospital enough. They then have to get on a bus to go hours on a bus to Milwaukee for a specialty clinic visit that could have been done in Iron Mountain. Ten hours on a bus for a 20 minute specialty clinic appointment seems like not the best use of the veteran's time or VA's dollars.

Do you have any idea of what the staffing standards are for the patient's travel time or for the overall cost, Dr. Agarwal?

Ms. AGARWAL. So Chairman, thank you for that question.

There is one thing that I should point out is that one area that you readily, and have pointed out to me, is the travel time and what it is that one can do about that. And to that end, our telehealth services have been expanding, which is, again, so that we can provide the care much closer to the home from the specialty services which may not reside in that facility.

And I think I will ask Dr. Murawsky to speak more about what goes at Iron Mountain and the travel time thereabouts.

But I think VHA has taken a position about—about providing the best care possible and the most optimal place, which would be closest to the home, whenever possible. And telehealth is one of those technologies that is sort of helping us achieve that now, and especially in specialty care areas there are a couple of models that are happening.

Mr. BENISHEK. Well, I can see that where you are kind of diverting the answer, because telehealth is not going to be an answer for——

Ms. AGARWAL. No.

Mr. BENISHEK. —many of the——

Ms. AGARWAL. So——

Mr. BENISHEK. —many of the problems that we are talking about——

Ms. AGARWAL. Right.

Mr. BENISHEK. —because, otherwise, they would have done it. I am just not happy with the fact that, we are waiting another three years after 30 years of beating around the bush it seems; whereas, in the private sector, this seems to move a lot faster.

Let me yield to the Ranking Member, once again.

Ms. BROWNLEY. Thank you, Mr. Chair. I just wanted to follow-up with Dr. Agarwal on what our colleagues have expressed today on the dais. And you have said, repeatedly, in your testimony today that in three years you will have a plan to accomplish these measurements and these goals.

At this moment in time, do you have a plan that is on a piece of paper that demonstrates how you are going to accomplish this over the next three years?

Ms. AGARWAL. Yes, ma'am, we would be happy to share that with you. We, certainly when we started the task force last year, that was the intention, and after they briefed the leadership, they have sort of proceeded on with the pilots. The data that they are getting is going to help us establish for the five specialties within this year and by the end of this fiscal year, we will have a plan on how to complete the productivity standards for all specialties by the end.

Ms. BROWNLEY. So, you are saying all specialties by the end of——

Ms. AGARWAL. Three years.

Ms. BROWNLEY. —three years? Okay.

Ms. AGARWAL. Yes.

Ms. BROWNLEY. All right. Well, I would appreciate it if you could share the plan, and I presume the plan has timelines in it so that we can monitor your progress?

Ms. AGARWAL. We will make sure that—we will have the timelines.

Ms. BROWNLEY. Very good.

You know, after ten years, 30 years, there is a reason for us to have some skepticism——

Ms. AGARWAL. I understand.

Ms. BROWNLEY. —just wondering how many people have sat in your seat over the last 30 years and said, I am assuring you that I will get this done in three years and we really do want to get it done.

I wanted to follow-up on Mr. Wenstrup's statements and the difference between staffing and productivity of a physician. It seems like everything he said made complete sense to me, so, I wanted to ask the IG if you could make any comments relative to this notion of really separating sort of staffing needs, vis-a-vis, physician needs and that measurement so that the physician can see more patients in a given day, rather than less, vis-a-vis, the private sector.

Ms. HALLIDAY. That is a good question.

From our perspective, VHA is going to need to make a major investment in collecting this information to actually measure productivity. They are going to need to define their business rules, and in defining their business rules, they are also going to need to identify those activities that vary from medical facilities so they can do comparability studies and look at efficiency over time.

I think if they do a good job of identifying their business rules, they will get meaningful data to which they can make well and informed decisions. That is the basis because it is so expensive to collect this type of information and we want it to have a very high value and utility, so it can be used to make the system better.

I look at the report we did here as looking at the first part of the patients entering the system, and I understand Dr. Agarwal's looking at, the quality of care, but I see that as the second part. And I would like the VHA to focus on this, because I do think that one of the biggest challenges in VA are waiting times, and, as the Chairman said, the inconsistencies in the quality of care of the services provided.

Ms. BROWNLEY. Thank you. Do I have enough time for one more follow-up question?

Mr. BENISHEK. Yes, please.

Ms. BROWNLEY. My last question would be if we don't have a system in place now——and, obviously, the demand is going to be higher over the next three years. So my question is: Without a measurement, without a plan, how are you anticipating planning staffing levels currently?

What are we doing in year one, two, and three before you have completed all of this?

Ms. AGARWAL. Thank you, madam. That is a very good question, and I will ask our operations network director.

Dr. MURAWSKY. Thank you, ma'am. Currently, the productivity data is available to all of our facility chiefs of staff, other selected members for individual level data across the system, and any physician within VHA can access the productivity data by practice, currently. So, that data is available for making decisions, which we then add on to data, as you are suggesting.

What does our market penetration look like in terms of veterans using us? What do we expect in those individuals coming home for our numbers to increase? What do we see for demand?

The primary care model, which is panel-based, is entry point for most of our veterans. So, as we look at new enrollees, that drives new FTE into the system for primary care.

As primary care goes up, facilities look at that ratio of primary to specialty care and begin to see as primary care goes up, we know there is going to be an increase in certain kinds of special services.

The goal of the PACT model is to bring as much of that care in the PACT Team as possible and use the specialists for only those things that they need to do, the things they are best trained for, to avoid the patient having to have excess visits—the things the patients need a specialist for. So, then we will have a certain ratio to be able to do that work.

In the current system, we look at those pieces of information, drives of the demand, access data, to make decisions on adding new providers.

Ms. BROWNLEY. So, for 2013, do you know exactly what you are looking at in terms of what your needs are for staffing?

Dr. MURAWSKY. I can only speak from the facilities that are within my network, that we look at our market penetration ratio, and what we are hearing from the Department of Defense, as what is coming home, and we try to adjust our staffing numbers for the next year to look at the FTE levels as a whole, that we can support with the budget we have.

Ms. BROWNLEY. Thank you. I yield my time.

Thank you, Mr. Chair.

Mr. BENISHEK. The doctor, from Ohio?

Mr. WENSTRUP. Yes, thank you. In my previous job before coming here, one of the things that I was part owner of a surgery center. At one point we sold it to the hospital. What you are seeing in situations like that, and within hospitals, is physician management, the direct-physician involvement, and I appreciate you being involved, Doctor, but this involves all the doctors that are on this staff, as far as managing the center.

So, although we were no longer owners of the center or the hospital, we were directly involved in how it was managed, and we

were incentivized, of course, by increased productivity. We were incentivized to decrease the cost-per-patient ratio, and we were always incentivized to have assured quality, as far as patient care. Now, this seems to work pretty well in a civilian environment.

And do you think there is any prospect or has there been any discussion along those lines of direct-physician involvement? I don't mean outside physicians, but the physicians that work at the VA, where they are somewhat incentivized to develop plans for the VA hospital, to be in a situation like that. Did you do—increase productivity, reduce costs, and assure quality?

Ms. AGARWAL. Certainly, sir. From the headquarters level, I know that—which is where I am at this point in time. I was at the medical center about seven or eight years ago and I do recall sitting with the chief of staff and having these very discussions at that time.

And at the central office level, there is certainly a bit of a difference in what sorts of discussions take place.

I am going to, again, rely on my network colleague to help address what they are doing at both the network level, because they are allocated a certain amount of money, and then—which goes down to different facilities—as to how at the more functional unit levels, are they having the participation amongst physicians and other colleagues in the nursing and pharmacy, all important parts of it.

And, in getting that sort of exact message across, that how do we increase access and how do we improve quality of care?

Dr. MURAWSKY. Thank you. We are a physician-lead organization, and—and my experience in moving up from the medical centers, the physicians lead the practices and are very engaged, both at the section chief level, even a practice manager level, and then the individual physicians in doing this; hence, we make the productivity by practice open and available to all physicians. Any frontline physician can go in and see how their practice performs.

We protect the individual information, so that this is not an I-am-better-than-you model. We do drive our decisions, and I think the question that you raised is exactly why some of the early work of the task force was to develop tools for our chiefs of staff, to provide them with information in a balance.

How does the productivity look at the practice level; what does the access look like at the practice level; are there surrogate measures of quality that we select out that are important to have; and what is the cost per patient; what are we spending on contract and fee services?

So, that when that section has their resource meetings and then brings that to the chief of staff to go to resources, they are looking at that information and saying, I am out of balance or I am in balance and what I am going to do?

The complicatedness, of course, is the mixed mission of having to balance our educational needs. Sometimes you have a very high number of residents or students. It does lower the overall productivity and you have to look at that and make some determinations.

Mr. WENSTRUP. Thank you. I guess where I am really driving is, I just would like to know how much participation really takes place from the doctors that are taking care of the patients. I mean, all

of those things that you mentioned are very legitimate. And how much actually takes place and what is their incentive to be driven and to be more efficient and to increase productivity?

Dr. MURAWSKY. So, we have those discussions, and as a primary care provider at the Hines Medical Center, we have team meetings. I am part of those meetings, and we discuss how is our panel size; what does it look like; where is it going; what is our ratio of new patients; are we growing; what do we expect to come in?

All of those things are discussed. My personal performance pay arrangement with my boss incentivizes me a very small amount—a couple hundred dollars in my case—for work around keeping my panel optimized. And we have that discussion individually with providers, so I had it with my boss at the VA at Hines, who does my performance at, clinically. We had that discussion.

In specialty care, the practices have that discussion among the groups—what are they doing? It varies from setting to setting. Some of our specialty-care practices are a single, part-time individual, because that is the level of facility that we have.

Mr. WENSTRUP. Thank you. I guess I want to be somewhat assured that each individual practitioner has some motivation to be part of that solution in some way, shape or form, whether it is monetary, or promotional or whatever.

But thank you, I yield back.

Mr. BENISHEK. The Member from California, Ms. Negrete-McLeod, do you have any questions?

[Nonverbal response.]

Mr. BENISHEK. All right. Thanks. Does anyone else have any further questions that they would like to ask?

If not, I guess we will wrap it up here. Thank you for coming. I think we have asked some questions here to get things started. Obviously, I think we are all disappointed by the fact that we don't have a plan already. I am disappointed by that, but I appreciate, Dr. Agarwal, your efforts to get this done.

I am just concerned by the fact that there seems to be a great deal of difference between facilities and that there does not seem to be overall guidance, towards the facilities to make sure that there is adequate infrastructure exam rooms, nurses etc. to make sure that the facility operates efficiently.

I think from today's testimony, we found that that occurs. It certainly happened in my experience, and there are circumstances where it does not occur, but the fact that we don't have a plan to be sure that there is at least some sort of efficiency is disappointing.

I look forward to your further testimony and I will monitor what happens from here. I appreciate everyone's testimony today and for your time. You all are excused, now. I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

Thank you, again, to all the witnesses and the audience members for joining us. The hearing is now adjourned.

[Whereupon, at 11:42 a.m. the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Dan Benishek, Chairman

Good morning. I want to begin by thanking all of those in attendance today for joining us at the first Subcommittee on Health oversight hearing of the 113h Congress.

I am honored to have been selected to serve as Chairman of this important Subcommittee, and I am pleased that Julia Brownley of California has been selected to serve as Ranking Member.

I look forward to working with her and the many new and returning Members of the Subcommittee individually and collectively to improve and protect the health of our honored veterans.

Having served on this Subcommittee before, I know that each of us shares an immense respect and deep admiration for the service and sacrifices of America's veterans.

My goal as Chairman, in part, is:

(1) to ensure that when a veteran accesses health care through VA, he or she is met with timely, consistent, high quality care and services and is unburdened by lengthy wait times or unnecessary travel requirements; and,

(2) to keep the dollars we spend on VA health care close to the bedsides of our veteran patients - that is to say, to prioritize patient care above administrative costs and bureaucratic overhead that serve the Department more than it serves our veterans.

I was proud to serve for twenty years as a part-time physician at the Oscar G. Johnson VA Medical Center in my hometown of Iron Mountain, Michigan.

In that capacity, I cared for my veteran neighbors every day and, in the course of that care, I got to know them, to talk to them, and to learn from them about the many challenges and frustrations they face accessing health care through VA.

As a Congressman, I have made it a priority to continue these conversations with my veteran constituents and I can tell you that – unfortunately – their experiences at VA haven't changed for the better.

There are many examples I could provide – examples of veterans seeing a different doctor every time they go to VA for an appointment and examples of veterans from my district being told to travel hundreds of miles from our home in Northern Michigan to the VA medical centers in Milwaukee or Detroit because local doctors can no longer provide needed services in our community.

I am convinced that these problems are rooted at least partly in the issue we will discuss today – the persistent lack of staffing standards at VA medical facilities.

On December 27, 2012, the VA Inspector General issued an audit of physician staffing levels for specialty care services.

The IG found that VA did not have effective staffing methodology to ensure that appropriate staff is in place to treat veteran patients at VA medical facilities across the country.

Since 1981, no less than eight audits and reports have been issued by either the VA Inspector General or the Government Accountability Office that have recommended VA develop and implement productivity standards and staffing measures to more effectively meet patient demand.

32 years later, alarmingly little progress has been made and our veterans are the ones who suffer for it.

That is unacceptable to those of us on this side of the dais and it should be unacceptable to those on that side of the dais as well.

Today, I don't want to hear excuses. I want to hear solutions.

I thank you all for joining us this morning.

Prepared Statement of Hon. Julia Brownley

Mr. Chairman, I would like to thank you for holding today's hearing.

As the new Ranking Member of the Subcommittee on Health, I look forward to working with you, the other Members of this Subcommittee, and all of our stakeholders to ensure quality, timely, and accessible health care to all veterans.

We are here today to address the very important issue of physician staffing within the Veterans Health Administration (VHA). We know that access to health care is essential to veterans. It improves treatment outcomes and quality of life for those who have it. And we know that health care professionals are VHA's most important resource in delivering high-quality care and services to our Nation's veterans.

Since 1981, there have been several reports that have recommended that VA implement measures to assess provider productivity, staffing levels, and associated resources. I understand that the wide range of specialties VHA offers varies in complexity, and that it is often difficult to quantify the work that specialists provide day in and day out.

However, in a system with over 152 medical centers and nearly 1,400 community-based outpatient clinics, it is vital that VHA is able to establish a staffing methodology to help evaluate productivity, identify best practices within specialties, and develop staffing plans in order to properly manage resources. Additionally, with recent veterans returning from war and becoming eligible for VA services in record numbers, VHA also needs to be looking toward the future to ensure that patient needs can be met.

I thank all of the panelists for being here today. And I look forward to hearing from them on how to proceed to ensure that VA staffing levels are adequate and productivity levels are sufficient in meeting the needs of our veterans.

Thank you, Mr. Chairman. I yield back.

Prepared Statement of Hon. Raul Ruiz

Thank you Chairman Benishek and Ranking Member Brownley for holding today's hearing. I am looking forward to learning more about the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) productivity standards as it relates to physicians and how it affects veteran care.

The importance of today's hearing resonates all too well with my past experience as an emergency room doctor. Productivity standards and ensuring appropriate staffing levels is critical to a well-run hospital. And the methodology that we established permitted us to not only maintain an appropriate workforce, but also to have experienced, trustworthy staff members who could deal with the pressures of the ER.

The importance of having this type of qualified staff on hand cannot be underscored enough. They are by a patient's side caring for them in some of the most vulnerable points in a person's life. They care not only for a person's physical wellbeing, but also for their emotional wellbeing. And they do this day in and day out because they are providing what hospitals are truly about: high quality, patient-centered care.

Our veterans deserve this type of care at all VA Medical Centers, and I believe the VA is currently doing what they can to provide this level of care. However, I believe that there is always room for improvement and I know the VA has the capacity and the leadership to develop appropriate procedures to measure physician productivity and recruit and retain doctors, nurses, and pharmacists.

If an opportunity arises where I could provide the VA with my expertise in the private sector, I would be delighted to work alongside you to develop a methodology that strengthens the care we provide our veterans. I hope you will consider my offer to collaborate and will reach out to my office so that we can have a longer discussion on this issue.

Thank you and I yield back the balance of my time.

Prepared Statement of Linda A. Halliday

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss our report, *Audit of Physician Staffing Levels for Specialty Services,* that

was issued in December 2012. I am accompanied by Mr. Larry Reinkemeyer, Director of the Office of Inspector General (OIG) Kansas City Audit Operations Division, who directed the team conducting this audit.

BACKGROUND

The need for the Veterans Health Administration (VHA) to develop a staffing methodology is not a recent issue. In 1981, the Government Accountability Office (GAO) recommended that VHA develop a methodology to measure physician productivity. Since then, six OIG and GAO reports have made similar recommendations. [1]

In January 2002, Public Law 107–135, Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, mandated that VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. Specifically, VA medical facilities should consider staffing levels and a mixture of staffing skills required for the range of care and services provided to veterans. Organizations also need to establish performance measures to make comparisons and assessments of different data to be able to take appropriate action.

In a memorandum dated January 25, 2005, the Deputy Under Secretary for Health for Operations and Management directed VHA to continue the development of a productivity-based model for specialty care services using the Relative Value Unit (RVU) measure. An RVU is a value assigned to a service (such as a medical procedure) that establishes work relative to the value assigned to another service. For example, a service with an RVU of "2," counts for twice as much physician work as a service with an RVU of "1." It is determined by assigning weight to factors such as the:

- Time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with the service and risk to patient

In 2006, VHA's Office of Productivity, Efficiency, and Staffing conducted studies of 14 specialty care services, which resulted in 9 recommendations. One of the nine was to have VHA develop RVU productivity standards and staffing guidance for the field.

AUDIT OF VHA'S PHYICIAN STAFFING LEVELS FOR SPECIALITY CARE

In order to evaluate VHA's progress in implementing the policy on the physician staffing levels, we assessed whether VHA had an effective methodology for determining physician staffing levels for 33 of VHA's specialty care services. Generally, we found that while there is a consensus among VHA officials that VHA needs to develop a methodology to measure productivity, there is no agreement on how to accomplish it. There is a lack of agreement within VHA on which methodology to use to measure productivity. Some VHA officials believed the RVU-based productivity model is not a good measure as a stand-alone component for staffing, while other VHA senior officials from the Office of Patient Care Services and medical facility officials stated that based on data availability, the RVU model is the best method currently available to measure productivity.

We were told VHA officials were concerned that its National Patient Care Database did not capture all of the physician workload needed for use in productivity-based staffing models. For example, VHA officials explained that physicians who supervise residents accomplish less workload than their peers who do not supervise residents because the residents will get credit for the work completed. While this may be valid if VHA is trying to establish individual physician productivity, it is not a valid concern when developing a productivity standard for a specific specialty within similar medical facilities. Further, VHA can adjust the productivity standard for physicians whose other duties, such as resident supervision, results in the physician accomplishing less workload then their peers.

If VHA decides not to use RVUs as the productivity standard, VHA can explore other options, such as panel size or other types of productivity-based workload measures. Panel size, which is used in primary care services, is the maximum number of active patients under the care of a specific provider. VHA currently collects data, such as the number of encounters and unique patients, which they could use

[1] Audit of VHA Resource Allocation Issues: Physician Staffing Levels (1995); Audit of VHA's Part-Time Physician Time and Attendance (2003); Issues at VA Medical Center Bay Pines, Florida, and Procurement and Deployment of the Core Financial and Logistics System (2004); Review of Selected Financial and Administrative Operations at VISN 1 Medical Facilities (2006); Follow-up Evaluation of Clinical and Administrative Issues Bay Pines Health Care System, Bay Pines, Florida (2006).

to develop a productivity-based methodology. While we do not endorse any one specific method to measure physician productivity, we do believe that VA needs to have measurable and comparable productivity standards in place to assist in determining the number of specialty physicians needed to meet patient care needs. Our concern is that VHA's decision-process to implement productivity standards has been pending too long.

Productivity of VHA Specialty Physicians

In the absence of a productivity standard, we established a rudimentary, conservative standard by identifying VHA's RVU median for each specialty care service to determine an approximate measure of current physician specialty productivity. The national median is the middle value among each specialty care service. Using that median, we analyzed the collective group of specialty physicians at all medical facilities and determined that 12 percent (824 of 7,011) of physician full-time equivalents (FTEs) did not perform to the standard. The 824 physician FTEs represented approximately $221 million in physician salaries during fiscal year 2011. Although we did not analyze the productivity of individual physicians, our results support the need for an in-depth evaluation of staffing.

Opportunities to Identify Best Practices

VHA does not have an internal measure to benchmark physician productivity within a specialty. GAO's Standards for Internal Control in the Federal Government[2] requires an organization to compare actual performance to results and analyze significant differences within that organization. We compared the staffing levels to the amount of work performed by eight specialty care services[3] at the five medical facilities[4] we visited. Specifically, we compared the workload output per clinical FTE for each specialty care service and found significant differences in workload.

- One medical facility classified as "1a" by the Facility Complexity Level Model had 1 FTE providing infectious disease care to 316 unique patients for a total of 603 encounters.[5] During the same period, another medical facility also classified as "1a" had 1.4 FTE that provided infectious disease care to 1,868 unique patients for a total of 3,476 encounters. The latter medical facility provided over 500 percent more encounters with .4 FTE or 40 percent more in staff.
- One medical facility classified as "1a" had .8 FTE providing endocrinology care to 1,053 unique patients for a total of 1,627 encounters. During the same period, a medical facility also classified as "1a" had .4 FTE that provided endocrinology care to 1,347 unique patients for a total of 2,286 encounters. Although the latter medical facility had about 50 percent less dedicated FTE, the medical facility provided 41 percent more encounters.

VHA needs to implement productivity standards to measure and compare the collective productivity of physicians within a specialty care service at similar VA medical facilities. By measuring and comparing internal productivity and staffing, VHA can identify staffing shortages and excesses along with best practices and those practices that should be changed or eliminated.

Staffing Plans Were Not Prepared

VHA policy requires medical facilities to develop staffing plans that address performance measures, patient outcomes, and other indicators of accessibility and quality of care. These assessments determine if staffing levels need an adjustment—up or down—to meet current or projected patient outcomes, clinical effectiveness, and efficiency.

Staffing plans are an important control to ensure effective and efficient use of funds by providing some certainty that medical facility officials conduct periodic assessments of their staffing needs. These plans also ensure medical facility directors have sufficient data to make sure staffing decisions address VHA's priority—pro-

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[2] The Federal Managers' Financial Integrity Act of 1982 requires GAO to issue standards for internal control in Government. The standards provide the overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges and areas at greatest risk of fraud, waste, abuse, and mismanagement.

[3] We reviewed the following specialty care services: cardiology, endocrinology, infectious disease, obstetrics and gynecology, ophthalmology, physical medicine and rehabilitation, psychiatry, and surgery.

[4] VA Medical Centers in Augusta, GA; Boston, MA; Houston, TX; Indianapolis, IN; and Philadelphia, PA.

[5] The Facility Complexity Model classifies VA medical facilities at levels 1a, 1b, 1c, 2, or 3. Level-1a facilities are the most complex and level-3 facilities are the least complex. VHA determines complexity levels by three categories—patient population, clinical services complexity, and education and research.

viding quality patient care—along with their other missions such as teaching and research.

None of the five medical facilities we visited could provide a staffing plan that addressed the facilities' mission, structure, workforce, recruitment, and retention issues to meet current or projected patient outcomes, clinical effectiveness, and efficiency. Medical facility officials stated that when requesting additional staff or filling a vacancy, they provide a workload analysis to justify the personnel action. However, medical facility officials could not always provide documentation or an adequate workload analysis to justify the need for additional staff.

For example, one medical facility provided us with the justification used to replace a part-time surgeon. It showed the surgeon was responsible for 13 percent of the work performed by the specialty care service. In the justification, the requesting official concluded the remaining two full-time surgeons would not be able to absorb the departing surgeon's patient care responsibilities. However, the requesting official provided no other information such as total workload, anticipated workload increases or decreases, or an analytical review of the other surgeons' ability to handle more workload.

This occurred because current VHA policy does not provide sufficient detail for medical facilities to develop their staffing plans. Officials from all five medical facilities stated they were not sure what was required to implement a staffing plan. According to VHA officials, the staffing policy was intentionally general in nature because medical facility officials determine staffing levels on various factors, such as the needs of each medical service, the number of residents, and the types of care provided. Without detailed staffing plans, VHA lacks assurance that medical facility officials are making informed business decisions that best ensure efficient use of financial resources in determining the appropriate number of specialty care physicians.

Recommendations

We recommended the Under Secretary for Health establish productivity standards for at least five specialty care services by the end of FY 2013 and approve a plan that ensures all specialty care services have productivity standards within 3 years. We also recommended that the Under Secretary provide medical facility management with specific guidance on development and annual review of staffing plans.

The Under Secretary for Health agreed in principle with our finding and recommendations. We consider the planned action acceptable and will track progress.

CONCLUSION

Staffing for specialty care services is an expensive resource which needs to be managed effectively. VHA has not established productivity standards for all specialties because of indecision regarding how to measure physician productivity. Instead of focusing on the difficulties of measuring productivity, VHA needs to focus on the benefits of discovering medical facilities that might have a best practice and identify practices that should be changed or eliminated. This would maximize the use of physician resources while increasing access and quality of care to more veterans.

Mr. Chairman, this concludes my statement. We would be pleased to answer any questions that you or other Members of the Subcommittee may have.

Prepared Statement of Larry H. Conway, B.S., R.R.T.

Mr. Chairman and distinguished members of the Subcommittee:

I am Larry H. Conway and I am the Director of Communications for the **National Association of Veterans' Affairs Physicians and Dentists (NAVAPD)** and I am honored to have this opportunity to represent NAVAPD in that role before the Subcommittee. I also currently serve as the Chief of the Respiratory Therapy Subsection at the Washington DC VA Medical Center, and for 38 years have practiced as a respiratory therapist in various hospitals, primarily in management roles. In these roles, I have become extremely familiar with using and developing various methodologies of assessing healthcare staffing needs and productivity systems. NAVAPD President Dr. Samuel Spagnolo regrets being unable to participate today but has asked me to present NAVAPD's concerns and thoughts on developing a methodology for determining VA's physician staffing needs, and the VA's ability to adequately meet patient needs in an efficient, effective manner.

NAVAPD's focus since its inception in 1975 has been promoting and supporting the highest quality care for our Nation's Veterans, and caring for those who provide care for them. To that end, NAVAPD supports the development of a balanced, fair and appropriately administered staffing and productivity system that will help as-

sure appropriate staffing levels to provide the excellent care due our Veterans without undue or inequitable stress upon the caregivers. The absence of such a VA-wide system, and the flaws in the systems currently in use in some facilities, have led to productivity assessment approaches that are neither fair nor balanced, and in fact misleading and useless in determining staffing needs and performance levels.

We became aware of concerns about these issues over the last two years through comments from our members. We reviewed the OIG Audit of Physician Staffing Levels for Specialty Care Services (December 27, 2012) and found that it confirmed many of the issues that had been brought to us. The processes being used, where and when used, are fundamentally flawed, based upon the wrong measurement units, and in some cases favored certain staff members while harming or diminishing others. The system can make a physician who performs procedures continually for their entire shift appear less "productive" than a fellow physician who performs procedures only a few hours out the shift. Whether this is because of a lack of understanding of the fundamentals of a staffing and productivity system or intentional, cannot be firmly ascertained. Regardless, these concerns and review of the OIG Audit culminated in an article in the current **NAVAPD Newsletter.** This article was written and planned for publication before NAVAPD became aware of this hearing and details many of the experiences of NAVAPD members and the parallel findings by the OIG.

Developing such a system for the VA is a challenge, but it is not nearly impossible and should not take a decade to accomplish. In my management roles across the United States, I have devised, reviewed, developed and refined multiple staffing and productivity systems. Developing a system is not complex, though it can be tedious. One barrier to progress is the assumption of an excessive degree of complexity. Beyond selecting the correct measurement units, the greatest difficulty will be in gaining consensus on the application of those measurement units and the assignment of measurement units to various procedures. NAVAPD assigns no blame to the VA for these difficulties and does not seek to engage in controversy or confrontation with the VA. Rather, NAVAPD would like to offer its thoughts to the Subcommittee regarding the misjudgments in developing a system, and further to offer assistance and expertise on how to actualize a viable, beneficial and transparent system well within the time frames recommended in the OIG Audit.

The Fundamental Problems

There are three issues at the heart of the current gridlock of defining and operating a valid system for the VA:

1. Misunderstanding or misconstruction of the basic unit of measurement, the Relative Value Unit (RVU); inclusion of extraneous factors in the RVU.

2. Adding skill-set, procedure difficulty, and stress factors to the RVU. This is a matter of skill-mix, which differs from basic staffing levels

3. Confusing and mixing staffing needs assessment, productivity assessment, and benchmarking.

RVU Selection, Definition, and Construction:

The OIG Audit stated:

"An RVU is a value assigned to a service (such as a medical procedure) that establishes work relative to the value assigned to another service. For example, a service with an RVU of "2" accounts for twice as much physician work as a service with an RVU of "1." It is determined by assigning weight to factors such as the:

- Time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with the service and risk to patient"

With respect, this is precisely the wrong approach and is at the heart of the confusion and disarray of the current system. When asking how many staff members are needed to effectively and safely perform a projected workload, it is an issue of time, not difficulty or skill or physical effort or difficulty or stress. For one thing, a more difficult, more stressful, more skilled procedure will by its nature take longer than a simple procedure

For purposes of determining the total number of staff hours (staffing) needed to accomplish a given workload, the RVU should be a simple, one-dimensional (single-factor) time-based unit. The RVU can be defined as any convenient standard block of time, i.e., one (1) minute, fifteen (15) minutes, one (1) hour, or any block of time that conveniently fits the overall duration of procedures. The VA could and should

certainly set a system-wide RVU of perhaps thirty (30) minutes. This will make the data from different services, facilities, and VISNs easy to assimilate, aggregate, and compare without the need for translation of base units.

Unfortunately, the RVUs being used unevenly throughout the VA include all of those factors described in the OIG Audit. They are similar to the Medicare-derived Resource Based Relative Value Units (RBRV). While similarly named, RBRVs and RVUs are not the same and not interchangeable. The RBRV is used to determine the dollar value (reimbursement) of various procedures, and thus includes all of the non-time factors identified above.

Figure 1

Contrast of Hypothetical RVUs and RBRVs—

1/2 hour of suturing in ED	1/2 hour of neurosurgery
a. Time = 30 minutes	a. Time = 30 minutes
b. Skill factor = 1	b. Skill factor = 7
c. Difficulty factor = 1	c. Difficulty factor = 5
RVU (a) = 30 minutes	RVU (a) = 30 minutes
RBRV (a x b x c) = 30 minutes	RBRV (a x b x c) = 1,050 minutes

A quick review of this example reveals that the total dollar value of the same time interval of neurosurgery would justify much more reimbursement than an equal time period of ED suturing based, upon the weighted RBRV. However, the amount of staff time required is the same for each, based upon the RVU.

For a measurement unit intended to determine the *dollar value* for a given procedure, as the Medicare RBRV is, inclusion of all of these factors is valid. The impact of inclusion of these non-time factors is illustrated in Figure 1, above.

However, a measurement unit intended to determine just the number of *needed staffing hours* (which translates to FTEs) should consider only the time for appropriate and safe completion of the projected workload. One-half hour of neurosurgery and one-half hour of wound suturing in the Emergency Department do not require the same skill-level and are not equally difficult. They are thus assigned differing dollar values. But they both take one-half hour of staff time, which is the question when determining how many staff members are needed to complete a whole mix of various procedures.

The question of how many of each type of staff is needed (skill-mix) can be addressed in one of two ways, as described in the next section, but must not be mixed into the RVU.

Assessment of Skill-Mix Need:

As used in these comments, skill-mix means how many staff of various levels of skill is needed. Obviously, a hospital cannot function with only one skill-level or specialty of physician. Having calculated how many total minutes or hours (which can all translate to FTEs) of personnel are needed for all procedures, how does one determine how many Family Practice, Emergency Care, Neurosurgeons, Cardiologists, etc. are needed within that total staffing complement?

The simplest way is to continue to use the RVU as defined previously, but segregate the types of procedures by specialty or skill-level. Thus, the procedures (and associated RVUs) done by Neurosurgeons will be totaled for Neurosurgeons. Those for Cardiologists will be totaled for Cardiologists, and so forth. This process will produce subsets of RVUs for each specialty/skill-level, which will define how many of each specialty/skill-level is required for the projected workload. All of the subsets added together will provide the total staffing complement. This concept is illustrated below in Figure 2.

Figure 2

Determining Skill-Mix and Total FTE Needs Using Simple RVUs—

Specialty	RVUs	Hours	FTEs
ER Physicians:	12,274	6,187	3.92
Cardiologists:	21,596	10,798	6.85
Primary Care	48,221	24,111	15.29
Intensivists	32,545	16,273	10.32
TOTAL Physician FTEs needed			36.38

— In this hypothetical facility there are four kinds of physicians.
— An RVU is defined as 30 minutes (0.5 hours), therefore Hours = RVUs x 0.5
— An FTE is paid 2080 hours annually, but with Vacation (80), Holiday (88), Report (120), and Sick (40) time removed, averages 1752 available work hours per year.
— At 90% productivity, it will take 3.92 FTEs to provide the 12,274 RVUs by ER Physicians.

Alternatively, the skill-mix need can also be calculated by using the RBRV or another unit that considers the factors listed in the OIG report. However, this requires an additional set of calculations and a conversion process between RBRVs and FTEs. There is no significant benefit in this additional, parallel system. Therefore, for the purpose of determining total FTE need and skill-mix need, a one-dimensional time-based RVU is the appropriate tool, not a multidimensional construct like the RBRV.

Confusing Staffing Needs Assessment, Productivity Assessment, and Benchmarking:

Assessing staffing needs and assessing staff productivity are related but not the same, and confusing the two into one system will degrade the effectiveness of the system for both. It will also create a disincentive for staff to participate in either system.

A (relatively) simple means of determining total staffing need and skill-mix has been described.

A productivity system functions in the opposite fashion from a staffing needs system. It should compare the number of staff hours available to the amount of work accomplished. Thus, if there were 1,000 hours of staff time available (based upon a needs assessment) but only 823 hours of work were accomplished (as calculated by RVU), the staff would be considered to be 82.3% productive. The level of productivity can be impacted and made difficult to accurately assess by several factors, some of which are described below.

Factors which can vary facility to facility:

1. Number floors to be covered
2. Acuity of the patients
3. Number, speed, and reliability of elevators
4. Age and speed of equipment
5. Computer systems
6. Number and efficiency of support staff
7. Number of available exam rooms
8. Delays in obtaining a bed
9. Patients not available
10. Teaching obligations
11. Untracked responsibilities such as telephone consults, hallway consults, prep time, documentation.

Fatigue and Delay factors must not be forgotten in determining productivity, while they are often ignored in calculating staffing levels. No one can function at 100% productivity continuously, either for individual health or fatigue reasons, or for the reasons listed above. Productivity specialists consider 5% to 7% a reasonable estimate/allowance for Fatigue and Delay.

Non-tracked responsibilities or obligations that are not directly related to procedures diminish productivity if not considered within the build of the productivity system. Because hospitals tend to build documentation systems around "billable items," or easily identified procedures, non-billable items are often not counted and thus unavailable for consideration unless recorded manually.

The impact on productivity of resident training is a particularly large factor that is missed in staffing and productivity systems. Even the OIG Audit underplays the impact of teaching. It states:

"VHA officials were also concerned that its National Patient Care Database did not capture all of the physician workload....For example, VHA officials told us that physicians who supervise residents accomplish less workload than their peers who do not supervise residents because the residents will get credit for the work completed. While this may be valid if VHA is trying to establish individual physician productivity, it is not a valid concern when developing a productivity standard for a specific specialty within similar medical facilities."

In fact, these teaching obligations and the impact upon the entire specialty and facility are significant. Many VHA facilities have specific contracted obligations to use and train residents. Resident training is time-consuming and can reduce significantly an attending physician's case output or require the physician to spend more hours discharging the same caseload. The more conscientious the teaching, the greater is the impact. Such obligations must be considered when setting staffing levels, productivity factors and goals whether facility or individual focused.

Poorly defined "Encounters" measure used by the VA are defined more in terms of complexity than time, making it difficult to use "encounters" as a denominator to establish staffing need or productivity. The amount of time required varies widely from one encounter to the next, but all are counted as "1." The more nebulous the measurement unit or documentation unit in terms of time required, the more difficult it is to truly assess staffing needs or productivity of existing staff.

However thoroughly and well consider, a productivity system inappropriately built upon a multifactor measurement unit, like the RBRV discussed previously, can cause hard working and diligent physicians to appear less productive than fellow physicians who do fewer, heavier weighted procedures. This effect is demonstrated in Figure 3 below, which is based upon the assumptions in Figure 1:

Figure 3

Contrast of Productivity by Hypothetical RVUs and RBRVs—
(In this example, an RVU is defined as 30 minutes)

The ED physician moves from patient to patient performing procedures that take 30 minutes continously during the shift:	The neurosurgeon completes performs two cases totaling 4 hours of surgery during the course of the shift:
a. Procedures done: 14	a. Procedures done: 2
b. Procedure time: 420 mins.	b. Procedure time: 240 mins
c. RVUs = 14	c. RVUs = 8
d. Skill factor = 1	d. Skill factor = 7
e. Difficulty factor = 1	e. Difficulty factor = 5
RVU (a) = 14	RVU (a) =8
RBRV (a x b x c) = 14	RBRV (a x b x c) = 280

In the same 8 hour shift, the ED physician spent a total of 7 hours (420 minutes) providing services while the neurosurgeon spent 4 hours (240 minutes) providing services. The RVUs indicate the amount of staff time required to provide the services of each (staff need). While the RVUs (required staff time) for the ED was 75% greater than for the neurosurgery, the weighted RBRV indicates (incorrectly) that the neurosurgeon was 20 times more productive than the ED physician.

Given that the types of procedures done by physicians are not necessarily their choice, but assigned, the situation can arise in which a physician, by virtue of their assigned procedures, could never achieve high productivity in a system that weights by skill and difficulty factors as well as time. A radiologist who is constantly assigned to read chest x-rays could read far more films and work far more hours and never generate the total number of RBRVs as a radiologist who does Brain MRIs or Radio-ablations. If RBRVs are then assumed to equal productivity, the radiologist who is assigned largely chest x-rays will always appear less productive, even if that is not the case.

If productivity as determined by RBRVs is a major determinant in performance assessment and performance pay, the radiologist who is assigned mostly chest x-rays is at a continuous – and perhaps intentional – disadvantage

In a medical system focused on profit, assessing the value of a physician based upon the "production" billable revenue of one versus another might make business

sense. In the VA system, profitability is not a factor and so assessing the productivity of a physician should be based upon the time spent producing care results.

Finally, **a benchmarking system** compares performance on a "select group" of procedures or services that are thought to be highly representative of work associated with and in common with each of the various participating facilities. Of major importance is noting that a benchmark system makes no attempt to account for all procedures or work performed. It therefore does not provide any estimate of the TOTAL work performed in any facility. It is a comparator system and presumes that if a facility has the best profile on the reported procedures, then that facility performed better overall than the other participating facilities.

Benchmark systems are often misused by trying to treat them as productivity systems. The two are completely different and distinct. There is no way to accurately assess true productivity (work produced per staffing unit) unless all work and all staffing is accounted for. By definition and practice, a benchmark system *does not* account for all of either.

On page 4, the OIG Audit discusses an attempted benchmark looking at infectious disease care and endocrinology care. The OIG investigators then ran productivity comparisons of the two specialties in two different "1a" facilities. While the results imply that one facility was far more productive, the fact is that other procedures and factors not in the scope of the benchmark reporting likely account for some of the variability. This attempt at using benchmark data to derive productivity information produced data that truly only showed that the results were suspect because no standards of measurement and comparison had been established. Because all factors and procedures are not included in a benchmark system, there is little chance of deriving generalized productivity information from it.

A benchmark system may be an effective tool for identifying best practices only if the scope and limitations of its data pool are recognized and considered in any conclusions.

The Greatest Barriers

The greatest barrier to the development and implementation of an accurate Staffing Needs Assessment system and a Productivity Assessment tool will be defining the measurement unit and applying it to all procedures. This will require two major accomplishments:

1. A complete inventory of procedures, events, obligations that account for sizable portions of staff time, billable or not, linked to a procedure or not; and

2. Consensus on the application of the measurement unit to each item in this inventory. For example, getting agreement on "What is the most accurate average time required to perform a Brain MRI?" What is the most accurate average time required to read an EKG?"

The next greatest barrier will be getting staff participation. No one likes another person monitoring them and their work. Health care providers are especially suspicious of such a system. They realize that they are working with people, not building cars, and that "cookbook" approaches do not account for the variability of people and their medical responses. It will therefore be important that the construction of the system and the operation of the system is transparent to all.

Finally, developing a means of easily collecting the data will be key to success. A process that would auto-populate a procedure tracking and counting system will assure the most accurate reporting.

I would like to conclude by reiterating that NAVAPD recognizes the enormity of establishing a Staffing and Productivity system for the VA, but supports that effort, and offers its assistance in making such a system a reality soon. Mr. Chairman, I would like to thank you and the members of the committee for your kind attention. I would be happy to answer any questions from you or other members of the committee.

Prepared Statement of Madhulika Agarwal, M.D., M.P.H.

Good morning, Mr. Chairman, Madam Ranking Member, and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) productivity levels for physicians. I am accompanied today by Dr. Carter Mecher of the Veterans Health Administration (VHA)'s Office of Public Health, and Dr. Jeffrey A. Murawsky, Director of VHA's Great Lakes Health Care System.

VHA believes it is essential to ensure that all employees within our Administration, including our physicians, are able to work as effectively as possible to provide appropriate, high-quality care and services and meet the needs of Veterans.

VHA currently uses both population-based (primary care physicians) and work value-based (specialist physicians) models to assess physician productivity, that will soon be used in over half of our physician workforce. VHA is committed to establishing appropriate productivity models for five additional specialties by the close of this fiscal year. Over the next three years, we will refine and develop additional models that are individualized for specialty care.

Measuring productivity in a health care setting is a complex issue. First, I would like to discuss some of those complexities as they pertain to VHA. I then will describe actions VA has already taken, and is in the process of taking, to measure effectiveness and productivity in achieving all of our statutory missions.

VHA has four principal missions for which it is responsible. These include patient care, medical education, research, and support to the Nation's emergency preparedness. In Fiscal Year 2012, eighty-four percent of our physician full-time-equivalent (FTE) workforce was providing direct patient care to Veterans, our primary responsibility.

VHA fully recognizes it is incumbent on us to effectively manage this very important resource. However, we also know that VHA—and the entire medical profession—has had a long history of challenges in this area. These issues include changing needs of patients; changing practice patterns, new delivery models, impact of technology innovations on patterns of care, challenges with physician recruitment and retention; and accurately measuring productivity in an integrated health system.

Just last month, the Bipartisan Policy Center issued a report entitled "The Complexities of National Health Care Workforce Planning," which described the issues facing the entire health care industry. The complexities addressed are no different from those that VHA faces. It is my privilege to inform this subcommittee, America's Veterans and their families, and other interested parties of the actions we are taking to ensure our physician workforce is optimally deployed to provide America's Veterans with the quality of care they have earned through their service and sacrifices.

Quality, accessibility, and efficient delivery of health care are basic principles VHA uses to develop physician productivity and staffing standards. To ensure this, VHA has established an Office of Productivity, Efficiency, and Staffing (OPES) to build tools to help program offices develop effective management strategies, systems, and studies to optimize clinical productivity and efficiency, and to support the establishment of staffing guidance that promotes the goals of clinical excellence; access; and the provision of safe, efficient, effective, and compassionate care. OPES produces a number of tools, such as the Physician Productivity Cube, which VHA uses to monitor productivity, staffing and efficiency.

VA has moved from a hospital-based system to a health care system with a focus on ambulatory care. The foundation of our integrated health care delivery system is primary care, and primary care physicians were our first priority for developing a staffing model. Primary care providers constitute the single largest component of our physician workforce, 34 percent. VHA now has a fully operational Primary Care Panel Size Staffing Model, which defines the number of active patients that may be assigned to each primary care provider. In developing this staffing model, our goal was to establish a primary care system that balances productivity with quality, access, and patient service. In addition, the staffing model permits VHA to measure the overall productivity of primary care providers and the capacity of our system, in order to understand and inform our primary care staffing needs. Currently we are completing the process of updating that model to reflect changes associated with VHA's deployment of patient-aligned care teams (PACT) at all our sites of care.

The second largest component of our physician workforce is our Mental Health providers. Psychiatrists now account for 14 percent of VA's physician workforce. Mental Health has experienced unprecedented growth in the past two years— driven by sharply increasing demand for Mental Health services. VHA has comprehensively studied our mental health provider resources to ensure that they are optimally deployed and used. We will be distributing a directive providing guidance for facilities to support this objective, entitled "Productivity Guidance for Mental Health Providers," by the end of spring, 2013.

Relative Value Units (RVUs) are used by Medicare, Medicaid, and many private practices and institutions, to track physician productivity. RVUs consider the time and intensity of physician services and have three components: (1) the Work RVU (wRVU) encompassing time spent before, during and after the service and considers the technical skill, physical effort, mental judgment, and potential risk of per-

forming a medical service; (2) the Practice Expense (peRVU) which considers the support staff, medical supplies and equipment needed to perform a procedure and; (3) the Malpractice (mpRVU) which measures the liability costs associated with each medical procedure. Each of these RVU components is determined by applying the Centers for Medicare & Medicaid Services' weights to CPT codes (Current Procedure Terminology) of patient encounters. Only the wRVU component is used for physician productivity measurement.

While many private sector healthcare organizations use the industry-accepted metric of wRVUs to determine productivity, wRVUs also are used in academic and private practices to determine physician compensation.

VHA intends to expand the use of wRVUs as only one of several measures to assess the productivity and efficiency of each specialty practice area throughout the organization.

Radiology, the third largest component of our physician workforce (nearly 6 percent of the total workforce) offers a good example of how wRVUs can be used to set productivity levels. A comprehensive study of the productivity of VA radiologists was performed in Fiscal Year 2005. The study found that the observed mean productivity of radiological specialists was 5,453 wRVUs per physician, and the median was 4,904 wRVUs. VHA determined that radiologists assigned to full-time clinical effort should produce 5,000 wRVUs of work in the course of a year. In Fiscal Year 2012, the observed mean productivity per clinical full-time equivalent radiology physician increased to 5,652 wRVUs. This productivity standard is assessed on an annual basis.

To assist local leadership in managing their specialty practices, information is available on the VA Intranet that provides data on productivity and includes factors that affect productivity, such as the presence and number of support staff. Utilizing the metric of a wRVU permits measurement of cost efficiency and the ability to study the relationship of productivity, efficiency and outcomes.

When the Mental Health directive is published, more than 54 percent of VHA's physician workforce will have standards to measure their productivity and efficiency. OPES has created a tool called the Physician Productivity Cube, a tool that captures physician productivity workload for physician specialties by measuring workload by wRVUs, number of encounters, and number of individual patients. It also gives our hospitals and health care systems the capability to assess their productivity and to compare themselves to national medians, medical centers of similar size and complexity, and private sector benchmarks. It is a quarterly reporting system of our physician workforce. However, given the inherent complexity of this effort, OPES is doing extensive validation of the local primary data contained in the cube's database.

The Office of Inspector General (OIG) was given access to the Physician Productivity Cube, and noted significant variation in observed productivity within VHA and recommended that VHA establish productivity standards. VHA has accepted this recommendation. Our work in specifically addressing the problems identified by OIG began six months before the OIG's report was released.

In June 2012, VHA established a Specialty Care Physician Productivity and Staffing Plan Task Force to further refine our methodology for specialty care physician productivity and staffing. VHA's task force focused on seven specialties excluding Primary Care, Mental Health, and Radiology, specialties for which models have already been developed or are near release. The seven specialties were Cardiology, Gastroenterology, Dermatology, Neurology, Orthopedics, Urology, and Ophthalmology, which account for a major portion of our remaining physician workforce, and are representative of all remaining specialties. The task force's recommendation was for an RVU-based approach that builds upon the extensive work OPES has already done in this area.

These specialty areas comprise smaller numbers of clinicians than Primary Care, Mental Health, or Radiology. The specialty services, however, are typically more heavily dependent upon the availability of capital infrastructure such as access to operating rooms and cardiac catheterization labs; and are more heavily involved in our research mission. The task force has initiated a pilot study in four Veterans Integrated Service Networks (VISN) to gain insight into unique facility characteristics that may affect physician productivity and thereby explain some of the observed variation. For example, surgeons with ready access to Operating Rooms (OR) will likely have higher productivity than those clinicians in an office-based or clinic practice. Moreover, working in operating rooms with efficient scheduling of surgical procedures, expedient room turnover, and adequate OR staff (nursing, anesthesiology) would be expected to impact surgical productivity. Understanding the influence of these local factors, such as adequate support staff ratios for our providers, is an important component of this VISN pilot project.

In addition, OPES is testing and refining new, enterprise-wide solutions for capturing workload that does not impose additional burden on clinicians who are treating Veterans. We believe the results of these pilot programs will provide the essential data needed to establish productivity standards in these specialty areas. VHA will make every effort to account for the unique characteristics of the local facilities in which our specialists practice.

VA is integrating physician productivity data and measures of access to care into a model to guide staffing decisions in specialty care. This approach coupled with measures of quality and the amount of specialty contract care, or non-VA community care, will help VA medical center leaders make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs.

VHA's primary goal is improving the health and well-being of our Veterans. We are reorienting to deliver more proactive, personalized and patient-driven care. In addition to our commitment to establish productivity standards for five specialties by the end of this fiscal year, excluding, Primary Care, Radiology and mental health, we will ensure a plan is in place to establish productivity standards for all specialty care services within three years. We will provide specific training to the leadership of all our health care facilities on how to utilize the data from the Physician Productivity Cube. We will provide medical facility directors more specific guidance on how to develop staffing plans and ensure medical facility management reviews them annually to ensure optimal efficiency.

In the process of introducing these changes, VHA will ensure that Veterans continue to have access to the highest quality primary and specialty care.

Mr. Chairman, this concludes my testimony. We appreciate the opportunity to appear before you today to discuss this important issue. My colleagues and I are prepared to answer your questions.

Materials Submitted For The Record

Congressional Hearing Deliverables

Date: March 13, 2013

Source: Hearing before the House Committee on Veterans' Affairs, Subcommittee on Health, "Meeting Patient Care Needs: Measuring the Value of VA Physician Staffing Standards" (Physician Productivity Standards)

Question from: Congresswoman Julia Brownley, Ranking Member

- Provide Plan for Completion of Productivity Standards for Specialty Physicians.

Response:

The Veterans Health Administration (VHA) will establish productivity standards for five specialties in fiscal year (FY) 2013 and the remaining specialties by October 2015 (end of FY 2015). To this end, the Specialty Physician Productivity and Staffing Task Force (Task Force) will leverage the extensive work VHA has already completed in building the necessary data sources to measure specialty physician productivity and staffing in an ongoing and systematic way.

The primary data source that will be used to assess Specialty Physician Productivity and Staffing in VHA will be the Physician Productivity Cube (PPC). PPC is an analytical tool that uses ProClarity Analytics software and provides users the ability to gain business insight and to investigate changing provider productivity performance and staffing levels. PPC is a critical component to VHA's ability to systematically assess Specialty Physician Productivity and Staffing within VHA and, as such, will continue to be refined and improved upon. The Task Force has and will continue to validate and make recommendations for improvement in this key data source, as well as develop additional tools for local leadership to improve their specialty practices with the ultimate goal of providing high quality, efficient specialty care to our Veteran patients.

To link productivity measurement to staffing standards, the Task Force developed a model that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians. This integrated approach, coupled with measures of quality and the amount of specialty non-VA community care (Fee-Basis care), was proposed to help VA medical center leaders make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs. Productivity data coupled with access measures provides a framework for determining specialty physician staffing. This model

was prototyped for the seven specialties of Cardiology, Gastroenterology, Dermatology, Neurology, Orthopedics, Urology, and Ophthalmology.

Through the use of Veterans Integrated Service Network (VISN) pilots, exstensive stakeholder input will be obtained and considered. VISN pilots (VISN 7, 12, 19 and 22) have been targeted to ensure an appropriate spectrum of U.S. regions (East, Midwest, and West as well as a mix of rural and urban) and practice settings (Medical Center Complexity Group (MCG) Levels) is included, as well as to ensure a core group of VISNs to assist in the diffusion of core competencies in specialty practice management knowledge. The VISN pilots will simulate implementation of productivity standards

(25th and 50th percentiles by specialty and MCG) and, through this, identify business rule gaps and any potential unintended consequences to the efficient delivery of specialty care services to our Veterans. Based on this feedback we will then move forward with the necessary modifications to foundational business rule's and deploy productivity and staffing standards for five specialties to be completed by

September 30, 2013.

VHA established four VISN pilots (VISNs 7, 12, 19, and 22) to simulate implementation of productivity standards for five specialties. These four VISNs were selected because they cover a broad geographic area and cross a number of different practice settings. Productivity standards were established based on 25th percentile and mean for each specialty. VISN pilots focused on reviewing the accuracy of the productivity data, identifying and addressing business rule gaps, and potential unintended consequences to the efficient delivery of specialty care services to our Veterans. Based on this feedback we will then move forward with the necessary modifications to foundational business rules and deploy productivity and staffing standards for five specialties to be completed by September 30, 2013.

Establishment and implementation of RVU-based productivity standards for the remaining medical and surgical specialties, is anticipated to proceed more rapidly once this foundational work is completed for the first five specialties.

There are three hospital-based specialty areas, Emergency Medicine, Anesthesiology, and Laboratory and Pathology that will require a slightly different approach to physician staffing. Emergency Medicine staffing must be adequate to ensure 24/7 coverage for VA Emergency Departments and Urgent Care Centers. Anesthesiology staffing must be adequate to ensure safe staffing for all operating rooms. Laboratory and Pathology staffing must ensure safe staffing for VA laboratories, pathology, and blood banks. VHA has established individual working groups for each of these specialties to develop alternatives to RVU-based productivity models.

The following summary of VHA's operational plan details the actions planned and in process to accomplish implementation of productivity standards for Specialty Physicians:

Stage I: Four VISN Pilots focusing on seven specialties. **Target date for completion: July, 2013**

- Office of Productivity, Efficiency and Staffing (OPES) establish preliminary productivity standards (25th and 50th percentile for Medical Center Complexity Group (MCG) Level) for the Specialties of: Cardiology, Gastroenterology, Neurology, Dermatology, Ophthalmology, Urology and Orthopedics in VISN Pilots.

Status: Completed for all seven specialties and all MCG levels.

- OPES develop and refine specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for Medical Center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs.

Status: Quadrant tool developed for all seven specialties.

- OPES develop methodology for capturing professional services associated with inpatient care for medical specialties.

Status: Methodology developed and workload estimated for all medical specialties.

- OPES provide preliminary productivity standards for the seven specialties for all VISN Pilot sites and identify outliers falling below 25th and 50th percentiles.

Status: Completed.

- VISN Pilots simulate productivity standard implementation and review factors associated with productivity outliers such as inconsistent application of foundational business rules (person class designation, labor deployment, and

professional workload capture) and modify business rules accordingly. See Appendix A.
Status: In process. Target date for completion: June 2013.

- VISN Pilots review OPES methodology for capturing professional services associated with inpatient care for accuracy and inclusion in productivity assessment.

Status: In process. Target date for completion: July 2013.

- VISN Pilots review other factors contributing to productivity including practice setting, support staff, specialty demand, contract and FEE Basis care, and coding accuracy.

Status: In process. Target date for completion: July 2013.

- VISN Pilots review and refine specialty management tools (Quadrant Report) and algorithms for assessing specialty physician staffing.

Status: In process. Target date for completion: July 2013.

- Communicate and establish core competencies within Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports).

Status: In process. Target date for completion: July 2013.

Stage II: Establish productivity standards for five specialties across VHA. **Target date for completion: October 2013.**

- Modify and finalize the preliminary productivity standards for at least five of the seven specialties.

Target date for completion: July 2013.

- VISN Pilots communicate and establish core competencies across all VISNs on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports).

Target date for completion: August 2013.

- All VISNs communicate and establish core competencies across all Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports).

Target date for completion: September 2013.

- Health Information Management Service (HIMS) and Compliance and Business Integrity establish procedures to ensure accurate coding for the five specialties.

Target date for completion: October 2013.

- Incorporate specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports into specialty physician staffing assessments for five specialties.

Target date for completion: October 2013.

- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in these five specialties.

Status: In process. Target date for completion: October 2013.

Stage III A: Establish productivity standards and staffing plans for the three hospital-based specialties: Anesthesiology, Laboratory and Pathology Medicine and Emergency Medicine that require core staffing levels. **Target date for completion: October 2015.**

- Establish VA sub-groups to address the three hospital-based specialties: Anesthesiology, Laboratory and Pathology Medicine and Emergency Medicine that require core staffing levels.

Status: Establishment of these subgroups, May 2013.

- Establish preliminary productivity standards and staffing plans for these three hospital-based specialties.

Target date for completion: October 2014.

- VISNs evaluate and refine preliminary productivity standards and staffing plans and communicate and establish core competencies across all VISNs on effective specialty practice management for these three hospital-based specialties.

Target date for completion: January 2015.

- Modify and finalize the preliminary productivity standards and staffing plans for these three hospital-based specialties.

Target date for completion: July 2015.

- Establish and implement productivity standards for these three hospital-based specialties.

Target date for completion: October 2015.

- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in these three specialties.

Target date for completion: October 2015.

Stage III B: Implement RVU-based Productivity Standards for the 22 remaining specialties (Table 1). **Target date for completion: Half the remaining specialties (second-tier) implemented by October 2014; and half the remaining specialties (third-tier) implemented by October 2015.**

- Prioritize and identify second-tier of specialties.

Target date for completion: July 2013.

- OPES establish preliminary productivity standards (25th and 50th percentile for Medical Center Complexity Group (MCG) Level) for the 11 second-tier specialties.

Target date for completion: October, 2013.

- OPES provide preliminary productivity standards for the 11 second-tier specialties for all VISNs and identify outliers falling below 25th and 50th percentiles.

Target date for completion: October 2013.

- OPES refine specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for Medical Center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs to encompass 11 second-tier specialties.

Target date for completion: December 2013.

- VISNs simulate productivity standard implementation and review factors associated with productivity outliers, such as inconsistent application of foundational business rules (person class designation, labor deployment, and professional workload capture), and modify business rules accordingly.

Target date for completion: January 2014.

- All VISNs evaluate and refine preliminary productivity standards and communicate and establish core competencies across all Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports) for the 11 second-tier specialties.

Target date for completion: March 2014.

- Modify and finalize the preliminary productivity standards and staffing algorithms for the 11 second-tier specialties.

Target date for completion: July 2014.

- Establish and implement productivity standards for the 11 second-tier specialties.

Target date for completion: October 2014.

- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in the 11 second-tier specialties.

Target date for completion: October 2014.

- HIMS establish Compliance and Business Integrity procedures to ensure accurate coding for the 11 second-tier specialties implementing RVU-based productivity standards.

Target date for completion: October 2014.

- Incorporate specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports into specialty physician staffing assessments for the 11 second-tier specialties.

Target date for completion: October 2014.

- OPES establish preliminary productivity standards (25th and 50th percentile for Medical Center Complexity Group (MCG) Level) for the 11 third-tier specialties

Target date for completion: October 2014.

- OPES provide preliminary productivity standards for the 11 third-tier specialties for all VISNs and identify outliers falling below 25th and 50th percentiles.

Target date for completion: October 2014.

- OPES refine specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for Medical Center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs to encompass 11 third-tier specialties.

Target date for completion: December 2014.

- VISNs simulate productivity standard implementation and review factors associated with productivity outliers such as inconsistent application of foundational business rules (person class designation, labor deployment, and professional workload capture) and modify business rules accordingly.

Target date for completion: January 2015.

- All VISNs evaluate and refine preliminary productivity standards and communicate and establish core competencies across all Medical Centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube, VHA Specialty Physician Benchmarking Report and Specialty Physician Workforce Reports) for the 11 third-tier specialties.

Target date for completion: March 2015.

- Modify and finalize the preliminary productivity standards and staffing algorithms for the 11 third-tier specialties.

Target date for completion: July 2015.

- Establish and implement productivity standards for the 11 third-tier specialties.

Target date for completion: October 2015.

- Revise VHA Policy Directives and Specialty Handbooks to reflect the establishment of productivity standards in the 11 third-tier specialties.

Target date for completion: October 2015.

- HIMS and Compliance and Business Integrity establish procedures to ensure accurate coding for the 11 third-tier specialties implementing RVU-based productivity standards.

Target date for completion: October 2015.

- Incorporate specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports into specialty physician staffing assessments for the 11 third-tier specialties.

Target date for completion: October 2015.

Table 1.

Aggregate Specialty	Total Worked FTE	MD Worked FTE (Clinical)	Imputed Fee & Contract MDFTE	% Total FTE	Status:
Internal Medicine	5043.48	4436.93	542.71	33.77%	Complete
Psychiatry	2147.69	1810.94	96.49	14.38%	Complete
Radiology	829.96	711.16	282.07	5.56%	Complete
Anesthesiology	553.89	491.62		3.71%	
Cardiology	505.12	419.39	40.51	3.38%	
Surgery	462.48	375.10	76.12	3.10%	
Physical Medicine & Rehabilitation	432.53	354.66	19.01	2.90%	
Geriatric Medicine	413.61	296.51	13.19	2.77%	
Neurology	412.57	302.05	31.17	2.76%	
Critical Care / Pulmonary Disease	410.33	300.24	13.86	2.75%	
Emergency Medicine	398.12	366.63	153.27	2.67%	
Pathology	353.68	276.39	41.14	2.37%	
Gastroenterology	347.11	278.37	41.01	2.32%	
Ophthalmology	293.62	266.39	75.68	1.97%	
Hematology-Oncology	281.29	220.70	12.12	1.88%	
Orthopedic Surgery	257.30	234.36	64.79	1.72%	
Nephrology	245.54	166.75	21.35	1.64%	
Urology	222.37	198.61	52.89	1.49%	
Infectious Disease	212.32	126.40	9.10	1.42%	
Endocrinology	185.66	124.61	8.05	1.24%	
Dermatology	141.21	116.65	35.77	0.95%	
Rheumatology	133.95	93.88	8.92	0.90%	

Table 1.—Continued

Aggregate Specialty	Total Worked FTE	MD Worked FTE (Clinical)	Imputed Fee & Contract MDFTE	% Total FTE	Status:
Otolaryngology	133.72	117.26	29.18	0.90%	
Vascular Surgery	114.82	91.39	18.35	0.77%	
Thoracic Surgery	95.09	76.32	30.04	0.64%	
Plastic Surgery	64.62	58.30	12.12	0.43%	
Neurological Surgery	62.92	50.28	23.47	0.42%	
Obstetrics & Gynecology	57.83	53.63	9.12	0.39%	
Pain Medicine	48.19	40.82	1.90	0.32%	
Preventive Medicine	40.67	32.50	6.55	0.27%	
Allergy and Immunology	31.10	23.50	7.79	0.21%	
Clinical Pharmacology	1.84	1.84	0.07	0.01%	
Medical Genetics	1.10	0.33	0.01	0.01%	
Grand Total	**14,935.71**	**12,514.51**	**1,777.80**	**100%**	

Appendix A.

Specialty Practice Review Sheet

Step 1: Open the Proclarity Briefing Book to get Provider-specific Productivity data for each specialty.

Step 2: Check Person Class Status for your Providers:
- Ensure all contributing Providers are included.
- Ensure no contributing Providers are excluded.
- For any inclusions or exclusions, check the Provider Person Class and make corrections via your service ADPAC.
- Report any change made.

Step 3: Evaluate workload to ensure that RVUs counts are consistent with expected results.
- Investigate any apparent under or over-counting of workload.
- Evaluate if there are problems with inpatient workload capture. Would it make a difference in what you do
- Evaluate if there are problems with resident workload capture.
- Evaluate if there is a problem with coding of workload.
- Report any changes you made.

Step 4: Evaluate the assigned MD FTEE in the Productivity Cube for each Provider.
- Navigate this Excel workbook to the tab for this Specialty. It includes your current dSs mapping as of PP2.
- Compare current mapping to the cube to determine whether there are obvious discrepancies.

Step 5: For each provider for whom you would map research, admin, or teaching time, navigate to the Tab in this worksheet with the business rules for mapping their time. You are only required to re-map providers who you are assigning protected time for Administration, Research, or Education. You may copy the Tabs to create separate mappings for each Provider that you can use for reference. These new rules were developed as working drafts by assigned SME so that we can apply consistent and rigid allocations of protected time. Review all the Providers in this specialty and re-map on the spreadsheet using the new rules.
- If you are going to allocate discretionary time, identify that time separately in the mapping worksheet. This time will be considered above ceiling and comments must be included to justify the mapping.
- Evaluate changes in mapping and consider the impact on productivity.
- Identify any concerns you had about the business rules and how to apply them.
- Check the assigned direct patient care time. Ensure that there are active clinics or inpatient assignments that match the level of effort assigned.
- Report any changes you made.

Step 6: Review whether you have an Access problem using specialty-specific productivity measures and the preliminary productivity standards.
- Specialties should not have low productivity and access problems.
- Specialties with low productivity and no access problems should consider rebalancing resources.
- Sites should explain variance from the above assumptions.

Step 7: Provide a Summary Review of each specialty.

- Assess whether your review resulted in any changes that would impact the productivity calculation.
- Assess any other facility-specific issues that impact your specialty that should be considered in the productivity calculation.
- Include other comments for consideration to include any ideas you have for improving our process for evaluating productivity.
- Provide an action plan that would implement any positive steps you would take to improve the productivity of your specialty.

Step 8: Save this worksheet and upload it, along with all of your other Specialty areas selected for review, to the SharePoint site XXXX and send an email confirming that the upload was completed to the VISN office with a copy to XXX by COB XXX. If you have any questions, please contact XXX.

Questions For The Record

Letter From: Hon. Dan Benishek, Chairman, Subcommittee on Health, To: Veterans Health Administration

March 25, 2013

Madhulika Agarwal M.D., M.P.H.
Deputy Under Secretary for Health for Policy and Services
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Agarwal:

On Wednesday, March 13, 2013, you testified before the Subcommittee on Health during an oversight hearing entitled, "Meeting Patient Care Needs: Measuring the Value of VA Physician Staffing Standards." As a follow-up to that hearing, I request that you respond to the attached questions and provide the requested materials in-full by no later than close of business on Friday, April 26, 2013.

If you have any questions, please contact Dolores Dunn, Staff Director for the Subcommittee on Health, at *Dolores.Dunn@mail.house.gov* or by calling (202) 225–9154.

Your timely response to this matter is very much appreciated.

Sincerely,

DAN BENISHEK M.D.
Chairman
Subcommittee on Health

Questions From: Hon. Dan Benishek, Chairman, Subcommittee on Health, Hon. Tim Huelskamp, and Hon. Jackie Walorski, To: Veterans Health Administration

Questions from Hon. Dan Benishek, Chairman

1. In response to a question from Ranking Member Brownley regarding how VA productivity standards compare to private sector productivity standards, you stated that, " . . . our productivity levels are best measured by like specialties and like facilities . . . " However, the December 2012 Department of Veterans Affairs (VA) Inspector General (IG) Audit of Physician Staffing Levels for Specialty Care Services describes a situation where a facility classified as "1a" had .8 Full-Time Equivalent (FTE) providing endocrinology care to 1,053 unique patients for a total of 1,627. Meanwhile, a facility also classified as "1a" had .4 FTE that provided endocrinology care to 1,347 unique patients for a total of 2,286 encounters. How do you account for such widespread disparities in efficiency among VA medical facilities of a similar size, complexity level, and patient population and what steps are you taking to address such inefficiencies? Please be specific.
2. Please provide the current physician-to-support-staff ratio at each VA medical center.
3. Regarding the pilot programs that have been initiated in Veterans Integrated Service Networks (VISNs) 7, 12, 19, and 22, please provide the following: (1) start-

ing and ending dates for the pilot programs: (2) the criteria used to choose the four selected VISNs for the pilot programs; (3) the criteria and/or any other standards used to measures the pilot program's performance; (4) any and all guidance sent to the field regarding the pilot programs; and, (5) information regarding the pilot program's implementation and status to-date.

4. According to the IG, none of the five VA medical facilities visited during the December 2012 audit used the Physician Productivity Cube. What actions have been taken to-date and/or what actions are planned for the future to inform and educate VA medical facility leaders about the Cube's existence and intended use?

5. What actions has VA taken and/or is VA planning to take to provide medical facilities with more specific guidance on how to develop appropriate staffing plans? Please provide a copy of any and all such guidance that has been issued to the field to-date.

6. What justification is required when a VA medical facility requests additional staff and what oversight is conducted at the facility, VISN, and VA Central Office levels when staffing decisions are being made? Please be specific.

7. What are the five additional specialties that VA will establish productivity models for in coming year?

8. Under the Primary Care Panel Size Staffing Model, how many active patients may be assigned to each primary care provider and why? Please be specific.

9. When will VA distribute the, "Productivity Guidance for Mental Health Providers?" Will you provide the Subcommittee with a copy of that directive when it is complete?

10. The IG suggested developing a staffing model based on best practices. Currently, does VA have the capability to capture and track the necessary information to develop such a staffing model? If so, explain in detail what systems are in place and how VA captures, tracks, and uses such information now.

11. How does the VA define an "encounter?"

Question from Congressman Tim Huelskamp

1. Please provide an update regarding the Liberal, Kansas Community-based Outpatient Clinic, which is currently operating without either a doctor or a nurse practitioner. The facility has not had a nurse practitioner for over two years and has been without a doctor since December 2011 – almost fifteen months. Please provide an explanation for these vacancies and list any and all actions taken to-date to fill them in order to provide care for veterans in Liberal and the greater Western Kansas community.

Questions from Congresswoman Jackie Walorski

1. In your testimony, you acknowledge that VA is primarily concerned with improving the health of veterans and in reorienting the system towards delivering more "proactive, personalized and patient-driven care." Can you explain how we are to believe this when the VA has failed to make simple changes based upon recommendations going back as far as 1981?

2. Why has the VA failed to implement physician staffing standards knowing how detrimental this is to providing quality care to our veterans?

3. When reading the December 27, 2012, IG audit, did you find it alarming that certain specialties were understaffed, therefore, significantly increasing patient risk? Why or why not?

4. Without appropriate staffing standards and procedures in place, how does VA evaluate physician productivity? Do you agree that such evaluations are necessary for ensuring proper patient care as well as making sure VA dollars are spent appropriately? Why or why not?

Questions and Responses From: Veterans Health Administration, To: Hon. Dan Benishek, Chairman, Subcommittee on Health, Hon. Tim Huelskamp and Hon. Jackie Walorski

1. In response to a question from Ranking Member Brownley regarding how VA productivity standards compare to private sector productivity standards, you stated that, "...our productivity levels are best measured by like specialties and like facilities..." However, the December 2012 Department of Veterans Affairs (VA) Inspector General (IG) Audit of Physician Staffing Levels for Specialty Care Services describes a situation where a facility classified as "1a" had .8 Full-Time Equivalent (FTE) providing endocrinology care to 1,053 unique patients for a total of 1,627. Meanwhile, a facility also classified as "1a" had .4 FTE that provided endocrinology care to 1,347

unique patients for a total of 2,286 encounters. How do you account for such widespread disparities in efficiency among VA medical facilities of a similar size, complexity level, and patient population and what steps are you taking to address such inefficiencies? Please be specific.

RESPONSE: A comparison of productivity or efficiency based solely upon the number of unique patients treated and the number of patient encounters is problematic. To accurately compare productivity and efficiency requires a measure that accounts for the complexity and intensity of services provided during those encounters, as well as consideration of factors such as support staff levels. Accordingly, the Veterans Health Administration (VHA) is utilizing Relative Value Units (RVU) to more accurately compare the productivity and efficiency of specialty physician services. Because each encounter generates a specific Current Procedural Terminology code that can be associated with a RVU, it is possible to ensure that comparisons of productivity and efficiency can be made.

We, too, have concerns about the variations depicted in the Inspector General's (IG) report. To that end, we designed a Veterans Integrated Service Network (VISN) Pilot to help us understand and remediate inefficiencies. The effort is focused on: (1) addressing the issues of accurate coding and workload capture; (2) consistent application of business rules to account for physician time of effort associated with direct patient care, research, medical education, and administrative responsibilities; and (3) capture of resident workload and association of that workload to supervising Department of Veterans Affairs (VA) staff physicians across seven specialties.

2. Please provide the current physician-to-support-staff ratio at each VA medical center.

Response: Within VHA there are over three dozen physician specialties practicing in a variety of settings (Medical Center Complexity Levels, Community-Based Outreach Clinics (CBOC), etc.). There is no one support staff ratio that will fit every practice. However, benchmarks can assist local managers in developing adequate support staff levels. VHA maintains such benchmarking tools by specialty and complexity level in the Specialty Physician Workforce Reports. The Specialty Physician Workforce Reports provide a benchmark for a clinic or 'office-based' practice. For example, in fiscal year (FY) 2012, an Orthopedic Surgery clinic in VHA had a support staff ratio of 1.42 per 1.0 Orthopedic Surgeon; whereas an Ophthalmology Clinic had a support staff ratio of 2.59 per 1.0 Ophthalmologist. VISN pilots are currently evaluating support staff ratios as part of the work underway in establishing FY 2013 specialty productivity standards. It should be noted that because most outpatient specialty practices share support resources as their duties include both outpatient clinics and inpatient services and procedures, variation exists within the labor mapping assignments of these support staff among the different specialty practices they support. This creates variation between practices, when compared at the national level that results from the labor mapping within the VHA Decision Support System. VISN pilots will seek to understand and manage this variation.

3. Regarding the pilot programs that have been initiated in Veterans Integrated Service Networks (VISN) 7, 12, 19, and 22, please provide the following: (1) starting and ending dates for the pilot programs; (2) the criteria used to choose the four selected VISNs for the pilot programs; (3) the criteria and/or any other standards used to measures the pilot program's performance; (4) any and all guidance sent to the field regarding the pilot programs; and, (5) information regarding the pilot program's implementation and status to date.

Response: The four VISN Pilots (VISN 7, 12, 19, and 22) were selected to ensure an appropriate spectrum of U.S. regions (South, East, Midwest, and West, as well as a mix of rural and urban) and practice settings (Medical Center Complexity Group (MCG) Levels) are included, as well as to ensure a core group of VISNs can assist in the diffusion of core competencies in specialty practice management knowledge.

The four VISN Pilots began focusing on seven specialties in January 2013 with a target date for completion by October 2013. They were tasked with simulating productivity standards implementation and reviewing factors associated with productivity outliers such as inconsistent application of foundational business rules (person class designation, labor deployment, and professional workload capture) and modifying business rules accordingly.

VISN Pilots were also tasked with: (1) reviewing the Office of Productivity, Efficiency, and Staffing (OPES) methodology for capturing professional services associated with inpatient care for accuracy and inclusion in productivity assessment; (2) reviewing other factors contributing to productivity including practice setting, sup-

port staff, specialty demand, contract and Fee Basis Care, and coding accuracy; (3) reviewing and refining specialty management tools (Quadrant Report) and algorithms for assessing specialty physician staffing; and (4) communicating and establishing core competencies within medical centers on effective specialty practice management inclusive of use of tools (Physician Productivity Cube (PPC), VHA Specialty Physician Benchmarking Report, and Specialty Physician Workforce Reports).

To assist the VISN Pilots, OPES: (1) established preliminary productivity standards (25th percentile and mean values for MCG Level) for the Specialties of: Cardiology, Gastroenterology, Neurology, Dermatology, Ophthalmology, Urology, and Orthopedics in VISN Pilots; (2) developed and refined specialty practice management tools (Quadrant Report) and Specialty Physician Workforce Reports that integrate productivity and access measures for medical center leadership to critically assess specialty physician staffing and make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs; (3) developed a methodology for capturing professional services associated with inpatient care for medical specialties; and, (4) provided preliminary productivity standards for the seven specialties for all VISN Pilot sites and identified outliers falling below 25th percentile and mean values.

The attached operational plan details specific actions already completed and guidance for VISN Pilots to review productivity data, as well as goals and target dates for completion.

4. According to the IG, none of the five VA medical facilities visited during the December 2012 audit used the Physician Productivity Cube. What actions have been taken to-date and/or what actions are planned for the future to inform and educate VA medical facility leaders about the Cube's existence and intended use?

Response: All sites have access to PPC and with each quarterly update an e-mail distribution to all users inclusive of Chiefs of Staff and Chief Medical Officers are notified of the cube update. More recently, medical center directors have been added to this e-mail distribution.

The attached operational plan details specific actions related to informing and educating VA medical facility leaders about the PPC and its intended use. Specifically, VISN Pilots will communicate and help to establish core competencies across all VISNs on effective specialty practice management tools (and reports including PPC, VHA Specialty Physician Benchmarking Report, and Specialty Physician Workforce Reports).

In addition, attached are Web-hit reports for PPC as well as the briefing books.

5. What actions has VA taken and/or is VA planning to take to provide medical facilities with more specific guidance on how to develop appropriate staffing plans? Please provide a copy of any and all such guidance that has been issued to the field to-date.

Response: To link productivity measurement to staffing standards, VA developed a Web-based tool that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians. This integrated approach, coupled with measures of quality and the amount of specialty non-VA community care (Fee-Basis care), was proposed to help VA medical center leaders make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs. Productivity data coupled with access measures provides a framework for determining specialty physician staffing. This model was prototyped for the seven specialties of Cardiology, Gastroenterology, Dermatology, Neurology, Orthopedics, Urology, and Ophthalmology.

The idealized staffing model considers:

- The productivity of the specialty practice or service; and
- The performance (access and quality) standards.

Specialty physician staffing could be defined as adequate when both:

- The specialty practice's productivity falls within an acceptable productivity range; and,
- Access to the specialty service by Veterans meets VA waiting time performance standards.

When access performance standards (waiting times and waiting lists) and Quality standards are not being met at a particular site, facilities should determine whether access imbalance is related to:

- Inadequate individual provider productivity;
- Inadequate systems to support high productivity, such as support staff, infrastructure; or

• Inadequate specialty physician supply.

The attached operational plan details efforts VA has completed including the development of a Quadrant tool, algorithms, and practice reports that VISN Pilots will test and refine for the seven specialties.

6. What justification is required when a VA medical facility requests additional staff and what oversight is conducted at the facility, VISN, and VA Central Office levels when staffing decisions are being made? Please be specific.

Response: There are three distinct processes, based on the grade level, which guide the approval of new positions. The separate processes are for:

- Grades GS–14 or lower, with the exception of GS–14 Associate/Assistant Directors;
- GS–15 and GS–14 Assistant/Associate Directors; and
- Senior Executive Service (SES) positions.

VA medical center (VAMC) leadership approves positions at the GS–14 level and below, with the exception of GS–15 and GS–14 Assistant and Associate Director positions. The VAMC Resources Management Committee (RMC) reviews requests for additional staffing allocations. These requests must include detailed justifications submitted by the initiating organization. Some examples of this information include supporting clinical and administrative workload, the impact the additional staffing request to alleviate workload issues, and cost and any additional data needed for RMC deliberation. If the RMC endorses the request, it is then forwarded to the medical center director for final approval. Oversight at the VISN and VA Central Office levels is primarily focused on the cumulative budget expenditures for overall salaries.

GS–15 and GS–14 Assistant and Associate Medical Center Director positions are reviewed by the Leadership Management and Succession Subcommittee (LMSS). LMSS is a subcommittee of the VHA National Leadership Council's Workforce Committee, responsible for reviewing and submitting the nomination packages for the Under Secretary for Health (USH) approval.

The USH has indicated that senior executive positions are one of the most significant resource issues VHA faces. The USH uses both SES and Title 38 SES equivalent executive positions to assist in carrying out VHA's mission to honor America's Veterans by providing exceptional health care that improves their health and well-being. The USH approves all VHA selections that are forwarded to the Secretary of VA, who maintains centralized final approval authority for all executive appointments.

VHA has established a comprehensive executive recruitment process through the partnership between VA Corporate Senior Executive Management Office (CSEMO) and VHA's Executive Recruitment Office. This collaboration utilizes the direct involvement of both VA and VHA senior leadership. The VA Chief of Staff meets weekly with VHA leaders to review the status of each senior executive vacancy. These meetings expedite the hiring process and ensure that VHA is recruiting the best qualified candidates for leadership positions. Additionally, VHA leadership meets weekly with CSEMO to develop strategies and action plans that improve the executive hiring process.

7. What are the five additional specialties that VA will establish productivity models for incoming year?

Response: In FY 2013, productivity standards are being established for the specialties of Gastroenterology, Dermatology, Neurology, Orthopedics, and Urology.

8. Under the Primary Care Panel Size Staffing Model, how many active patients may be assigned to each primary care provider and why? Please be specific.

Response: VHA policy detailing expected panel sizes for primary care clinics is documented in VHA Handbook 1101.02 Primary Care Management Module. Panel size determination is calculated based on patient characteristics of the Veteran population, reliance on VHA, staff, space and local determination. Expected panels for VHA primary care (patient-aligned care teams) physicians largely fall in the range of 1,000 to 1,400. Veterans from special populations (e.g., women's health, elderly, end-stage renal disease, Veterans returning from combat) may require additional time and resource-intensive care management and care coordination to provide high quality care. Nurse practitioners and physician assistants are expected to have a panel size of 75 percent of a physician's panel.

9. When will VA distribute the "Productivity Guidance for Mental Health Providers?" Will you provide the Subcommittee with a copy of that directive when it is complete?

Response: The directive entitled "Productivity Guidance for Mental Health" is in the final stages of VHA's approval process, and we anticipate that it will be published in July 2013. A copy of the directive will be provided to the Subcommittee upon publication.

10. The IG suggested developing a staffing model based on best practices. Currently, does VA have the capability to capture and track the necessary information to develop such a staffing model? If so, explain in detail what systems are in place and how VA captures, tracks, and uses such information now.

Response: Specialty-specific "best practices" data are now available via the PPC for productivity performance; when coupled with access measures, in the Practice Management Tool, VHA can identify "optimized specialty practices" given these two dimensions.

The 'penultimate' staffing model includes specialty-specific patient quality and/or outcomes data. Currently, both within VHA and externally, data are not mature enough to handle the necessary specialty physician attribution necessary in such a model. Much work, again within VHA and externally, is necessary. Currently, the Center for Medicare and Medicaid Services (CMS), through such systems as the Patient-Centered Episode System, are working to consider episodes as they occur and interact at the patient level. Allocating services when there are concurrent episodes that overlap and require multiple specialist physicians to treat a single patient is very complex, but this allocation is necessary to ultimately understand the value of our specialist workforce.

11. How does the VA define an "encounter?"

Response: An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating, and/or treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or those accomplished via telemedicine technology. Source: VHA Directive 2009–002.

Questions from Congressman Tim Huelskamp

1. Please provide an update regarding the Liberal, Kansas Community-Based Outpatient Clinic, which is currently operating without either a doctor or a nurse practitioner. The facility has not had a nurse practitioner for over two years and has been without a doctor since December 2011 – almost fifteen months. Please provide an explanation for these vacancies and list any and all actions taken to-date to fill them in order to provide care for veterans in Liberal and the greater Western Kansas community.

Response: The Robert J. Dole VAMC identified two critical issues in provider staffing challenges. These include hiring specialists for the main campus in Wichita, Kansas, and hiring a provider for the Liberal, Kansas, CBOC.

The Dole VAMC designed plans to expand specialty capability in alignment with the VISN 15 Strategic Plan and in concert with the University of Kansas-Wichita School of Medicine. To date, specific successes lie in expansion of Orthopedic Surgery, Pain Management, and initiation of a Spine Service including both operative and non-operative management. Other established specialties remain stable with plans for overall growth in the medical center.

The acquisition of physician or mid-level provider coverage at the Liberal CBOC presented challenges. Since March 2012, the VA Healthcare Recruitment Consultant in Leavenworth, Kansas, has sent 20 broadcast e-mails to focused physician groups to solicit interest in the Liberal CBOC. Five physicians responded to the marketing efforts. Two accepted offers with one of the two later declining. The second candidate is currently in the hiring process, with an anticipated start date of summer 2013.

To provide services for the 175 Veterans enrolled in the Liberal CBOC, the medical center plans include:

- Wichita campus Advanced Practice Registered Nurse provides telemedicine coverage every Wednesday;
- Parsons CBOC Advanced Practice Registered Nurse provides telemedicine coverage every Thursday and two Fridays monthly;
- Continue current staff at the Liberal CBOC (one Registered Nurse, one Licensed Practical Nurse, and one receptionist) daily for triage and patient assist-

ance. For the days without scheduled telemedicine coverage, a designated provider at the Wichita main campus supports the Liberal staff. Regular physician on-site coverage is anticipated in the summer of 2013. With this hire, the physician will be stationed part-time at Liberal but available by telemedicine when off-site at the Hutchison CBOC.

A decision to hire a J–1 physician was made as all attempts to hire a United States citizen and permanent candidates for Liberal over the last couple of years have been exhausted. The candidate was selected February 2013 and accepted the position; the provider will work part-time in Liberal and part time in the Hutchinson clinic. The physician is expected to start at the clinic in a few months, depending on the amount of time the administrative process will take. In the meantime, coverage has been via telemedicine services from other Primary Care clinics to meet the patient care needs at the Liberal CBOC.

- Human Resource staff continues to work with the National VHA Recruitment consultant, Mr. James Marfield, to hire a full-time provider for the Liberal clinic.

Questions from Congresswoman Jackie Walorski

1. In your testimony, you acknowledge that VA is primarily concerned with improving the health of veterans and in reorienting the system towards delivering more "proactive, personalized and patient-driven care." Can you explain how we are to believe this when the VA has failed to make simple changes based upon recommendations going back as far as 1981?

Response: VA has already established productivity standards for more than half (54 percent) its physicians; has been analyzing and reporting RVU productivity data for all specialists since 2008; and has committed to establishing productivity standards for five specialties by the end of this year. The Specialty Physician Productivity and Staffing Task Force (Task Force) has concentrated on establishing RVU-based productivity standards for seven additional specialties representing an additional 15 percent of VHA's physician workforce, so that by the end of FY 2013, more than two-thirds of physicians in VA will have productivity standards.

Primary Care, the largest component of our physician workforce (34 percent), has been employing a panel model for standardizing productivity and staffing in primary care since 2004. Mental Health, the second largest component of our physician workforce (14 percent), has developed a productivity model that will be implemented this year. Radiology, the third largest component of our physician workforce (6 percent), has employed an RVU-based productivity model that has set a productivity standard of 5,000 RVUs/Full-Time Equivalent (FTE) since 2008 directive.

VA has already established a system for collecting, analyzing, and reporting RVU productivity data for all medical specialties. In 2007, VA established OPES and in 2008 began reporting physician productivity using RVUs. VA has provided specialty physician productivity data utilizing RVUs on the VA Intranet PPC to VA managers since 2008. The productivity data utilized by the IG was derived from this VA physician productivity report.

In developing the primary care staffing model that was implemented in 2004, our goal was to establish a primary care system that balances productivity with quality, access, and patient service. In addition, the staffing model permits VHA to measure the overall productivity of primary care providers and the capacity of our system, in order to understand and inform our primary care staffing needs. Currently, we are completing the process of updating that model to reflect changes associated with VHA's deployment of patient-aligned care teams at all our sites of care.

The second largest component of our physician workforce is our mental health providers. Psychiatrists now account for 14 percent of VA's physician workforce. Mental Health has experienced unprecedented growth in the past 2 years—driven by sharply increasing demand for mental health services. VHA has comprehensively studied our mental health provider resources to ensure that they are optimally deployed and used. We will be distributing a directive providing guidance for facilities to support this objective titled, "Productivity Guidance for Mental Health Providers," by July 2013.

While many private sector health care organizations use the industry-accepted metric of work RVUs (wRVUs) to determine productivity, wRVUs also are used in academic and private practices to determine physician compensation. VHA intends to expand the use of wRVUs as only one of several measures to assess the productivity and efficiency of each specialty practice area throughout the organization.

Radiology, the third largest component of our physician workforce (nearly 6 percent of the total workforce), offers a good example of how wRVUs can be used to

set productivity levels. A comprehensive study of the productivity of VA radiologists was performed in FY 2005 and radiology productivity standards were implemented in 2008.

In June 2012, VA established a task force to recommend and establish productivity standards in five specialties by the end of FY 2013, and to develop a plan to ensure that all specialties have productivity standards by the end of FY 2015. To link productivity measurement to staffing standards, the Task Force developed a Web-based tool that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians. This integrated approach, coupled with measures of quality and the amount of specialty non-VA community care (Fee-Basis Care), was proposed to help VAMC leaders make informed decisions on the appropriate numbers of specialty physicians to meet patient care needs. Productivity data coupled with access measures provides a framework for determining specialty physician staffing. This model was prototyped for the seven specialties of Cardiology, Gastroenterology, Dermatology, Neurology, Orthopedics, Urology, and Ophthalmology.

2. Why has the VA failed to implement physician staffing standards knowing how detrimental this is to providing quality care to our veterans?

Response: Productivity standards are not the same as physician staffing standards. Although wRVUs are increasingly being employed in the private sector to measure physician productivity, physician staffing standards only exist for just a few of the more than 36 physician specialties. Staffing standards typically are only applied to hospital-based 24/7 services such as Emergency Medicine and Hospitalists. These specialties represent a very small fraction of VHA's physicians. For hospital care, the most critical staffing requirements for ensuring quality care to Veterans are nursing staffing standards since nurses are at the very front line of health care delivery and provide 24/7 care to inpatients. VA has well-established nursing staffing standards that are specific for the location of care (psychiatry, medicine, surgery, intensive care, etc.) in place for all VAMCs.

Specialty physician productivity standards and physician staffing are complex issues. Multiple variables influence both. Productivity is an essential component to evaluate staffing but managers need to incorporate other contributing factors such as access, clinical setting and support staff, and patient needs to assess specialty physician staffing levels. VA has created a framework that integrates specialty productivity data and access measures to guide staffing decisions. This approach coupled with measures of quality and non-VA community care will help VAMC leaders make informed decisions on the appropriate number of specialty physicians to meet our Veteran's needs and provide quality care.

3. When reading the December 27, 2012, IG audit, did you find it alarming those certain specialties were understaffed, therefore, significantly increasing patient risk? Why or why not?

Response: The IG audit examined productivity based upon wRVUs. As part of the audit, the IG noted variation in productivity—identifying both low and high outliers in terms of productivity or RVU generation per clinical FTE for various specialties. The IG did not equate either decreased productivity or increased productivity to either understaffing or overstaffing. Determining appropriate levels of specialty physician staffing from productivity is much more complex. For example, high productivity might mean that specialty physician staffing is appropriate and physicians are working hard and being clinically productive. High productivity could also mean that specialty physician staffing is inadequate and physicians are working hard to compensate for being short-staffed. Moreover, high productivity could potentially mean that specialty physician staffing is adequate and physicians are working hard but other factors are contributing to physicians feeling harried (inadequate support staff, clinic inefficiency, and excessive clinical demand due to inappropriate specialty referrals). A simple measure of productivity alone (RVUs/FTE) cannot discriminate between these different scenarios.

Conversely, low productivity could mean that specialty physician staffing is excessive or it could mean that physician staffing is appropriate but productivity is being limited due to inadequate support staff or clinic inefficiency. Our understanding is that the IG did not examine these other contributing factors and did not equate high or low productivity to understaffing.

Adequate staffing results when supply of clinical services is adequate to meet demand. However, demand for clinical care is also complex. The demand for clinical services varies across the United States and this variation in care is not limited to VA. In some parts of the country, there is sufficient care, while in other areas care is limited. In some cases, the amount of care provided in the United States is driven

not by need, but by local availability and local practices. More care does not necessarily equal higher quality and improved outcomes. In fact, former CMS administrator Donald Berwick M.D., estimated that 20–30 percent of all health spending was of no benefit to patients, and a coalition of 25 medical specialty societies and 15 consumer organizations have recently launched a national campaign to reduce use of more than 100 overused tests and treatments. Ironically, "doing less" takes more time than "doing more" (e.g., explaining to a patient why antibiotics are unnecessary and might be harmful rather than simply writing a prescription).

Measures of access (waiting times) represent the balance of the demand for care and the availability of care. Within VA, there was no correlation between productivity and access—specialties with long waiting times were as likely to have average productivity levels as they were to have below average productivity levels.

4. Without appropriate staffing standards and procedures in place, how does VA evaluate physician productivity? Do you agree that such evaluations are necessary for ensuring proper patient care as well as making sure VA dollars are spent appropriately? Why or why not?

Response: VHA believes it is essential to ensure that all employees within our Administration, including our physicians, are able to work as effectively as possible to provide appropriate, high-quality care and services and meet the needs of Veterans. VHA currently uses both population-based (primary care physicians) and work value-based (specialist physicians) models to assess physician productivity. VHA is committed to establishing appropriate productivity models for five additional specialties by the close of this FY. Over the next 3 years, we will refine and develop additional models that are individualized for specialty care.

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