

EVALUATING VA PRIMARY CARE DELIVERY,
WORKLOAD, AND COST

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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EVALUATING VA PRIMARY CARE DELIVERY, WORKLOAD, AND COST

Thursday, October 22, 2015

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

The subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Bilirakis, Roe, Huelskamp, Coffman, Wenstrup, Abraham, Takano, Ruiz, and Kuster.

Also Present: Representative Walorski.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Dr. BENISHEK. The subcommittee will come to order.

Before we begin, I would like to ask unanimous consent for our friend and colleague and member of the full committee, Congresswoman Jackie Walorski, to sit on the dais and participate in today's hearing. And she will be joining us shortly. Without any objection, so ordered.

Thank you all for joining us for today's subcommittee hearing Evaluating VA Primary Care Delivery, Workload, and Cost.

During today's hearing, we will be discussing the findings and recommendations of a Government Accountability Office report regarding the primary care that is provided to veteran patients at Department of Veterans Affairs' medical facilities across the country.

I was glad to join many of my fellow committee members in requesting this report which will be publicly released today and I commend the GAO for their work.

During their investigation, the GAO found the department lacked reliable data on how many patients VA primary care providers were seeing. The GAO also found that VA had failed to put appropriate oversight processes in place to verify whether the primary care data that the VA medical facilities were reporting was accurate or to monitor the primary care that was being provided to veteran patients.

For six of the seven VA medical facilities that the GAO visited, panel size varied from a low of a thousand patients per provider to a high of 1,338 patients per provider. The GAO found that the cost of the care in VA primary care clinics also varied widely.

VA has been unable to respond to repeated requests for cost of care information by me and other members of this committee for more than a year now.

But the GAO found that in fiscal year 2014, VA expenditures per primary care encounter ranged from a low of \$150 to a high of \$396 across the system and expenditures per patient ranged from a low of \$558 to a high of \$1,544.

Data inaccuracies, oversight, and management failures and a lack of continuity or uniformity in care or costs across the country have sadly come to characterize the VA healthcare system over the last several years.

Nonetheless, the GAO findings are alarming. For many veteran patients, an appointment with the primary care clinic is the first appointment they have at a VA medical facility. For them, primary care is the gateway to VA care.

Without accurate data and effective oversight, the VA cannot guarantee that VA primary care providers are productively providing high-quality care or that veteran patients are receiving timely access to care. And without minimizing variations in costs across the system, the VA cannot guarantee that primary care is being delivered efficiently from VA facility to VA facility.

My suspicion based on my 20 years of work as a contract physician at a rural VA medical center and three years as chairman of this subcommittee is that primary care is not being provided efficiently or effectively at far too many VA medical facilities and as a result, far too many of our veterans are falling through the cracks.

Meanwhile, software that could have addressed some of VA's primary care data reliability issues were shelved after the department had spent almost \$9 million on it supposedly because of a lack of the one and a half million dollars in funding that was required to implement it nationally.

What is more, the department plans to take until September of 2016 to issue new primary care guidance and until September of 2018 before findings and decisions regarding primary care encounter and expenditure data to strengthen primary care monitoring will be made.

That is unacceptable particularly considering that GAO reported that some providers at facilities with high panel sizes have already expressed to VA medical center leadership that their ability to provide safe and effective patient care was being hindered by their workload.

The VA must take action today to protect VA primary care patients and to help VA doctors and nurses provide higher quality care to our Nation's veterans.

I will now yield to Mr. Takano who is sitting in today for our ranking member, Ms. Brownley, for any opening statement he may have.

OPENING STATEMENT OF HON. MARK TAKANO

Mr. TAKANO. Thank you, Mr. Chairman, for calling this hearing. Thank you.

Today the subcommittee is looking at the efficiency and effectiveness of the department's ability to deliver primary care to veterans enrolled in VA's primary care.

Since 2010, VA has provided primary care services through a patient-centric medical home model of care called the patient aligned care teams or PACTs. The PACT teams are made up of physicians, nurse practitioners, physician assistants as well as support staff. This model is designed to improve access, continuity, and care coordination among other things.

Many veterans seeking mental health services have benefitted from this model because they have not been subjected to the stigma attached to visiting a mental health clinic. While we have worked hard to destigmatize mental health, I understand this is still a challenge for many veterans.

In its written testimony, VA reminds us that it is difficult to compare VA's enrollee population to that of the private sector. VA patients are older and sicker than their counterparts and overall, 20 percent have documented mental health diagnoses.

In order to get the right care to the right veteran, the VA needs to know how many veterans are being treated at each facility. The report the GAO released today found that VA data on primary care panel sizes are unreliable and that proper oversight mechanisms are not in place.

Due to the absence of reliable panel size data and oversight processes, GAO concluded that this could significantly inhibit VA's ability to ensure that facilities are providing veterans with timely quality care that is delivered efficiently. GAO also found that VA was in violation of federal internal control standards.

As you know, Mr. Chairman, VA's primary mission is to provide high-quality, safe healthcare to veterans. A top priority for this subcommittee is to ensure that VA has the tools and resources it needs to enable that to happen.

I thank the witnesses for their testimony and I look forward to hearing from our panel.

Thank you, Mr. Chairman. I yield back the balance of my time.

Dr. BENISHEK. Thank you.

Joining us on our first and only panel this morning is Randy Williamson, Director of Healthcare for the Government Accountability Office.

We are also joined by Dr. Thomas Lynch, the VA Assistant Deputy Under Secretary for Health Clinical Operations. And Dr. Lynch is accompanied by Dr. Richard Stark, the VA Director of Primary Care Operations, and Dr. Gordon Schectman, the VA Chief Consultant for Primary Care Services.

Thank you all for being here this morning.

Mr. Williamson, we will begin with you. Please proceed with your testimony.

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Thank you, Mr. Chairman and Mr. Takano and members of the subcommittee.

I am pleased to be here today to discuss GAO's report released today on VA's processes for determining and overseeing workload capacity of its primary care teams at its medical centers.

Primary care services are often the entry point to the VA healthcare system for veterans and these services are delivered by primary care teams consisting of physicians, nurses, and support staff.

Determining how many patients to which each primary care team can reasonably deliver care referred to as the panel size is critical to ensure that our Nation's veterans receive timely, quality care and is delivered in an efficient manner.

For example, if panel sizes are too high for primary care teams at a particular facility, this may lead to veterans experiencing delays in receiving care, whereas low panel sizes may be associated with inefficiency and wasted resources.

To better ensure that VAMCs have reasonable primary care panel sizes, VAMCs are required to record and report panel size data including the number of primary care providers, support staff, and available exam rooms.

VA's central office inputs these data into a model it developed, determines the appropriate primary care panel sizes for each VAMC, and provides this data to VAMCs. However, VAMCs can deviate from these model panel sizes as they see fit.

We attempted to compare VA's model panel sizes with actual panel sizes for all of its VAMCs, but we found that systemwide, some data that VAMCs record and report to central office were inaccurate and unreliable.

For example, panel size data included patients who had died or who had not been seen in the last two years. Also, there were missing data and the number of reported exam rooms were sometimes erroneous. Absent accurately reported data, VA's central office has no good way of determining whether primary care panel sizes are too high or too low.

We conducted detailed reviews at seven VAMCs and after correcting reported inaccuracies at six of them, we found that actual panel sizes ranged from 23 percent below to 11 percent above the model panel sizes that central office determined to be appropriate at these locations.

Panel sizes for these VAMCs ranged from a thousand patients per full-time providers to 1,338. VAMC officials attributed the differences to varying degrees of patient demand, staffing shortages, and/or exam room shortages.

Some VAMCs decided to establish lower panel sizes to prevent provider burnout and attrition. Other VAMCs with higher panel sizes were experiencing staff shortages due to recruiting and retention difficulties associated with rural locations or the inability to compete with higher pay offered by the private sector. Also, some VAMCs were not affiliated with a university medical school that could have provided a supplementary pool of physicians.

We also found that cost for primary care visits which can be an important measure of how efficiently primary care is being deliv-

ered varied widely at VAMCs. The cost per primary care visit varied from \$158 to \$330 at the seven sites that we visited.

We also found that oversight to better ensure accuracy of data VA submit is basically lacking. Moreover, even if accurate primary care panel size data existed, neither VA's central office nor many VISNs perform systematic oversight to identify large gaps between the model panel sizes and the actual panel sizes at its facilities.

Also, cost per visit data is not even considered to be relevant as a measure of how well VAMCs are managing the delivery of primary care services.

Absent meaningful oversight to correct potential imbalances in primary care panel sizes, some VAMCs may be putting veterans at risk by not providing timely, quality care.

For example, one VAMC we reviewed with the highest panel size, 1,338, had a vacancy rate among its primary care providers of 40 percent. Some primary care providers at that facility expressed concern to VAMC leadership that the high panel sizes were impeding their ability to provide safe and effective primary care services.

This situation is all too reminiscent of veterans' access issues that have arisen at other VAMCs in the recent past. The problems with poor data and insufficient oversight that we noted in the report are precisely why GAO added VHA to our high risk earlier this year.

To correct the issues we noted in this study, we made several recommendations to improve data accuracy and establish a more robust oversight process. While VA concurred with our recommendations, we are concerned that VA may not be moving fast enough to make needed improvements. Without major improvements, VA is likely missing opportunities to identify VAMCs that warrant further examination and to strengthen the efficiency and effectiveness of primary care.

This concludes my opening remarks.

[THE STATEMENT OF RANDALL B. WILLIAMSON APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Williamson. I appreciate it.
Dr. Lynch, please go ahead.

THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY RICHARD C. STARK, M.D., DIRECTOR OF PRIMARY CARE OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND GORDON SCHECTMAN, M.D., CHIEF CONSULTANT FOR PRIMARY CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF THOMAS LYNCH

Dr. LYNCH. Good morning, Mr. Chairman, Congressman Takano, members of the committee. Thank you for the invitation to discuss the delivery of primary care services to veteran patients by the Department of Veterans Affairs.

I am accompanied today by Dr. Richard Stark to my left and Dr. Gordon Schectman to my far left.

Mr. Chairman, VHA has over 5.3 million veterans enrolled in primary care. We have almost a thousand sites of care and over half of the patients receive care in community-based outpatient clinics near their homes.

In many rural areas, we provide care via telemedicine or in mobile medical units. In recent years, we have implemented extended hours and all patients have access to after-hours medical advice call centers.

The majority of our patient population has multiple chronic diseases. VA patients are generally older, more complex, less healthy, and less socioeconomically well off than those in the private sector. Veterans have a higher prevalence of common chronic health conditions such as diabetes, hypertension, and heart disease.

Overall, 20 percent of veterans have documented mental health diagnoses and most of our primary care sites have integrated mental health capabilities so that patients do not have to travel for routine mental health care. In addition, our primary care teams have training and experience identifying and managing combat-related sequela such as TBI or PTSD.

Beginning in 2010, as Congressman Takano mentioned, VA began providing primary care through the patient-centered medical home model of care. VA refers to these as patient aligned care teams or PACTs and they involve a team-based approach to healthcare.

Through the PACT, patient care is not only provided in person in our clinics but also through virtual modalities such as by telephone, email, or by telemedicine. This team-based model is also being used to explore new venues of providing primary care including the provision of care in the home through video technology and the use of scribes in the clinic setting to enhance provider productivity and patient satisfaction.

The more than 8,000 PACTs are made up of a variety of clinical and clerical staff including physicians, nurses, and clinical assistants. It has been demonstrated that patients who have been placed in well-implemented PACTs have lower hospital readmission rates, improved levels of patient satisfaction, and higher results on measures of quality of care.

Overall, VHA exceeds the private sector in outpatient measures of quality such as preventive care and the management of diabetes and cardiovascular disease.

While facilities must have the flexibility to adjust panel size based on local resources and patient complexity, central oversight is also important. And reliable panel sizes are essential to assure continuity and coordination of care.

VA is appreciative of GAO's findings in this regard and agrees that greater oversight and responsibility for the accuracy of data are needed. Through the changes recommended, our processes to identify and manage instances of significant variation will be strengthened.

Primary care leadership in VA has also recognized the issues of our aging data systems and that this has been a contributing factor

with regards to inaccurate documentation and the monitoring of panel size.

In response to this issue, a redesign and reengineering of the software that tracks and helps manage patients, the primary care management module has been underway and will begin full deployment this year. The updated database will enable both greater control over the accuracy and reliability of panel data and more granular and precise data about staffing and space.

The report by the GAO also found that primary care cost data reported by VHA facilities were reliable but subject to variability. And we concur with the GAO's assessment that VA is missing an opportunity to potentially improve the efficiency of primary care service delivery through heightened oversight of encounter use and costs.

When considering cost, it is important, however, to note that the comprehensive integrated services offered by PACT are generally not present in the private sector. PACTs offer integrated mental healthcare, social services, coordination with non-VA care as well as prevention and wellness support.

However, many of these services are housed in medical centers which are often aging and not properly configured for efficient outpatient care. This makes cost comparisons with non-VA care models difficult to accomplish.

Mr. Chairman, VA continues to be a veteran-centric organization and to deliver patient-centered, world-class healthcare.

This concludes my testimony and we look forward to further discussing VA primary care with the members of the committee.

[THE PREPARED STATEMENT OF THOMAS LYNCH APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Lynch.

I will yield myself five minutes for questioning.

Mr. Williamson, this struck me as a result of these data inaccuracies, you only calculated actual panel sizes for six of the seven selected facilities where you were able to use updated data provided by each facility and corrected for inaccuracies.

So the data that the VA gave you initially, that was not adequate for you to do any analysis at all; is that right?

Mr. WILLIAMSON. Correct. We got data from VA, and we looked at it and did some further investigation. And we saw a number of outliers that just didn't look right. And as we explored those at the sites that we reviewed in detail, we found out indeed there weren't accurate.

One of the biggest issues was that there were a number of people included in the panel sizes that either had died or had not been seen in VA for the last two years.

Dr. BENISHEK. So this data that the VA gave to you, Dr. Lynch, that is the same data you used to analyze what is going on there?

Dr. LYNCH. I think, Mr. Chairman, VA has made some significant changes since this report was put together. And we would be happy to discuss those further with you.

Dr. BENISHEK. Well, it is just of concern to me, while I would like to know what those are, but it is of concern to me that, Mr. Williamson says that the data you are collecting isn't useful with-

out going over it a second time and fixing it up so that it made some use. So that is of great concern to me.

And, you know, one of the things I have been trying to do in this committee is to try to get the VA to collect more data.

The panel size to me, I don't know that that is the biggest issue other than the fact that it is a guide to how many providers you need, but certainly I think there should be some discretion at the local level to decide what the panel size should be so that you prevent this burnout issue and that 1,200 might not be the right number. It may be different in different areas, so I can understand that.

What I am concerned about, though, is a little bit about the cost per visit. That seems to be a more important part of it because it is difficult for me to figure out. I don't pretend that there should be the same cost per visit as it is in the private sector for many of the reasons that both of you discussed.

But does the cost of the visit, does that include the facility's charges, too? I mean, like the rent of the place that you are at or the cost of the building and the utilities, is that all a factor in that?

Mr. WILLIAMSON. It includes everything including depreciation on VA buildings.

I would also like, Mr. Chairman, to go back to something Mr. Lynch said. The VA data that VA gave us is still flawed. I mean, the data that VA has in the system and probably the figures that VA gave you just now is based on flawed data.

The improvements that VA have planned including, the new PCMM software will correct a lot of the data problems, but the improvements have not been implemented yet. And I take issue with the fact that significant improvements have been made, as Dr. Lynch suggests.

Dr. BENISHEK. Well, right. I mean, that is the whole basis of this hearing is the fact that they may be making plans on data that has no validity. And then to make a plan then when the change in the plan doesn't work, then there is a surprise and, you know, it is a problem. But I am just concerned about the variability in the cost.

Mr. WILLIAMSON. Yes.

Dr. BENISHEK. And as I understand it, the variability took into account already the variability based on location.

Mr. WILLIAMSON. Right.

Dr. BENISHEK. And I don't understand why there is such a huge difference in the cost.

Mr. WILLIAMSON. Well, some of the reasons we were given when we performed detailed work at the seven facilities, for example, was that some facilities used telehealth and telephone calls extensively while others don't. And that is one reason why a facility may show lower costs.

Dr. BENISHEK. Does the data include like the severity of the visit or the severity of illness of a patient and degree of complexity of the visit? That is not included in this from what I can tell.

Mr. WILLIAMSON. No. It is just basically the cost; that is all the costs associated with that particular encounter and the encounter itself.

Dr. BENISHEK. So, Dr. Lynch, does the VA collect any of that data? I mean, like Medicare when you do a patient visit, you have to check the complexity of the visit. Does that happen in the VA?

Dr. LYNCH. Yes, sir, it does.

Dr. BENISHEK. So where is that data? I haven't seen anything.

Dr. LYNCH. So I guess I would ask Mr. Williamson whether their data was raw data or whether they adjusted for differences between facilities in terms of the age of the facility or the complexity of the patient.

Mr. WILLIAMSON. We adjusted for geographical labor costs because labor costs are a big factor. Say from Los Angeles versus St. Cloud, there is a very big difference in labor costs. So we adjusted for labor costs and then used VA data for that.

Dr. LYNCH. But for age of the facility or complexity of the patient population, there probably needs to be some adjustments as well.

Mr. WILLIAMSON. That is right. That is the reason that you want to, if you see big variations, to determine the reasons for variations and that is why VA oversight would help identify possible inefficiencies that may be happening at VAMCS. Yes, there are a number of reasons why those costs could vary.

Dr. BENISHEK. Do you have the data on the complexity of the patient visits, Dr. Lynch?

Dr. LYNCH. We do, sir.

Dr. BENISHEK. It would be helpful, I think, for the subcommittee to see like what is the average intensity level of the visit because there is—I don't remember exactly the numbers. Maybe Dr. Abraham remembers. He is closer to private practice than I was, you know, because they have level one, two, three, four, five outpatient visit.

And, you know, I can understand having complex patients that have a higher complexity would cost more, but I think we need to have that information on a regular basis to sort of monitor and supervise how the VA is taking care of patients.

Is there a way of doing that on a regular basis, Dr. Lynch?

Dr. LYNCH. I would hope we can find a way. Speaking as a clinician, I don't disagree with you. I think the more data we have to identify how best to treat patients, the better off we are going to be. So I am not arguing with anything you are saying.

I think with respect to the GAO report, we are aware of a number of the deficiencies. The PCMM model which either Dr. Stark or Dr. Schectman can speak further about will help us basically look at panels and make sure they are properly impaneled. It will help us work through and eliminate those patients who may have died or may not have used VA care. These are all important things. We need to know that and you probably need to know it as a committee.

Dr. BENISHEK. I am sorry. I realize I am over time. I will yield now to Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Williamson, did I hear you correctly? The chairman asked a question that I am interested in about the underutilized space and how that factors into your conclusions.

Did that factor into the cost of care?

Mr. WILLIAMSON. No, it didn't. As you know, many VA facilities are old and were built when VA had more of an inpatient model, and since VA has converted to an outpatient model, the issue of shortage of exam rooms has come up quite a bit. But, in looking at cost per encounter, it is going to be hard to factor in exam rooms unless you do a specific analysis of that facility.

Basically, just used the data that VA gave us.

Mr. TAKANO. So you didn't factor in the—

Mr. WILLIAMSON. No.

Mr. TAKANO. So the cost differentials wouldn't—

Mr. WILLIAMSON. No.

Mr. TAKANO. Okay.

Mr. WILLIAMSON. We used labor costs.

Mr. TAKANO. Okay. Dr. Lynch, the report references a pilot project regarding primary care management model at the primary care operations office at selected facilities in 2014. It was mentioned in the chairman's opening statement. It was planned to be implemented agency-wide after resolving certain software interoperability issues.

Why is the implementation on hold and when will it be implemented systemwide?

Dr. LYNCH. So I am going to pass this off to Dr. Stark, but I want to make the point it is no longer on hold.

Dr. Stark.

Mr. TAKANO. It is being implemented now?

Dr. LYNCH. It is in the process of being implemented.

Mr. TAKANO. Okay. Dr. Stark, go ahead.

Dr. STARK. Yes. The PCMM web which is what we call the new software that we have developed was deployed at four pilot sites a little over a year ago. As a result of that deployment, some problems with interoperability were identified and further work needed to be done.

It was determined that that extra work would result in additional funds being needed to complete the contract.

Mr. TAKANO. Is \$1.5 million?

Dr. STARK. That is the \$1.5 million.

Mr. TAKANO. Were you able to find that or—

Dr. STARK. Yes.

Mr. TAKANO [continuing]. You were able to implement?

Dr. STARK. Yes. The Office of Information Technology had to pull money from a number of other projects and identified some excess funding. And they were able to locate that funding and were back on track. And really that resulted in a delay of only two or three weeks in the deployment schedule.

Mr. TAKANO. Okay. So we are moving ahead with an improved data collection? This concern over data that is not adequate for the GAO, the VA is moving ahead with trying to resolve that?

Dr. STARK. Yes. This software has been a long time coming. And one of the reasons for developing it was to correct some of the issues that we had with inaccurate data and replacing the old software that had really been in place for 15 or 20 years and had been patched in all kinds of ways over the course—

Mr. TAKANO. Well, this is news I wasn't expecting to hear. I am glad to hear that VA is moving forward with improved data collection so that we can get a better handle on per patient costs.

You know, the GAO has also found that the VA was in violation of federal internal control standards. Dr. Lynch, what are you doing to ensure compliance going forward with those standards?

Dr. LYNCH. The VA is taking this very seriously. Dr. Carolyn Clancy who is the interim under secretary for over a year has taken that on as one of her tasks to begin addressing the concerns that GAO has that have placed us on the high-risk list. And that includes looking at policies and implementation of our policies and assuring that we have proper data resources.

Mr. TAKANO. Dr. Lynch, I am very concerned about something that has been said in previous testimony in different hearings. I understand from testimony by a man named Mr. Giroir or it could have been Ms. Giroir, I don't remember the gender, but this person testified that 43 percent of network directors had acting director status. Sixteen percent of VHA medical centers lack a permanent director. More than two-thirds of network directors, nurse executives, and chiefs of staffs are eligible for retirement, so two-thirds of those existing staffers, as are 47 percent of medical center directors.

As you try to address a topic like this of meeting compliance, which to me is a managerial challenge—I know very well what happened when I was on the board of a community college and we had an acting chancellor and how that acting chancellor was limited in their ability to actually move the institution forward if we had acting presidents of campuses.

But having acting directors of almost half, I have to imagine that this has an impact on your ability to make sure that we are in compliance with a standard like this.

Dr. LYNCH. It does and VA is moving to fill those positions as rapidly as we can. And we appreciate the help that Congress and the committees have given us in creating the leeway to do that. But you are absolutely correct. We need to fill those positions. We need to get permanent managers in position and help us move the system forward.

Mr. TAKANO. Well, I know you have a challenge because I understand that frequently administrators are compensated at 70 percent below the private sector for comparable positions, but I also understand that it has been a real challenge within the VA in terms of personnel and your personnel office in a number of different respects. But I would say this is a very critical thing with, you know, so many acting administrators.

Dr. LYNCH. Two things, I think. Number one, there is a bill that is currently under consideration which would allow us to use the hybrid Title 38 designation for medical center directors, non-physician medical center directors, which will help us increase salaries, make positions more desirable. I think we already have one of the most desirable missions of any healthcare system in the country, which is treating veterans. And I think we have been working with H.R. to try to develop a more efficient process to hire people. We recognize those as challenges and we have been trying to work on those, sir.

Mr. TAKANO. I thank you, Mr. Chairman for indulging me, and I thank you for your testimony.

Dr. BENISHEK. I hesitate to say anything because I ran over too. Dr. Roe?

Dr. ROE. Thank you, Mr. Chairman. And thank you all for being here today. And the whole point of this hearing is how to more efficiently provide care for veterans. It is primary care, which is the entry level for most folks. And the entire country now, medical profession, is undergoing a transformation. Many of us on this panel this morning who are physicians started our morning out with the American Group Medical Association, representing 175,000 private practice doctors around the country. And they are figuring out with ACOs and the new payment models, which is pay for performance and outcomes, how to negotiate this and how to become more efficient. And I think the VA may still be stuck in the older model. And it really needs to look at what is going on out in the private sector.

I want to look at, Dr. Lynch you said a couple of things about the VA panels are older and sicker and so forth. Well I just looked up at the NIH website while you were saying this and 18.5 percent of the population in general 18 and over have mental illness. It does not mean they are in treatment but they have mental illness. So the incidence is the same as the VA. And if you look at the incidence of a soldier recruited today versus the population in general, they are the same. So I do not know that, and I know Mr. Williamson we have had an opportunity to talk. And I think that in your testimony you stated that the demographics of the VA patients, at least Dr. Lynch did in VA's written testimony, are consistently different from a majority of the private primary care practices. Is that data accurate? Because I do not believe that it is. I think taking care of veterans is like taking care of any other patient.

Mr. WILLIAMSON. Well as far as setting the panel size at 1,200, which is kind of the rule of thumb for VA, VA did an extensive literature search. They made adjustments because of the acuity of older patients. They set panel sizes lower than the private sector. I am not here to tell you that is right or wrong but that is the reason and the rationale that they gave us.

Dr. ROE. And a typical panel, and I will just tell you having practiced medicine for 31 years many doctors under-code in the private sector. And I will, as we go around, you will find out that we under-code what is actually done so our data may not be accurate either. You think, well, I do not want Medicare to come in and look at all this. So I mean, I know that I probably under-coded—

Mr. WILLIAMSON. Yes.

Dr. ROE [continuing]. The severity of the illness of the patients I was taking care of. I heard Dr. Lynch, and I want to expand on this a little bit because I believe you all are on to something by helping make these panel sizes. Look, the panel size we know with VA is about half the size that it is in private practice approximately. And I think you can increase the efficiency and the satisfaction of practice by having someone do two things. One is provide an adequate space for the doctors to work, and then an adequate support staff. An adequate support staff, I mean, let the doctor be

the doctor. And the scribe you are talking about I think every office visit I make practically now is that there will be someone there to enter the data into the computer. It is an added cost for a practice but I also think it adds tremendous efficiencies. How many places, how many scribes are you actually, because the medical center where I am in Johnson City, Tennessee, I do not think there are any.

Dr. LYNCH. I am going to ask Dr. Schectman to address that question.

Dr. SCHECTMAN. So the concept of using scribes to enhance efficiency, productivity, is a very attractive one. We have explored what is happening in the private sector in order to understand better and we have really networked with the advocates of this. There are scribes here and there in the VA but what we have done is established a formal pilot in order to—

Dr. ROE. There isn't, is not a formal pilot? I think the Secretary said there was the other day.

Dr. SCHECTMAN. No, no, no, there is. I am saying we have, what we have a pilot ongoing now to evaluate scribes—

Dr. ROE. Where? Where and how many?

Dr. SCHECTMAN. There are currently three sites and only about four or five providers.

Dr. ROE. How many? Four or five?

Dr. SCHECTMAN. Right. So it is a limited—

Dr. ROE. So it is nothing.

Dr. SCHECTMAN. It is limited.

Dr. ROE. That would be pretty limited when you—

Dr. SCHECTMAN. Well, but we are, we are planning on expanding it. We have sites who are interested in participating and we are planning to add them. And also including a comparison with voice technology so that we can really see whether or not—

Dr. ROE. Again, the motivation I think is different. Just to give you an example, all of us up here are private practitioners. And if I am going to see 25 or 30 people a day, and I have got an electronic health record that takes me two minutes or three minutes longer to do that than it does, I have added an hour and a half so that the last patient is an hour and a half late. The VA does not, I do not know how many they saw, but I did just some quick calculations. If you have a panel of 1,000 and you see ten people a day, which is not really hitting it too hard, that is 2,000 visits a year based on ten months. And that is two visits per person, per year. Which as Mr. Williamson said, some people are in and out. And I admit, it is hard. So I mean, patients of mine died too and I did not know it till they did not come in a year or two and I saw their obituary in the paper. I get that is hard to figure out. But you will after a year or two figure it out when they have not been in. You make a phone call and find out. That is what we did, you have not been in for your appointment.

Dr. SCHECTMAN. We agree with the need to explore this further.

Dr. ROE. Okay and thank you. I yield back, Mr. Chairman.

Dr. BENISHEK. Ms. Kuster.

Ms. KUSTER. Thank you, Mr. Chairman, and thank you to our panel for being with us. One of the questions that I wanted to explore has not been discussed yet, and if it is not in the realm of

this conversation I am happy to move on. But I know we have heard on this panel before about the difficulties with scheduling. And it occurs to me that that is one of the primary obstacles to running an efficient panel, is knowing that when a physician comes in in the morning they are going to be seeing people throughout the day and they are not going to be waiting for appointments that were canceled. It seems to me a couple of years ago I spoke with a vendor who had a very efficient system. They just scheduled the most likely to show up in the morning, the less likely to show up in the middle of the day, and the least likely to show up at the end of the day when they can double or triple book and make for a much more efficient day. And I just had a question, is that taken into consideration or is it something that is being considered going forward so that the physicians that we do have can work in an efficient way?

Dr. LYNCH. So that specific model, no. But I will let you know that VA has awarded the contract for our new medical scheduling appointment program. It will be pilot tested in Boise, Idaho to assure that it delivers what we expected it to deliver. We are also in the process of implementing some scheduling enhancements, which will be rolled out over the next six months to help our schedulers work more efficiently and provide better scheduling opportunities.

VA has also looked at the no show rate, the missed opportunity rate. We have several initiatives in place. We do have a program and an algorithm that allows us to identify those patients that are most likely not to show up for an appointment. Right now the strategy we are using is to try to contact those patients and confirm their appointment. But certainly it would be worth looking at different scheduling alternatives to see if that would be a useful technique as well.

Ms. KUSTER. And absolutely contacting the patients. I remember I was shocked to hear that that had not been going on. So I think all of us in the civilian world rely on that reminder, even if it is an automated call.

My other question has to do with the associate providers and the use of associate providers, PAs, medical assistants, nurses, and the like. Did you look into that in terms of efficiency or were you solely focused on the physician panels?

Dr. LYNCH. I am going to let Dr. Stark take a shot at that.

Dr. STARK. Yes, currently about 30 percent of our primary care providers are non-physicians, so they are nurse practitioners which I think is about 24 percent, and physician assistants are about six percent. So we make extensive use of those other healthcare professions in primary care and they have been very helpful to us in helping us meet the demand.

Ms. KUSTER. And are they folded into your data? Is a typical panel for a nurse practitioner also 1,200 patients?

Dr. STARK. No. Actually the panel size for a nurse practitioner or a physician assistant is generally set at about 75 percent of a physician panel. And but nevertheless those, that data is part of the panel capacity information that we use. So we take that into account.

Ms. KUSTER. And then the last question I have has to do, again, efficiency speaking on behalf of the VISN, the hospital in White

River Junction, Vermont. I am in New Hampshire, but most of my veteran constituents in the northern part of the state go to the Vermont facility. They are having wonderful success with telemedicine. I was surprised to learn actually in mental health, very, very effective. Patients, vets are very comfortable once they get settled into the chair and have the eye contact. Did you take that into account? And is that a direction that other VISNs could follow for greater efficiency, greater effectiveness, and keeping costs down?

Dr. STARK. Absolutely. We have used telemedicine in a number of our sites, particularly in rural areas where it is difficult to recruit providers. You know, telemedicine can really serve a lot of the needs of veterans without requiring that face to face visit. In some places they have even set up sort of telemedicine hubs where they hire it easier to hire staff in a particular location. Those providers see a panel of patients at a distant location on a regular basis. So it is an effective tool, absolutely.

Ms. KUSTER. My time is up. But I would also note that they are having great success with PT, physical therapy, in a distant location, which I was impressed by. People could just stay at home. So thank you very much. Thank you, Mr. Chair.

Dr. BENISHEK. Dr. Abraham, you are recognized.

Dr. ABRAHAM. Thank you, Mr. Chairman. I thank the panel for being here, and I think we have got three primary care docs here, and then a health director here. So this is a good captive audience, and I am going to hit this from the private sector like Dr. Roe did.

Mr. Williamson, you said that these hospitals that were built back in the sixties and seventies were more built for our inpatient population, and we get that. But when we are having veterans wait too long to get an appointment, when they get there too long to see the doc or the NP or the PA, you know, I ran a multiphysician practice and I really did not care what the docs or the NPs really cared about it, I cared about the patient. And how hard would it be to open up, let us say, an inpatient room, make that an exam room? You have got a bed, you have got a couch. All you need is a stool for the doctor to roll around in. I carry the otoscope in my right pocket and my stethoscope in my left, and we are there. That is such a simple thing to utilize a facility that you already have in place and that you already are paying the electricity on anyway. So, again, just, you know, common sense. The three docs can tell you, we can convert that hospital room into an exam room in 15 minutes or less and be ready to go to work. And you know, whether the NPs or the docs had to climb the stairs to get there, that is not really, I really do not care as long as the patient can get there and see somebody.

Going back to Dr. Roe's comment about the scribes and the under-coding, and he is exactly right. Because we get so wrapped up in not knowing how to use the software it takes us forever to code a visit. A scribe is an expert. They have been trained in that. And what I can tell you, we got scribes in my practice, once we started using them we never over-coded but we coded appropriately. Revenues went up. We saw more patients because the scribe knew what they were doing better with the software than we did. So Dr. Schectman, back to your comment. I would advocate, and I can show you hard data across the nation where scribes have

enhanced profitability in the VA system or in any system, any private business. But more importantly you get to see more patients and you get to see more patients in a very effective manner. You get to be the doc, as Dr. Roe said. We are not typists and we are not certainly scribes.

And going back to data collection, we have got ICD-10 out right now. And if you guys have looked at it, which I know you have, ICD-10 has software where you can collect this data on patients saying what their diagnosis is, what their treatment outcome is.

So my point is this. I understand that, you know, you guys are a government bureaucracy and you have to move a little slower because you are dealing with taxpayer monies, and we get that. But you know, I want to say that from the business model point this is not nuclear physics or rocket science. This is pretty simple stuff. And when we as private doctors have to actually make a payroll and we are responsible for families making a living and taking a paycheck home to their children, we know how to do business. And the VA could do this. It is not that hard.

So again, just more of a statement than a question. And again, I think Dr. Lynch, you said something about voice recognition software, we are trying to get it with the VA. Well, you know we have got that. Dragon Speak or any of those Dragon models, they have been working for 15 years and they are wonderful. So, you know, in private industry all these things are available and they are available now, and I think we need to think about incorporating them into the VA system. Thank you, Mr. Chairman.

Dr. BENISHEK. Thank you. Dr. Ruiz.

Dr. RUIZ. Thank you, Mr. Chairman, and Acting Ranking Member for holding this. I am not a primary care doc, I am an emergency medicine physician and we were born because the system was broken and there was a high demand and people could not see their doctors, or there was an emergency that needed immediate care. And from there we developed efficiencies within the emergency department to take care of the patients. When there is not a bed, we use a gurney in the hallway. We double up. We do whatever it takes to take care of the patients. And I think that has always been my point, and that I want to stress with the VA healthcare system, is that we need to move from an institution centric system to a veteran centric, treat the veteran first mentality and try to have all the flexibilities that we can to make it work.

And in saying that I have done a lot of work with physician shortages in rural areas in my district and others and I have done research on this matter. And when you approach a physician or a panel size difference for the healthcare provider there is oftentimes a mentality where we need to look at this in the perspective of the physician, in other words match the patients, in other words call the patients the burden for the physicians to create wellness in the physician's life so that they can have a better experience, right? Or you can look at this in a patient perspective and say we need to make sure that we have the adequate amount of physicians in the pipelines and train the physicians and the staff to meet the patient demand. So there is a difference in the perspective. And I know that you all understand that. I just want to make sure that that is the central point, is that we are looking at this in the perspective

of the patients and in the short term utilize whatever means necessary to get them the care, either in the VA facility or outside of the VA facility. But give the care the veterans need. Otherwise they will end up in the emergency departments because they cannot see their doctors, or because their diabetes got to an extreme point, or their mental health has deteriorated and is to a point where they need to be institutionalized.

And one of that things that our country has defined as an adequate ratio in the community is one physician per 2,000 patients or people. To be considered medically underserved it is one to 3,500. So my question to you is where do you get the panel size of one to 1,200? And second is have you looked at counting simply the full time equivalent physician for a VISN per population, veteran population size of a VISN and just utilize the one to 2,000 ratio to determine if you have enough physicians within that VA system?

Dr. LYNCH. Dr. Schectman, do you want to—

Dr. SCHECTMAN. I appreciate those comments. Regarding panel size, there is controversy in terms of what is the right panel size. I agree with you, a lot of the literature does suggest, for example, the panel size should be 2,000 or greater. There have been push back in the literature actually that this is too much, that in fact this would require, in order to provide comprehensive care the way the patient centered medical homes do this would require providers working 20 hours a day really in order to get all the preventive care done, as well as the acute care, as well as the chronic care done. So the push back has been to lower it. And this article that I am thinking about, really, recommended lowering it to 1,700 or 1,800 for the private sector but noted that in the VA due to the complexity of the patients and other issues regarding the way teams are configured and the way care is delivered that a panel size of 1,200 or 1,300 is very, very appropriate.

You know, in fact the independent assessment reviewed this very, very carefully and devoted pages to describing this issue about what is the right panel size. And actually from the AAFP took a formula which the AAFP is advocating and applied that to the VA and came up with a panel size recommendation very, very similar to our model panel capacity.

So I do not know considering all of the issues involved in terms of panel size, I do not know if we are too far off the mark. I think it is very hard to compare us to the private sector without really a lot of, you know—

Dr. RUIZ. Well, there is different comparisons you can make with different institutions that provide similar care and departments that provide similar care for similar type patients as the VA. I think the overall point here is what are you going to do with the data? And second of all, do not wait for the data to act. Do not wait for the data to get more physicians, more ancillary staff. I mean, it is the common sense. It is the patients that are waiting in the lobby. It is the patients that have not been seen. It is the patients that are waiting that need the care. So do not wait for the data. It is good to have the data so you can make better decisions. But do not wait for the data. And the end goal is to add more support

for the patients not to have a comfortable patient load to make the physician's life better.

Dr. SCHECTMAN. I agree with you 100 percent.

Dr. RUIZ. Thank you.

Dr. BENISHEK. Thank you, Dr. Ruiz. I just want to make a brief comment. And that is everyone is saying that the VA patients are sicker, but you have not really shown us any data to actually prove that. I mean, I understand that, having worked in the VA. But you have not shown me a list of, you know, the complications that people have. There is nothing like that. So—

Dr. LYNCH. I would refer you to Assessment A of the independent assessment, which does address the issue of VA demographics and does come to the conclusion that VA patients have a higher comorbidity than those in the private sector.

Dr. BENISHEK. That is the data I would like to see.

Dr. WENSTRUP. Thank you, Mr. Chairman. Thank you all for being here today. I appreciate it. One of the things I am trying to get a grasp on is we talk about this ratio of doctor to patients in primary care. You know, it can vary from practitioner to practitioner, and is there a local flexibility to that? And also locally being able to try to figure out why within the same facility one is able to see more than the other and do it effectively. For example, in our practice, you know, we had 26 doctors. If one is seeing 50 patients in a day and another one is seeing 25 there may be a reason for it. It may be as simple as you need another medical assistant, which more than pays for itself, right? So I am just curious if there is that flexibility on a local level to adjust depending, to adjust in a couple ways, either give a practitioner more patients if they are able or adjust how they are operating to bring that level up?

Dr. LYNCH. Dr. Stark.

Dr. STARK. Yes, there is definitely flexibility at the local level. That is one of the things that is very important to us, which is why our model panel sizes are basically recommendations and kind of a starting point and then we allow the local facility to adjust the panel sizes to the characteristics of the practice, the characteristics of the providers, the resources they have available so that they can tailor their resources to what they have to make sure that their veterans get the best of care.

Dr. WENSTRUP. And are the supervisors or administrators of these facilities keenly aware of this and working towards that? Or does it take the practitioner to bring attention to it?

Dr. STARK. Well in most cases the primary care leadership is very attuned to this and adjusts those panels on a regular basis. And we provide them guidance on how to do that as well.

Dr. WENSTRUP. You know, and there are some models that may be similar to the VA setting. I mean, I understand the difference between your typical private practice fee for service, etcetera. But as far as the proper patient load, you know it seems to me, I know in DoD, still serving in the Reserve, there is this move, especially in the Army, that we do not want to just be treatment facilities we want to be healthcare facilities, and we want to be preemptive, and more preventive, and things like that. But very often people do not go to the doctor until they are sick and really we may do better if we schedule appointments in like for example MDVIP, which

used to be owned by Proctor and Gamble. So Secretary McDonald should be familiar with it. And it is a program where people do pay a fee, but they come in even when they are well to make sure that they are being kept up on their medicines and things like that. And they limit their number of patients that they see, and they still do some fee for service type things, but things that are not covered. Well, you know, in the VA it is pretty much all covered. So is there a drive towards this? Doctor, you are shaking your head. So please weigh in on that.

Dr. SCHECTMAN. Well actually I was thinking more in terms of a comment you made before in terms of developing better regulation, panel management, and so on, and the fact is that being deployed everywhere and so on. And in response, you know, to actual previous legislation we now have, you know, clinical managers which have been hired, high level, with specifically that job in order to make sure panels are managed properly, that data is accurate, that in fact there is an understanding at the front line primary care level in fact that, you know, there is some, they have some authority over their panels and they need to be good feedback, and there needs to be this alignment of leadership at every level. And these, they are currently being trained. There are training programs that we have developed in the VA specifically for this. Dr. Stark is actually one of the major initiators of this.

Dr. WENSTRUP. Throughout are they physician driven?

Dr. SCHECTMAN. The program is physician led.

Dr. WENSTRUP. Okay. That is helpful. But to my other point, too, you know, there are models within the private sector that we may be wanting to take a look at that say what is the right number and are we providing those visits where, you know, hey, you have diabetes and I do not want to see you when you crash, I want to see you every four months anyway, you know, and that type of thing.

Dr. STARK. Yes, the patient centered medical home model or PACT is really the embodiment of that philosophy. And so we take that very seriously.

Dr. WENSTRUP. And are there tools to evaluate are we actually saving money by doing that? Because I believe that overall we do if we are truly a preemptive healthcare facility as opposed to just treating.

Dr. STARK. Yes. We have looked at that. It is still preliminary and it is difficult to make those assessments but as Dr. Lynch mentioned earlier, high performing PACTs have lower hospital readmission rates and other indicators of better outcomes that end up costing us less.

Dr. WENSTRUP. Well might I suggest that we maybe look at some of those concierge type services that you actually could provide I think in the VA, that type of entity that might be helpful for us in the long run. Thank you. I yield back.

Dr. BENISHEK. Dr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the subject of the hearing today and the GAO report, which I find very interesting and very insightful. By my count I think that is the, this is the 38th report that has documented data inconsistencies. And by the way, I just made that number up. But there has been a lot of reports on that. And but the question I guess for Dr. Lynch or

Dr. Stark, I might add, bluntly, how valid and reliable is the data that we have been discussing here in your opinion?

Dr. LYNCH. I will take a start that I think there have been some inconsistencies and they have given us some challenges. I think that the new primary care module that will be looking at PACTs are going to address some of those inconsistencies, especially in paneling patients who may have died or who may not be seeing VA, and maybe looking to give us more accurate data and allow us to monitor that data. I will let doctor—

Dr. HUELSKAMP. My question though was validity and reliability. Could you address each of those separately, of the data here? The GAO reports vast inaccuracies, but validity and reliability, can you distinguish between the two for me?

Dr. LYNCH. I think we have concurred with the GAO that our data is not reliable and therefore there may be some lack of validity. I think however when we look at things at a larger level we can get some information but we can get better information and we are working on that.

Dr. HUELSKAMP. And I appreciate that recognition. Because, I mean, we have been hearing data back and forth. And if it is not reliable, I mean, this discussion is really rather fruitless until we have the reliable data. But is there punishment for employees who fail to report the data accurately and who is responsible for, finally at the end of the day, who at the VA is responsible for the data we are discussing?

Dr. LYNCH. The facilities and central office are responsible for the data. Would I blame an individual? Probably not so much as our system that has not provided the tools they need to provide us accurate information, and that is what we are working on.

Dr. HUELSKAMP. So who is responsible then? At the end of the day, when you go back to your office and say they asked me a lot of questions about data. I admitted it was not reliable and probably invalid, strike one and two. Who do you call, Dr. Lynch, and say, okay, fix this problem?

Dr. LYNCH. Central office takes ownership for trying to put that data together, sir. And we are working to provide new tools to do that.

Dr. HUELSKAMP. Is there any one person? Or who ultimately, who do you call? Not central office. I do not know how many people work in the central office. But who is responsible? Who is going to fix this, in other words?

Dr. LYNCH. There are a number of offices that are responsible. VHA central office is probably the individual group that is responsible for getting you the data that you need, sir.

Dr. HUELSKAMP. But is there an individual that is in charge of this data project? Or it is just a committee of folks?

Dr. LYNCH. It is a number of people in central office that are trying to work to solve this problem, sir.

Dr. HUELSKAMP. And so they are all guilty and all responsible or all unaccountable? I am just trying to—

Dr. LYNCH. I think they are all trying very hard to work through a system of data. It is put together in a computer system that was never meant to do what it is supposed to do today.

Dr. HUELSKAMP. And you mention—

Dr. LYNCH. Our computer system goes back to 1985. Our system changed significantly in 1995 when we went from inpatient care to outpatient care, and our systems have not changed substantially, sir.

Dr. HUELSKAMP. And we are still determining, here trying to figure out what is the appropriate panel size, even though we are not for certain we are even measuring panel size, and we are not for sure what we—by the way, does an encounter include a phone call? Is that one encounter? How do you count that?

Dr. LYNCH. It can be billed as an encounter, sir, yes.

Dr. HUELSKAMP. Does an email to a patient, is that an encounter?

Dr. LYNCH. To my knowledge right now an email does not count as an encounter, is that right, Dr. Stark?

Dr. STARK. If it meets certain criteria for medical decision making it can be coded as an encounter.

Dr. HUELSKAMP. Do we know what percentage of the encounters are, and that is fundamental to the second part of the report in terms of the vast wide range of cost. So if a phone call and perhaps an email can be an encounter, do you know how many, what percentage of encounters actually fit that—

Dr. STARK. About 30 percent of our encounters are by telephone.

Dr. HUELSKAMP. And what percent are emails?

Dr. STARK. I do not have that data. That is a relatively new—

Dr. HUELSKAMP. Yes, that is only 20 years old. I get that. I am just kidding, I do not know how long you have been counting that. But in the private sector, do they count that as encounters? Just a phone call, a reminder you are going to have an appointment? Or something like that? Or—

Dr. STARK. Phone calls do count in the private sector. It is a lesser weight encounter than a face to face visit.

Dr. HUELSKAMP. Okay. I would like a little more followup then on the data, breaking that down, what that encounter is. Because that was critical to the second part of the GAO report, trying to figure out, we have got this wide range of expenditures. And just to let you know, the piggy bank is about empty. So we need to do a better job of how we spend this money. I yield back, Mr. Chairman.

Dr. BENISHEK. Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman. Well one thing that is not acknowledged in this report is something that I think VHA leadership is very good at, is very effective at, without parallel. And that is your ability to cut bonus checks to each other. I mean, that is extraordinary in the amount of money spent on that for whatever reason.

But let me, as someone who is involved in healthcare on the House side, on the Armed Services side, and on this side, that when our severely wounded coming out of Iraq and Afghanistan are handled different than our severely wounded were, coming out of Vietnam. In Vietnam they were stabilized in the military system and then they went to the VA for their rehabilitation. Now we keep, extend them on active duty for their rehabilitation, unless they specifically request to go to the VA which is very rarely done. Then they are medically retired so they are under the TriCare system. So I hope we can improve the VA to where we feel confident

about putting our war wounded there, but that is certainly not the case today.

What is extraordinary I think about this report, and I think about the culture of the VA, is that when mediocrity is legally protected, this is the system you get. The military system, and I am 21 years in the military, we have a number of former military officers here, some current, Dr. Wenstrup. But it is a merit based system. Let me tell you, Dr. Lynch, you would not survive in the military system. Period. And maybe you were there at one time, and I know a lot of people in the VA come from the military, but they have forgotten all the values that they learned in the military. And let me tell you there are a lot of good people in the rank and file of the VA, do not get me wrong. And they are the people that step forward as whistleblowers that we are trying to protect here on this committee from retaliation from leaders like yourselves. And so it is just extraordinarily disappointing that, what we are seeing today. We need to make the Choice program work. I think the Choice program will make you better. That the fact I think you take the veterans of this country for granted. And I think that having some level of competition will be helpful. And I think we need at the end of the day to have some system when we get the Choice program to work that the VA is not very cooperative in making it work that that demand needs to reflect if relative demand to the VISN, if people prefer the Choice program to the VISN then we need to bring down the number of employees in the VA for that specific VISN. That will come eventually.

Let me just reference the report. The GAO report indicated that in its comments, well, to this report, VA did not provide information on how it plans to address unreliable panel size data accountability. In response GAO recommended that VA specifically assign responsibility for verifying each facility's reported panel size data. Who should have this responsibility? And when will VA publish its guidance identifying those individuals? Dr. Lynch.

Dr. LYNCH. So that would fall to Dr. Stark and his office.

Mr. COFFMAN. Okay.

Dr. LYNCH. And we are in the process of validating our data as we implement the new PCMM web system to monitor our panel sizes. That is part of the process to improve the accuracy of our data.

Mr. COFFMAN. And Dr. Lynch, why do you think that the culture of the VA is what it is today? That why we get the scandal after scandal after scandal in the VHA system? Why do we have the wait time system that, where there was manipulation of the wait time for appointments in order to get cash bonuses? And that went all the way up, and I believe that the head of the Phoenix hospital has, I do not think she has been fired yet, or do you know what the status of that person is? I understand they are on paid leave, can you speak to that?

Dr. LYNCH. I think the former director has been terminated, sir.

Mr. COFFMAN. Has been terminated?

Dr. LYNCH. Yes.

Mr. COFFMAN. Okay. Mr. Chairman, I yield back.

Dr. BENISHEK. Thank you. Ms. Walorski.

Ms. WALORSKI. Thank you, Mr. Chairman. Dr. Lynch, several months ago we did a hearing, I do not even know, it could have even been last year. I do not remember. But we talked about the issues on the credentialing process for vendors and some of the confusion that happened around the country with unauthorized vendors being in different places and that kind of thing. So I have been working on legislation that I introduced that would create a uniform framework for enabling the presence of medical vendors. This is not necessarily a new issue. But as you examine ways to reduce the administrative burdens and improve efficiencies in your VMACs, have you considered creating a standard framework for vendor access? Has that been talked about?

Dr. LYNCH. We have been working following those initial meetings to come up with a process that allows us to have full eyes on what is coming into our institution, where it is coming from, and where it is going. Yes, Congresswoman.

Ms. WALORSKI. Okay. Are you looking at solutions from the private sector organizations to help streamline that process?

Dr. LYNCH. I was not part of the group. I cannot confirm that. But I would suspect we have been looking at the private sector. We have been doing that with increasing frequency now.

Ms. WALORSKI. And then I would ask you this. I know you are not directly on it. But are there any things that you have heard that have come out of any of those meetings where Congress can be a partner in accomplishing that goal?

Dr. LYNCH. I have not heard of any specific asks for Congress but we certainly keep that in mind.

Ms. WALORSKI. Okay. And could you at least check on it and get back to us?

Dr. LYNCH. I will.

Ms. WALORSKI. Okay. I appreciate that. And then I have a question, a final question, on the independent assessment that was released a few weeks ago concluded that VHA and the Office of Information Technology, which I have asked about many times, are not effectively collaborating, which has hindered VA's ability to ensure IT investments align with its healthcare objectives. So who within the VHA is responsible for coordinating and establishing those objectives between those two offices?

Dr. LYNCH. So right now we have a new head of OI&T, Ms. Laverne Counsel. I think I can honestly say we have a new sheriff in town who has—

Ms. WALORSKI. On IT?

Dr. LYNCH. On IT.

Ms. WALORSKI. Okay.

Dr. LYNCH. Who has begun to take an interest in issues such as collaboration and understanding how the different parts of the organization can work together. I suspect at this point in time that the lead for those communications would probably be Dr. Shulkin, but I suspect it will also move down as the more specific needs are identified. But there has been a change in attitude—

Ms. WALORSKI. And you welcome that change?

Dr. LYNCH. Pardon?

Ms. WALORSKI. And you welcome that change?

Dr. LYNCH. I do welcome that change.

Ms. WALORSKI. And I think there has to be real change and that there has to be a structural change to be able to enhance those interagency cooperations because of the fact the GAO report has talked about this as being a serious issue before. I have asked many, many times on this committee prior to this new IT person about, specifically about IT because so much money has gone into it that has been tax money. There has not been a whole lot of accountability and transparency and there has not been a whole lot of interagency cooperation. Also, I would hope if you could take that message back, I know you are not specifically directed to, but I would hope that we would see improvement in those two. And again, so that the end goal is helping the veteran get the healthcare they were promised. And with that, Mr. Chairman, I yield back.

Dr. BENISHEK. Thank you, Ms. Walorski. I want to thank all of you for being here today to give us your testimony, Mr. Williamson, Dr. Lynch, Dr. Stark, and Dr. Schectman. I think you pretty much got the idea that a lot of us are very frustrated about the rate of change or the pace of change. The reassurances that you are on it, you know, are all well and good, Dr. Lynch. And you know, I believe you are sincere. It is just that at this level here we get very frustrated by the pace of the actual change. And you know, Mr. Williamson has just put out the report today, and all of a sudden we find out there has already been change in the way that they are going to do it. They are implementing the new software. But we have not really seen the results of that. So we would like to see—

Dr. LYNCH. I think I would say, Mr. Chairman, we welcome the opportunity to come back and share with you the results that we, our findings as we implement that software.

Dr. BENISHEK. Yes. Well, I am hopeful that that will be soon. So if there are no further questions, you all are excused. I ask unanimous consent that all members have five legislative days to revise and extend their remarks and to include extraneous material. And, without objection, so ordered. The hearing is now adjourned.

[Whereupon, at 11:17 a.m., the committee was adjourned.]

APPENDIX

United States Government Accountability Office



Testimony

Before the Subcommittee on Health,
Committee on Veterans Affairs, House
of Representatives

For Release on Delivery
Expected at 10:00 a.m. ET
Thursday, October 22, 2015

VA PRIMARY CARE

Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care

Statement of Randall B. Williamson,
Director, Health Care

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

I am pleased to be here today to discuss our report on the provision and oversight of primary care services at Department of Veterans Affairs (VA) medical facilities, which is being publicly released today.¹ As you know, primary care services are often the entry point to the VA health care system for most veterans, including an aging veteran population and a growing number of younger veterans returning from military operations in Afghanistan and Iraq. Veterans may obtain primary care services at VA's 150 medical facilities, which include medical centers and more than 800 community based outpatient clinics (CBOC).² Primary care services are delivered through patient aligned care teams consisting of a primary care provider and support staff—a nurse care manager, clinical associate, and administrative clerk.³ When other services are needed to meet patient goals and needs, these teams oversee and coordinate that care. VA's medical facilities are overseen by 21 Veterans Integrated Service Networks—called networks—and by VA's Central Office, which oversees the entire VA health care system.⁴

In recent years, VA has emphasized providing primary care as the way to enhance health care delivery to meet veterans' needs. In support of this emphasis, VA has detailed guidelines regarding how primary care is to be provided and staffed, including a requirement that medical facilities record and report data on primary care panel size—that is, the number of patients for whom a patient aligned care team delivers primary care services.⁵ According to VA, panel size is an important factor in helping VA determine the total number of patients that can be cared for in the VA

¹GAO, *VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care*, GAO-16-83 (Washington, D.C.: Oct. 8, 2015).

²VA medical facilities manage primary care clinics located within their respective medical centers and associated CBOCs. CBOCs provide outpatient primary care and general mental health services on site.

³Primary care providers are physicians, nurse practitioners, or physician assistants.

⁴VA's 21 Veterans Integrated Service Networks oversee the day-to-day functions of facilities that are within their network.

⁵See VHA Handbook 1101.02, *Primary Care Management Module (PCMM)* (April 29, 2009) and VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook* (February 5, 2014).

health care system; moreover, maintaining appropriate panel sizes helps ensure that providers will be able to offer quality care in a timely manner to a reasonable number of patients. Panel sizes that are too high may lead to veterans experiencing delays in obtaining care among other negative effects, while panel sizes that are too low may be associated with inefficiency and wasted resources. Reliable data on panel size can also help VA facilities manage and VA Central Office and networks oversee VA's primary care program. In addition to data on panel sizes, VA policy also requires facilities to record and report data on primary care encounters—that is, the number and types of visits to a primary care provider—and expenditures for delivering primary care. According to VA officials, data on encounters and expenditures may help VA oversee its primary care program by identifying potential inefficiencies.

In this context, my testimony today discusses the findings from our report analyzing VA's panel size, encounter, and expenditure data. Accordingly, this testimony addresses (1) what VA's panel size data show across facilities and how VA Central Office and networks use these data to oversee primary care, and (2) what VA's encounter and expenditure data show across facilities and how VA Central Office and networks use these data to oversee primary care. In addition, I will highlight two key actions that we recommended in our report that VA can take to improve the reliability of its primary care panel size data and improve VA Central Office and the networks' oversight of facilities' management of primary care.

To conduct our work, among other things, we analyzed fiscal year 2014 data for all VA facilities on 1) modeled panel size, which represents the number of patients on a primary care panel for whom a patient aligned care team is expected to deliver primary care, as projected by VA for each facility, 2) facility-reported panel size, which represents the average number of patients on a primary care panel; 3) the number of primary care patients, providers, support staff, and exam rooms reported by each facility; and 4) expenditures per primary care encounter. In addition, we conducted a more detailed, nongeneralizable examination of these data at seven VA facilities, which we selected based on geographic diversity

and differences in facility complexity.⁶ Our review revealed concerns about facilities' reported panel sizes and other data elements that were attributable to inaccuracies in how facilities recorded the data, which precluded us from using these data to report panel sizes across all VA facilities. As a result of these data inaccuracies, we calculated actual panel sizes for six of the seven selected facilities where we were able to use updated data provided by each facility and correct the data for inaccuracies.⁷ In addition, we reviewed VA policy documents and interviewed officials from the Veterans Health Administration's (VHA) Primary Care Operations Office and Office of Finance, within VA Central Office, as well as officials from selected facilities and their associated networks.⁸ We also assessed oversight activities for VA Central Office and across the networks we reviewed in the context of federal internal control standards for control environment, information and communication, and monitoring.⁹ The work this statement is based on was performed in accordance with generally accepted government auditing standards. Further details on our scope and methodology are included in our report.

⁶VA assigns each facility to one of five complexity groups (1a, 1b, 1c, 2, and 3) using a facility complexity model where level 1a facilities are the most complex and level 3 facilities are the least complex. VA's complexity model uses multiple variables to measure facility complexity in four categories: patient population served, clinical services offered, education and research complexity, and administrative complexity.

⁷We calculated actual panel sizes based on updated data each facility provided to us at the time of our review from November 2014 through March 2015. We verified the reliability of the data each facility provided us by checking for missing values and outliers as well as interviewing facility officials knowledgeable about the data. For one of the seven facilities, we were unable to correct for the inaccurate number of full-time equivalent providers. Therefore, we did not use or report on the panel sizes for this facility and instead report on six facilities.

⁸VA policy documents we reviewed included VA Handbook 1101.02, *Primary Care Management Module (PCMM)* (April 29, 2009) and VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook* (February 5, 2014). VHA's Primary Care Operations Office is responsible for executing policies related to primary care delivery and for monitoring primary care. VHA's Office of Finance develops policies related to the recording and reporting of primary care encounter and expenditure data.

⁹See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999) and GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

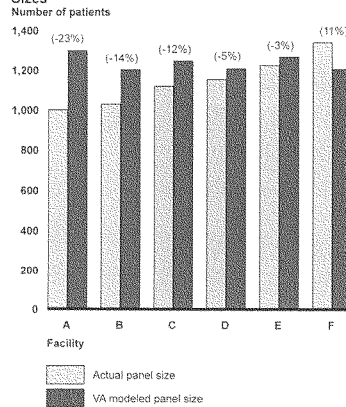
VA Lacks Reliable Data on Medical Facilities' Primary Care Panel Sizes and Does Not Have Effective Oversight Processes to Verify and Use Facilities' Data to Monitor Primary Care

We found that VA data on primary care panel sizes are unreliable across VA's 150 medical facilities. Federal internal control standards state that reliable information is needed to determine whether an agency is meeting its goals for accountability for effective and efficient use of resources. However, in contrast with these standards, we found missing values and other inaccuracies in VA's 2014 data, such as values that appeared too high or too low. Officials from VHA's Primary Care Operations Office confirmed that facilities sometimes record and self-report these data inaccurately or in a manner that does not follow VA's policy and noted that this could result in the data reliability concerns we identified. Because some medical facilities' reported panel size data are unreliable, VA Central Office and network officials cannot readily determine each facility's average primary care panel size nor compare these panel sizes to each facility's modeled panel size to help ensure that care is being delivered in a timely manner to a reasonable number of patients.

Primary Care Operations Office officials told us that they intend to address data reliability issues over time. Specifically, the Primary Care Operations Office is in the process of implementing new software, called web-Primary Care Management Module (PCMM), which officials believe will address some concerns about the reliability of the data because the software features controls to help ensure that facilities record and report the data accurately and consistently. In preparation for the implementation of web-PCMM, Primary Care Operations Office officials said they have been training network and facility staff on the features and capabilities of the new software and instructing facility staff to review and correct their panel size data to help improve data accuracy. It is not yet known the extent to which the new software will address the data reliability issues we identified because facilities will continue to self-report data. The Primary Care Operations Office started piloting the new software at selected facilities in 2014 and had planned to implement it agency-wide after resolving software interoperability issues identified during the pilot. However, officials said that implementation is currently on hold because of a lack of funding, and the officials could not provide an updated timeframe for its system-wide implementation. According to these officials, VA has spent about \$8.8 million through July 2015 on the development and implementation of web-PCMM and requires an additional \$1.5 million to implement it agency-wide.

Although reliable data on reported panel sizes were not available for all of VA's facilities at the time of our review, we were able to obtain updated data from six of seven selected facilities and calculate the actual panel sizes for those six facilities.¹⁰ We found that for these six facilities, the actual panel size varied from 23 percent below to 11 percent above the modeled panel size. (See fig. 1.) Such wide variation raises questions about whether veterans are receiving access to timely care and the appropriateness of the size of provider workload at these facilities. Officials we interviewed at the three facilities where actual panel sizes were the highest cited growing patient demand, staffing shortages, and exam room shortages as factors contributing to higher panel sizes.

Figure 1: Comparison of Six Selected Department of Veterans Affairs (VA) Medical Facilities' Actual Primary Care Panel Sizes to Their Fiscal Year 2014 Modeled Panel Sizes



Source: GAO analysis of six selected facilities' panel size data from November 2014 through March 2015. | GAO-16-114T

¹⁰We did not calculate the actual panel size for the remaining selected facility because we were unable to correct for inaccurate data on full-time equivalent providers reported by this facility.

Note: We were unable to compare reported panel sizes to fiscal year 2014 modeled panel sizes at all VA facilities because of inaccuracies we identified in facilities' reported panel size data. For six selected facilities, we calculated actual panel sizes based on updated data obtained from each facility from November 2014 through March 2015 that we verified as reliable.

Moreover, we found that while VA's primary care panel management policy requires facilities to ensure the reliability of their panel size data, it does not assign responsibility to VA Central Office or networks for verifying the reliability of facilities' data or require the facilities to use the data for monitoring purposes. Primary Care Operations officials said that they have not validated facilities' reported panel size data or used the data to monitor primary care because the office has a limited number of staff and mainly relies on the networks and facilities to ensure that the data are recorded and reported correctly and that monitoring is conducted. This practice is inconsistent with federal internal control standards that call for agencies to clearly define key areas of authority and responsibility, ensure that reliable information is available, and use this information to assess the quality of performance over time. Primary Care Operations Office officials stated that VA Central Office is in the process of revising its policy for primary care panel management and is developing additional guidance to require VA Central Office and VA networks to verify reported panel size data in addition to other monitoring responsibilities. However, as the revised policy and guidance are still under development, it is unknown when they will be implemented and whether they will fully address the issues we identified.

In our report, we concluded that the absence of reliable panel size data and oversight processes could significantly inhibit VA's ability to ensure that facilities are providing veterans with timely, quality care that is delivered efficiently. To address these shortcomings, we recommended that VA incorporate in policy an oversight process for primary care panel management that assigns responsibility, as appropriate, to VA Central Office and networks for (1) verifying each facility's reported panel size data currently in PCMM—and in web-PCMM, if the software is rolled-out nationally—including such data as the number of primary care patients, providers, support staff, and exam rooms; and (2) monitoring facilities' reported panel sizes in relation to the modeled panel size and assisting facilities in taking steps to address situations where reported panel sizes vary widely from modeled panel sizes. VA agreed with this recommendation and said it plans to take steps to implement it, including issuing guidance by September 2016 clarifying VA Central Office and networks' oversight responsibilities with regard to primary care panel size data. Given the importance of these panel size data, we will continue to monitor VA's progress in implementing the recommendation.

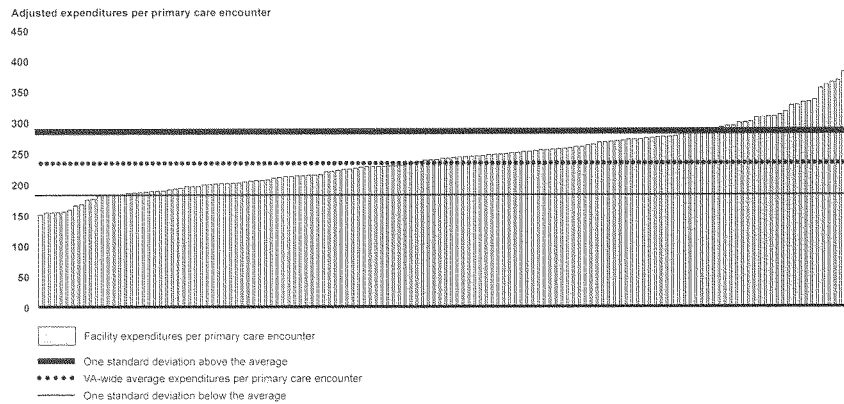
VA's Encounter and Expenditure Data Show Wide Variation across Medical Facilities, and VA Central Office and Networks Do Not Use These Data to Monitor Primary Care

In contrast to VA's panel data, we found that primary care encounter and expenditure data reported by all VA medical facilities are reliable, although the data show wide variations across facilities.¹¹ For example, in fiscal year 2014, expenditures per primary care encounter ranged from a low of \$150 to a high of \$396 after adjusting to account for geographic differences in labor costs across facilities. (See fig. 2.) We also found that expenditures per encounter at about 40 facilities were potential outliers that VA Central Office and the networks may need to examine further.¹² We also analyzed expenditures per unique primary care patient—that is, a patient with at least one primary care encounter in fiscal year 2014—and found similar variation across VA's facilities. Such wide variations may indicate that services are being delivered inefficiently at some facilities with relatively higher per encounter costs compared to other facilities.

¹¹Data for some of VA's 150 facilities that are part of a larger hospital system were combined with another facility's data. As a result, the expenditure and encounter data that VA provided included 140 facilities. The analysis includes expenditure and encounter data for traditional and telephone primary care.

¹²According to officials from VHA's Office of Finance, one standard deviation is typically used to identify potential outliers when examining encounter and expenditure data. Our analysis found that expenditures per encounter at 20 facilities were at least one standard deviation above the average and at 23 facilities were at least one standard deviation below the average.

Figure 2: Department of Veterans Affairs (VA) Expenditures per Encounter by Facility Adjusted for Geographic Variance in Labor Costs, Fiscal Year 2014



Source: GAO analysis of VA data. | GAO-16-114T

Note: Data for some of VA's 150 facilities that are part of a larger hospital system were combined with another facility's data. As a result, the expenditure and encounter data that VA provided included 140 facilities. The analysis includes expenditure and encounter data for traditional and telephone primary care.

While VA verifies and uses these data for cost accounting and budgetary purposes, VA's policies governing primary care do not require the use of the data to monitor facilities' management of primary care. In contrast, federal internal control standards state that agencies need both operational and financial data to determine whether they are meeting strategic goals and should use such data to assess the quality of performance over time. By not using available encounter and expenditure data in this manner, we concluded that VA is missing an opportunity to potentially identify inefficient practices or processes at facilities and improve the overall efficiency of primary care service delivery. Using panel size data in conjunction with encounter and expenditure data would allow VA to assess facilities' capacity to provide primary care services and the efficiency of their care delivery.

To address this shortcoming, our report recommended that VA review and document how to use encounter and expenditure data in conjunction with panel size data to strengthen monitoring of facilities' management of primary care. VA concurred with this recommendation and said it plans to take steps to fully implement it with a target completion date for presenting its findings and decisions by September 2018. Given the significant lead time that VA has indicated it needs to implement this recommendation, we will continue to actively monitor its progress.

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contacts & Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 (williamsonr@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Rashmi Agarwal, Assistant Director; Aaron Holling; and Michael Zose.

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**STATEMENT OF DR. THOMAS LYNCH, M.D.
ASSISTANT DEPUTY UNDER SECRETARY
FOR HEALTH FOR CLINICAL OPERATIONS
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

October 22, 2015

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the House Committee on Veterans' Affairs Subcommittee on Health, I would like to thank you for the opportunity to discuss the Department of Veterans Affairs (VA) improvements in high-quality primary care being provided to our Veterans.

The Veterans Health Administration (VHA) has over 5.3 million Veterans enrolled in primary care in our health system. The patient demographics are considerably different from the majority of private primary care practices. Currently, our average patient age is 62, with 21 percent of our patients being over the age of 75. Roughly 7.5 percent of our patients are female, and 51 percent have service-connected disabilities. Geographically, 35 percent of our patients reside in rural or highly rural areas, with 10 percent having a documented history of homelessness. The majority of the population has multiple chronic diseases, and overall, 20 percent have documented mental health diagnoses.

Beginning in 2010, VHA began providing primary care through the patient-centric medical home model of care. This model, which VA calls "Patient-Aligned Care Teams" or PACTs, involves a team-based approach to health care. The focus is on improving access, continuity, and care coordination, along with prevention and health promotion in a patient-centered environment. Through PACTs, patient care is not only provided in

person in our clinics, but also through alternate methods such as by telephone, secure messaging, and by telemedicine. In addition, Primary Care-Mental Health Integration programs completed more than one million direct encounters with Veterans during fiscal year (FY) 2015, conveniently serving 7.2 percent of the VA primary care population within their PACT sites and providing liaison to specialty mental health care when more complex services are necessary.

VHA PACTs are made up of physicians, nurse practitioners, and physician assistants, as well as support staff including registered nurses, licensed practical nurses, and clerical staff. Our providers spend a percentage of their time in other clinical activities for their patients beyond direct face-to-face patient care. This may include obtaining specialty care referrals by written or verbal consultation, by electronic consultation, or through other means, and following up the results, reviewing lab and diagnostic test results, and coordinating care with other providers, both within our VA system and through the Veterans Choice Program or other care-in-the-community programs. It has been demonstrated that patients who have been placed in well-implemented PACTs have lower hospital readmission rates, improved levels of patient satisfaction, and higher results on measures of quality of care. Overall, VHA exceeds the private sector in outpatient measures of quality such as the Healthcare Effectiveness Data and Information Set particularly in the areas of preventive care and management of diabetes and cardiovascular disease. In FY 2015, VHA primary care completed 93 percent of new patient appointments and 97 percent of established patient appointments within 30 days of when the patient requested to be seen.

VHA is considered a national leader in the patient-centered medical home concept. In an effort to ensure efficient and functional workplaces for our teams, PACT has fundamentally transformed VHA outpatient facilities' design to enable improved team communication and efficiency and to improve the Veterans' experience. We have also developed a process to identify the patients at highest risk for hospitalization or emergency room visits in order to take meaningful action. We have developed tools that support proactive ongoing management of Veterans with diseases common to primary care. In support of continuity of care, the Computerized Patient Record System displays the assigned PACT, allowing other VA clinicians to identify the responsible primary care team. We have established Centers of Excellence in Primary Care Education to develop innovative approaches to prepare physician residents and students, advanced practice nurse and undergraduate nursing students, and associated health trainees for primary care practice in the 21st Century.

Due to the importance of continuity and coordination of care in primary care, it is imperative to have reliable data regarding panel sizes. The productivity and efficiency of primary care providers is closely related to the size of the patient panel they manage. VHA is appreciative of the Government Accountability Office (GAO) findings in this regard, and agrees that greater oversight and responsibility for the accuracy of data are needed. Through the changes recommended, our processes to identify and manage instances of significant variation will be strengthened.

Primary Care (PACT) panel capacity is the maximum number of patients who can be accommodated by a team; the panel size reflects the actual number of patients assigned. Panel capacity varies from panel to panel because of adjustments to ensure

that appropriate resources are available to care for the patients on the panel. Adjustments to a baseline (currently 1,200) are made for the number of support staff, number of rooms available, and patient complexity and gender. Further adjustments are made for provider type and full-time employees. Approximately 30 percent of PACT Primary Care providers are Nurse Practitioners or Physician Assistants and have panel capacities set at 75 percent of physician panels. In addition, panels for special populations such as Home-based Primary Care and Geriatrics are set to lower capacities. The current average panel capacity for physicians in conventional PACTs is 1,161, with an actual panel size of 1,076 (93 percent of capacity). The average panel capacity for non-physician Primary Care Providers (PCP) is 755, with an actual panel size of 697 (92 percent of capacity).

These adjustments ensure that Veterans are assigned to teams with the correct resources to provide the access and care they need. While the calculated model size serves as a recommendation or estimate, local managers are allowed to further adjust capacity to account for various local considerations and responsibilities. This method is designed to provide flexibility to match providers, team, patient, and practice characteristics, but consequently results in variations in panel sizes throughout our system.

In distinguishing VA panels with other health care providers, there are only a few entities that are comparable with clearly defined patient populations. These organizations include Kaiser-Permanente, the Department of Defense, and certain county health care systems. The panel sizes in these health systems are comparable to those found within VHA. In evolving to systems such as Medical Home or PACT,

which are designed to improve the quality of a patient's health and to add health care value, it is important to include patient panels that are sized to reach system objectives.

According to a 2012 article published in the *Annals of Family Medicine*, the average panel size in the United States is 2,300 patients. This figure is not consistent with delivering high-quality care under the traditional practice model. Under this panel size, a primary care physician would need to spend 21.7 hours per day to provide all recommended acute, chronic, and preventative care. In this study, the authors cite the VA health care system, specifically noting that the patient population in VA is traditionally older and has more chronic conditions than the hypothetical population seen in other studies. Their analysis suggested that the 1,200 patient average panel size target would be reasonable for the VA system, under a care model that delegates a share of primary care physicians' tasks to other members of the primary care team.

It is also important to discuss what occurs when local leaders identify the need for additional providers. With more Veterans enrolling in VHA care, if additional providers are needed, we must identify those needs early. The panels must have the ability to accommodate additional enrollees appropriately. Simply expecting all teams to be at the maximum panel size all the time does not allow for surges in enrollment that occur. In addition, other Veteran needs impact panel sizes. PACT providers who care for Veterans who have been former prisoners of war, for example, necessarily need more time with each patient in order to address the sequelae of those exposures and panel size may be adjusted downward to accommodate them.

Primary care leadership in VHA has recognized the issues with our aging data systems. This has been an auxiliary factor that contributed to inaccurate determinations

of panel sizes. In response to this issue, a re-design and re-engineering of our software that tracks and helps manage panels, the Primary Care Management Module, has been underway since 2011. The upgraded database will begin national deployment later this year and will enable both greater control over the accuracy and reliability of panel data and provision of more granular and precise data about staffing and space. This will enable primary care managers throughout the organization to have the reliable data they need to monitor productivity, assure optimal access, and maintain continuity of care. VA will continue to provide guidance to field staff ensuring awareness of their responsibility of monitoring and oversight of data quality.

The report by GAO found that primary care cost data reported by all VHA facilities were reliable, but varied ranging from a low of \$150 to \$396 per encounter. GAO further stated that VA is missing an opportunity to potentially improve efficiency in improving primary care service delivery through heightened oversight of encounter use and costs. VA concurs with the findings of this assessment and acknowledges that primary care managers have not fully understood or routinely used encounter and expenditure data to explore the impact of cost, and further recognizes the possibility of incorporating data to guide precision decision making.

It is important to recognize that the comprehensive, integrated care model that PACT represents includes services that provide value to Veterans, but are not generally present in private primary care practices. For example, integrated mental health care, social services support, coordination with non-VA care, prevention and wellness support, and management of complex multisystem diseases are routine in VHA primary care practices. In addition, almost half of our primary care practices are housed in

medical centers, many of which are aging and not designed for efficient outpatient care. This makes cost comparisons with non-VA care models difficult to accomplish.

VHA has formed a project team that will analyze all aspects of primary care costs within the administration and provide comparisons to other models. This analysis will take into account Veteran population demographics and current resource allocations. The full examination of costs will be shared with leaders throughout the organization and used to better align the administration's expenditures to improve efficiency, productivity, and quality of care.

Mr. Chairman, VA continues to be a Veteran-centric organization, and delivers patient-centric, world-class health care. Overall, we are proud of our documented record in the industry of providing effective, high quality, and safe health care. VA remains dedicated to providing the best care possible, and we believe our mission will never be complete.

Mr. Chairman, this concludes my testimony. We look forward to answering the Committee's questions.