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MAXIMIZING ACCESS AND RESOURCES: AN EXAMINATION OF VA PRODUCTIVITY AND EFFICIENCY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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MAXIMIZING ACCESS AND RESOURCES: AN EXAMINATION OF VA PRODUCTIVITY AND EFFICIENCY

Thursday, July 13, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:02 p.m., in Room 334, Cannon House Office Building, Hon. Brad Wenstrup [Chairman of the Subcommittee] presiding.

Present: Representatives Wenstrup, Bilirakis, Radewagen, Dunn, Rutherford, Higgins, Brownley, Takano, Kuster, and Correa.

Also Present: Representative Roe.

OPENING STATEMENT OF BRAD WENSTRUP, CHAIRMAN

Mr. WENSTRUP. The Subcommittee will come to order. Good afternoon and thank you all for joining us for today's hearing, "Maximizing Access and Resources: An Examination of VA Productivity and Efficiency."

Today, we will discuss clinical productivity and efficiency in the Department of Veterans Affairs' health care system. As a clinician and a veteran, this is an issue I hold near and dear to my heart. As one of our witnesses, the Government Accountability Office, will note this afternoon, VHA's bottom line has grown significantly over the last decade, increasing from $37.8 billion in fiscal year 2006 to $91.2 billion in fiscal year 2016.

As a Federal agency, VA has an obligation to be a responsible steward of the taxpayer dollars that so generously fill its coffers. As the Federal agency responsible for providing health care to our Nation's veterans, VA has an obligation to be a responsible servant worthy of caring for the greatest fighting force the world has ever known.

However, it is not clear whether or not the increasing amount of money that has been allocated to VHA has resulted in a more productive, efficient health care system or in veteran care that is more accessible, more high quality, or more cost effective, and that is our goal.

This afternoon, we are going to examine findings from both a recent GAO report and from the 2015 independent assessment, which will detail a variety of concerns with clinical efficiency and provider productivity at VA medical facilities.

For example, we are going to hear how the current models and metrics at VHA uses to assess clinical efficiency and provider productivity failed to account for all providers and services, failed to accurately reflect the intensity of clinical workloads and staffing levels, and may be populated with inaccurate data, as well as how VA central office policies and procedures failed to provide sufficient monitoring and oversight, even when problems have been identified.

We will also discuss how VHA's productivity compares to leading private sector health care systems and what industry best practices VHA may be able to use to increase quality and efficiency. For example, we are going to hear that the number of patients assigned to VHA primary care providers is 12 percent lower than the private sector benchmark for patients of a similar acuity, which all begs the question, what are we paying for?

To be clear, VHA is taking strides in making progress, and not all of the barriers to increased productivity and efficiency are under the control of the individual VA medical facilities or providers. As we discussed during yesterday's Full Committee hearing on VA's capital asset deficiencies, the average VA medical facility building is five times older than the average building in a not-for-profit hospital system in the United States and is not well situated to the provision of high quality care or to efficient practice of medicine in the 21st century.

As a doctor myself, I know firsthand the constraints that are placed on a provider who lacks sufficient clinical space and adequate support staff. In the private sector, room-to-provider ratios are typically 3 or 4 to 1. In the VA health care system, providers typically only have a 1-to-1 room-to-provider a ratio, as well as significantly fewer nurses and administrative staff. So that means, in many cases, the deck is stacked against a VA doctor the second they step into their clinic.

We need to find solutions for those providers, for the taxpayers whose hard-earned dollars are supporting VA's massive bureaucracy in increasing frequency and, most importantly, for the veterans who deserve a more efficient, accessible VA health care system.

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

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman.

Paired alongside yesterday's hearing on capital asset management, the topic of VHA productivity and efficiency is both timely and vital as we discuss VHA's ability to care for our Nation's veterans in the future.

Yesterday, former Secretary Principi stated he did not believe VA would survive another decade of capital asset constraints on the scale we see now. I could not help but think of how this issue of provider productivity and efficiency ties directly into the issues we see with capital asset management at the VA.

As Ranking Member Walz and Chairman Wenstrup mentioned in yesterday's hearing, it is crucial that VA be able to accurately de-

termine the capabilities of its staff when determining the fitness of its infrastructure. I am concerned that VHA does not have the tools necessary to make this determination. Even more concerning is the idea that VHA is relying on faulty productivity and efficiency data while shifting significant resources, including taxpayer dollars, into the community and away from VHA facilities.

It is difficult to believe VHA is confident in its multibillion dollar budget request for fiscal year 2018 when it is increasingly evident VHA does not have the tools necessary to make decisions using proven processes that are based on sound data. In its report, GAO made many recommendations similar to those made by Grant Thornton in its 2015 assessment of VHA's productivity. While VA has concurred with these recommendations, I am curious as to why they were not addressed immediately following the assessment by Grant Thornton.

If the same issues are being raised repeatedly by multiple parties almost 3 years apart from each other, I do not think VHA can boast of its progress in addressing the issues. I understand that some of the recommendations made by Grant Thornton and GAO are difficult, even for the private industry, to address, but VA has a track record of leading the health care industry, and I will continue to hold VA to that standard, the standard of an industry leader.

I am hopeful VHA will take the issues raised during this hearing seriously, and I hope my colleagues and I are able to support you as you address these issues in a timely manner. While the adoption of a new generation electronic health record system will assist in accurately collecting workload data, VA's capital asset portfolio will not wait the 8 or 9 years it will take for VA to set up the new electronic health record system.

Therefore, this new system cannot be the excuse VHA uses to further delay the implementation of both Grant Thornton's and GAO's recommendations. During today's hearing, I hope to learn more about this issue so that I can support VHA in its efforts to develop an accurate and useful system that promotes the productivity and efficiency of VHA's health care providers.

Thank you, Mr. Chairman. And I yield back.

Mr. Wenstrup. Thank you, Ms. Brownley.

Unfortunately, at this time—you heard the buzzer—they have called us over to vote. And I hate when this happens. We are going to have to go to vote, and I am going to ask you if you would please stay nearby, and we will come back and continue on after the vote series that is taking place right now. And I appreciate your patience on that. Thank you.

[Recess.]

Mr. WENSTRUP. Welcome back. I am going to take a liberty, because we have a time constraint on this room. Before I introduce you, so I can give you a minute or two to prepare, rather than 5 minutes for your opening statement, if it is possible that we could reduce them to 3 minutes, and then we will have adequate time for questions. If that is okay, I would like to proceed in that direction.

So joining us on our first and only panel is C. Sharif Ambrose, principal at Grant Thornton LLP, one of the authors of The Independent Assessment; Randall B. Williamson, Healthcare Director

from the Government Accountability Office, Dr. Jonathan Perlin, former Under Secretary for Health and now the President of Clinical Services and Chief Executive Officer of Hospital Corporation of America; and Dr. Carolyn Clancy, Deputy Under Secretary for Health for Organizational Excellence, who is accompanied by Dr. Murray Altose, the Chief of Staff of the Louis Stokes Cleveland VA Medical Center. I want to thank you all for being here.

And, Mr. Ambrose, you got the short straw, I guess. We would like to begin with you and you are now recognized for 3 minutes. But having you go first, if you are over a little bit over, I think we will be okay with that. So you are now recognized.

STATEMENT OF C. SHARIF AMBROSE

Mr. AMBROSE. Thank you. And good afternoon, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to discuss Grant Thornton's 2015 report on VA provider staffing and productivity. My name is Sharif Ambrose. I am a principal at Grant Thornton, where I lead our public sector health care practice, and we provide consulting services to government clients, including the Department of Veterans Affairs. And it has been our distinct privilege and honor to support the U.S. Department of Veterans Affairs and the veterans it serves for the past 20 years.

I am accompanied by my colleague Erik Shannon, who leads our commercial health care advisory practice, who also contributed to this assessment.

CAMH served as the program integrator and as primary developer of 11 of the Veterans Choice Act independent assessments. CAMH is a federally funded research and development center operated by the MITRE Corporation.

We conducted our assessment in 2015 of current provider staffing levels, caseload, and productivity, and in comparison with health care industry benchmarks.

Among our findings in assessment G is a couple I would like to share with the Committee. First, we found that VA doesn't systematically track fee-based provider productivity and does not capture the FTE level information for fee-based provider care providers. We also found that staffing levels per patient population were in most specialties lower than the industry ratios. The ratios, however, are not sufficient to establish whether VHA is staffed to meet demand, because of factors that make it difficult to measure clinical workload of VHA and to compare to industry benchmarks.

Further, we found that the number of patients assigned to VA general primary care providers is 12 percent lower than the private sector benchmark for patients of a similar acuity. And with respect to specialty providers, our analysis shows that VA specialists are less productive than their private sector counterparts on two measures: encounters and work relative value units, otherwise known as wRVUs.

We studied root causes, and our team examined many of them that drive VHA provider productivity and found several factors that limit the ability of providers to optimize productivity.

First, we found that VA providers have a lower room-to-patient ratio than their private sector counterparts. Room-to-provider ra-

tios in the private sector are typically 3 to 1, and we found that VA providers typically only have a 1-to-1 ratio, which doesn't allow them to see as many patients as their private sector counterparts. Similarly, VA providers have significantly fewer nurses and administrative support staff, which means the providers can't be as efficient as they otherwise could be.

We outlined many recommendations in our report. First and foremost is that we recommended that VA evaluate the design and implementation of their staffing models, to which they are sufficient to ensure all eligible veterans have access to high-quality and timely care.

I think I will yield my time, in the sense of time, to the other witnesses. Thank you.

[THE PREPARED STATEMENT OF C. SHARIF AMBROSE APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you. I appreciate that.

Mr. Williamson, you are now recognized.

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Thank you, Chairman Wenstrup and Ranking Member Brownley. VA has developed productivity metrics to measure physician providers' time and effort to deliver procedures and methods to track clinical efficiencies at VAMCs. Using the metrics, VHA's Office of Productivity, Efficiency and Staffing, or OPES, reports data on each VAMC for VAMCs to use in identifying suboptimal clinical productivity and efficiency.

GAO's recent study in this area identified limitations with VHA's metrics and methods that limit VHA's ability to assess whether resources are being used effectively. Regarding productivity, there are several needed improvements. First, while OPES reports provider productivity data for 32 different clinical specialties, the data only covers VA employed providers. It excludes contracted providers that work at VAMCs and others, such as nurse practitioners who are other major contributors to patient care. Also, VA providers are not always accurately coding the intensity of their clinical workload, that is, the amount of effort needed to deliver the procedures they perform. Finally, VAMC providers may not always be recording their clinical time accurately.

To its credit, VA has implemented or is developing new initiatives to improve productivity and efficiency data. For example, they have intensified training for providers in the field on proper methods for coding, and they are attempting to solve other staffing issues as well that relate to labor mapping.

GAO made recommendations to further improve productivity and efficiency data, and VHA has concurred with all of them.

Perhaps the most significant issue from our study centers around VHA's lack of oversight and monitoring to better ensure that VAMCs with suboptimal productivity and efficiency are held accountable for making substantive improvements. Currently, VAMCs with suboptimal productivity are required to develop remediation plans and submit them to their respective VISNs for review. However, current VA policy does not require VISNs or Cen-

tral Office to monitor VAMCs' implementation and resolution of these plans.

Moreover, VAMCs are not required to address or monitor their overall efficiency at all. And as a result, they do not develop remediation plans to address inefficiencies identified by OPES data. Our review of data shows that some VAMCs perform poorly on these metrics year after year, and there appear to be few real incentives for VAMCs to improve these metrics.

In summary, achieving better productivity and efficiency will better ensure that VHA is using resources wisely and maximizing access to health care services for veterans.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF RANDALL B. WILLIAMS APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you very much.

And, Dr. Perlin, you are now recognized for 5 minutes.

STATEMENT OF JONATHAN B. PERLIN, M.D., PH.D.

Dr. PERLIN. Thank you, Mr. Chairman, Ranking Member Brownley, and we thank Chairman Roe and Members of the Subcommittee for the opportunity to be here today.

HCA is the largest private provider of health care services with the privilege of about 28 million patient encounters annually. We have about 241,000 employees, including 8,000 nurses, exclusive of another 37,000 voluntary physicians, and we have the privilege of seeing patients at 168 hospitals and 1,200 other sites of care. So, roughly speaking, we are similarly sized to VA.

We also are proud to acknowledge that included in our dedicated workforce are many veterans and military spouses, and in the last year alone, we hired more than 5,400 military veterans and 1,100 military spouses, and that led, in 2015, to the Chamber of Commerce Foundation's Award for Hiring Our Heroes, the Lee Anderson Veteran and Military Spouse Employment Award.

On that basis, on the basis of my history in VA, I believe that I have a unique perspective to offer on this particular topic, having served as Under Secretary, Deputy, Chief Quality Officer, and like Dr. Shulkin in his current and previous capacity, actually seeing patients in VA.

I note Dr. Shulkin's 100-day briefing at the White House, where he offered a number of observations that he came to from a business and clinical perspective, and I will note three that I believe are directly relevant to GAO's assessment of VA productivity.

Dr. Shulkin's first diagnosis of risk concerned access. His comments identified substantial progress overall, including same-day access for primary and certain specialty services but also identified remaining opportunities for improvement. Obviously, increases in provider efficiency are an important means for creating additional capacity and access.

His second diagnosis of risk concerned prompt payment of external providers. This is an area in which legislative relief would be helpful. Consolidation of disparate models for obtaining services outside of VA and, frankly, comportment with Medicare or private insurer reimbursement models would facilitate provider participa-

tion and increase veteran access to services. The complexity of the different VA models imposes statutory inefficiencies on VA's overall management of care both within and outside of VA.

The third area noted by Dr. Shulkin was quality, and VA is to be commended for making their star ratings public. VA is increasingly benchmarking against private sector, and in many instances, VA's performance is as good, if not better, and I note, in particular areas, these areas, because they are salient to the comments on productivity within GAO.

GAO notes, as Mr. Williamson said, that the productivity metrics are not complete, and the new information system should provide a resource for capturing workload. This is a perennial challenge, as is the attribution to particular providers, and this is well-demonstrated in the history of attributing performance metrics around quality and safety.

I would note that in our organization, when we think about the care of hospitalized patients, rather than trying to capture every individual action, we summarize by looking at things like employee equivalents per occupied bed.

GAO also notes that intensity of service may not be quantified. That is something that is incentivized more in private sector because it calibrates to a reimbursement.

So, on the basis of my experience with VA management systems of more than a decade ago and my research for this particular hearing, I would note that VA's Central Office has taken steps to help VAMCs monitor provider productivity by developing tools to oversee performance and efficiency. VA and HCA share a strategic and operating advantage in that scale, and within that scale is the capacity to look for not only negative but also positive variation. If the underpinnings of better performance can be understood, replicated in scale, it becomes the means to elevate the performance of the entire system.

So understanding variation within the system in comparison with external performance standards is really why both internal and external benchmarking is necessary. Internal benchmarking is a tool for learning and management. It can function as an important control system for facilities, for VISNs, and for VACO leadership to manage performance.

External benchmarking is necessary to understand whether internal performance is superior, consistent with, or inferior to external organizations. External benchmarking is limited by differences in data availability and data definitions, but I would note that the biggest challenge to external benchmarking is not related to data but, rather, certain inherent features of VA and the patients it served.

First, veterans using VA are systematically more complex than commercially insured or even mixed commercial-government patients, and so benchmarks need to be calibrated to that increased complexity. Second, the VA benefits package is systematically different than either commercial insurance or other government programs like Medicare or Medicaid, and there are many more things that VA providers can, should, and really must do to care for veterans appropriately.

Indeed, in the capitated system, it is rational to take all necessary actions for preventive services or other interventions that reduce the need for future services or subsequent interventions. Again, there is this tension between work and recording of work.

Third, our views were developed in fee-for-service environments and really do calibrate recorded work with compensation. In point of fact, it is not only about efficiency, but recording quality. In our organization, we always look at productivity and compensation together only with quality, which is the nonnegotiable foundation.

Fourth, in our organization, in our physical plants and, as you referenced, the Ranking Member referenced in your statements, the VA physical plant doesn't support multiple exam rooms, and this compromises the ability for the most efficient care.

Finally, I would note that, as you noted as well, that there may not be as many supportive staff. And there are times when it may be inefficient or inappropriate for VA to produce all of its care internally. And in this respect, I agree with the Secretary's perspective to use private sector services when geographic access, wait times, capacity, demonstrated clinical performance excellence or technology are not available in VA.

Let me close with the comment that looking at quality is obligatory. Quality and safety are always the most efficient. Rework for breaches in either is neither efficient nor consistent with the performance excellence the taxpayers deserve and the veterans should expect and certainly have earned through their service and sacrifice.

Thank you.

[THE PREPARED STATEMENT OF JONATHAN B. PERLIN, M.D., PH.D., APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you. Just under 3 minutes. You barely made it.

Dr. Clancy, you are now recognized.

STATEMENT OF CAROLYN CLANCY, M.D.

Dr. CLANCY. Thank you. Good afternoon, Chairman Wenstrup, Ranking Member Brownley, other Members. I am very happy to be here. I am here with Dr. Murray Altose, who is the Chief of Staff from the Cleveland VA Medical Center.

Let me just reiterate that our top priority is improving access to care for our veterans, and improving productivity and efficiency is a means to that end.

As the others have noted, we have developed a pretty sophisticated tool that is calculated in industry-based resource: relative value units. And this is used widely across our system, and we can actually see that by the number of web hits. We have seen an increase of 37 percent in the past year in terms of the number of people actually looking at this.

Getting to optimal productivity and efficiency is, by definition, a team sport, where deployment of providers is continuously evaluated and revised, and there is a very strong collaboration between the clinical workforce and the administrative function.

As others have noted, we implemented clinical productivity metrics in 2013 and have developed statistical models to track effi-

ciency at our medical centers. We have designed reports to provide our leaders and facilities and networks with essential tools to understand which clinics are working under, at, or over capacity, and we have something called the SPARQ tool that I know you have seen, Mr. Chairman, which actually gives our leaders a sense of whether clinics are working under, at, or over capacity.

Since the tool's introduction, as I noted, we have measured reportable progress, as demonstrated by increase in RVUs. Our system-wide focus on improving access to care, prioritizing urgent clinical needs, and achieving same-day access for veterans with urgent primary care or mental health needs has resulted in a 13-percent increase in clinical workload, with a concurrent increase in RVUs for a clinical employee of 9 percent.

Specialty practices that are not meeting productivity aren't required to develop remediation plans. And, in fact, there is a monthly meeting between clinical operational leadership at Central Office with the network with those who are reported as outliers, using statistical trigger tools.

We have concurred with the GAO recommendations and are already working to complete them. I want to make note and really recognize my colleagues who developed data to assess the clinical productivity of advanced practice providers several years ago. In most of health care, the work of those providers has been subsumed under the billing done by the clinicians, physicians with whom they work. So we will be setting performance standards for those providers in the very near future and I believe may become actually the reference for other systems, because of expanding full practice authority.

Thanks to the Congress, the group practice managers that we have at all of our facilities now overseeing staff and clinic flow I think has been one of the most exciting developments in our system. They are charged with specialty practice management and have quickly and adroitly begun addressing the myriad issues in optimizing clinical practice in realtime. Our best facilities—Cleveland would be one—have established a regular rhythm, with close collaboration between the group practice management, the chiefs of staff, the service chiefs and so forth, and they are constantly conferring about how to do better.

And, with that, I think I will simply conclude my remarks. We find the GAO's recommendations helpful. We have made progress and will continue to move in that direction.

[THE PREPARED STATEMENT OF CAROLYN CLANCY, M.D., APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, I thank you all, and I am going to take some 5 minutes for questioning. I appreciate you all being here.

I can tell you a lot of the ideas that I hear coming out of today are greatly appreciated, but, to be honest with you, there are a lot of ideas that I and other Members of this Committee have been talking about and asking to be implemented since I have been here, which is 5 years, 2013.

For example, with metrics, and even as of this week, when I asked about being able to measure RVUs, I am told, well, we don't have them for everybody. And today we heard that contractors are

excluded. This is not the way to really, in my mind, develop some understanding of what is taking place. If we set up metrics, we should be able to set up metrics to evaluate the VA health care system in general, each VISN, each hospital, each facility, CBOC, each practitioner, for that matter. And it is a matter of simply training people to know how to code.

And what my first question is, are our providers not able to code the way that private practitioners do so that we can track RVUs? It is a relatively simple system if you know how to bill and how to code what you have done. Is that missing from our health care system in the VA?

Dr. CLANCY. Many of our providers are quite good at it. I would almost expect certainly that they are less good at it than private sector providers, because they don't have the same direct billing incentive, and we don't have the same number of expert coders on the ground locally.

So, with that caveat, some are better than others, and we are committed to training those who are having more trouble.

Mr. WENSTRUP. Across the board, contractors and everything?

Dr. CLANCY. Contractors we have a little more trouble with, because the nature of our contract is that we are not paying for their time. We are paying for the services they produce on a fee-for-service basis. So we are not actually hiring someone to work a full day in the clinic or half a day.

Mr. WENSTRUP. Well, then if they are on a fee-for-service basis, they know how to code.

Dr. CLANCY. Yes, exactly.

Mr. WENSTRUP. So they don't need the training.

Dr. CLANCY. Exactly.

Mr. WENSTRUP. They already got it.

So you mentioned, Dr. Clancy, that those that are suboptimal, they have to present a plan. How can they present a plan if they don't know what they don't know? It seems to me that a plan should be delivered to them. Someone should be assessing their clinic and say: Hey, you know what, this 1-to-1 ratio doesn't work. Maybe they don't know that if that is all they have ever seen. Why are they developing the plan when they are already operating a system that is doing wrong? I would love to have their advice on how they can get it better, but why are we waiting for them to develop a plan? Shouldn't we be giving them the plan?

You know, we would do that in our own practice. If one is producing more than the other—and we are always concerned about quality; you got to concede that for sure—but, hey, this doctor has two medical assistants; you only have one; and they are seeing twice as many patients and delivering the same quality. So the plan needs to probably come from someone else who has had some success.

Dr. CLANCY. Well, the plans have to be signed off on by their service chief. So this is not just asking someone who is doing a bad job to tell me how can you do better, okay?

Secondly, as I think you are aware, many of our facilities—and you referenced this in your opening remarks—are very much space-constrained. Having three or four rooms to work with feels like, you know, something from Star Wars. But most—

Mr. WENSTRUP. My question comes into really, or my concern is, who is providing the guidance in creating the plan so that they are more productive? That I think we have to talk about, because you said that they submit their own plan. Well, they are not the experts, obviously, if they are suboptimal. You need someone who knows how to be optimal to create the plan, in my opinion.

Dr. CLANCY. The guidance is two parts: One is technical in terms of what do these trigger tool means and what do your metrics actually mean, so that they can understand the delta that we are seeing, particularly if they are not actually all that familiar with it. But the real guidance is operational leadership, and I might just ask Dr. Altose to chime in on that.

Dr. ALTOSE. So I would offer that the agenda that is offered to the facilities by Central Office I think is reasonable. The priorities are set. The resources are distributed. The oversight does take place.

The big issue, in my opinion, is simply operations at the local level. And it is complicated because, as has been pointed out in much of this testimony, there are many parties who contribute to the provision of care, both on an ambulatory basis and in the hospital.

Mr. WENSTRUP. So this leads to my next question, when you talk about incentives. I have not been made aware of incentives for quality and productivity that are measured that are there. And you said you are working on that. I would like to hear some of your ideas, and that is my last question before we move on.

Dr. ALTOSE. I can also speak to that and point out that, particularly in an ambulatory setting, efficiency and productivity is based on a team effort that involves schedulers, clerks, providers, nurses, technologists. And each and every one of those parties need to be able to contribute, and one aspect lacking is going to seriously compromise efficiency and productivity.

Reward needs to be offered not to individuals but to teams. This is a team effort. It requires an effective team, and rewards need to be distributed to the team, not necessarily to any one individual.

Mr. WENSTRUP. I would agree with that.

Ms. Brownley, you are now recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I wanted to go back to my opening comments that I made. And this question is for Dr. Clancy. And I mentioned in my opening comments about, in the current GAO report, they have made many recommendations that are similar to the Grant Thornton report that took place in 2015. The VA concurred with those recommendations at that time. So I am curious as to why we are now in 2017, that was 2015 why haven't we met those recommendations of which you said at that time, I believe, that you concurred and would work towards? And now you are saying you are going to work towards the GAO recommendations as well. So is it a lack of budget, tools, what?

Dr. CLANCY. I think one of the biggest critical gaps for us has been getting the right people into key leadership positions. I mean, at our best facilities, this culture and strong sense of it is a team sport starts from the top. And it was one of Dr. Shulkin's, when

he was Under Secretary, top priorities was to make sure that we filled critical gaps in leadership across our system.

Some of those are only recently filled, but we are in so much better shape since he started at VHA. And with our system, that took time to get the right people into their seats. Meanwhile, at every level, we are seeing much more attention to the technical tools.

So the two game-changers, I believe, are the full practice authority for advanced practice nurses. And, also, we have already got the tools to know how much they are contributing in terms of RVUs. And the second is the group practice managers. Now, getting that practice up and all those slots filled I would say has taken over a year, but we are now at full or very close to 100 percent capacity there. They have been trained in what is essentially a new role in our system and one that I think is very, very important.

That is why I was expressing our appreciation to the Congress for insisting on this, because trying to figure out exactly what this person was, how they would fit in the existing system did take some time, and it took some training for them to understand how they would be doing their jobs. But I think that we are beginning to see the benefits of that now.

Ms. BROWNLEY. Thank you. And I also wanted to follow up with you on—I think in your testimony back in May of 2016, the VHA's Health Information Management Program Office developed and implemented training for providers to improve coding accuracy. So have all the providers now received this training?

Dr. CLANCY. They have certainly all been offered. I would take it for the record to tell you exactly what proportion. As you know, in our system, we have some regular turnover among providers, but we are committed to reaching those, A, who haven't been trained or have somehow missed the opportunity and, B, are not doing so well. That is going to be our first priority focus rather than a blanket across the board for people who are already doing a good job.

Ms. BROWNLEY. So, just so I understand, so the people who have been on board and have not—you talked about the churn and I get that, that piece of it. But are you talking about just the churn not having been trained or still others in the organization that have not been trained?

Dr. CLANCY. Well, in some of our organizations, we have people who are effectively working part-time, because they have got split appointments with academic affiliates. They may have teaching responsibilities and so forth, which is also another factor in considering how our productivity stacks up against the private sector. Do they have those same missions or not?

I wouldn't be shocked to know that some of them may have not taken full advantage of the opportunity to be trained, and we will be making sure that everyone gets it.

Ms. BROWNLEY. And then, once a provider has been trained, then how are you holding them accountable?

Dr. CLANCY. Again, this is a regular review, and we are reviewing centrally, in terms of who are the outliers. Right now, for example, our best estimate—or at the end of 2016—was that 14 percent of our specialty practices are under capacity, working under capacity in terms of productivity.

And then there is a question of diagnosis. Is it that the physicians are not doing their best work, or is it, as in one place I visited, that there are no schedulers—there are almost no schedulers to schedule patients for them to see, which obviously would be a problem—and so forth? So that is how we are putting this all together.

Ms. BROWNLEY. Thank you.

And may I have another minute?

For HCA, in your testimony, you state that accurately capturing the workload of providers who are managing the care of hospitalized patients is difficult, even in the private sector. In order to mitigate the administrative burden of providers, you recommend that workload be captured as a byproduct of work.

And I guess my question is, is there a system in the private sector that the VA could look to or purchase off the shelf that would achieve the sort of accurate capture of this information?

Dr. PERLIN. Thanks, Congresswoman.

That is a terrific question. The systems, the electronic health records used in the private sector are really optimized for the coding efficiency. In point of fact, it takes much of the burden for coding off the provider and allows, frankly, less expensive, more efficient people to code behind the scenes so that the provider is taking care of patients and the coders are coding. So I think there is a workflow issue that could be used in the near term.

In the longer term, recognizing the Chairman's comment that he didn't want to wait until the full re-platforming, as VA does replatform, I suspect that that system will have many of those tracers embedded so that workflow can be and captured as a byproduct of work rather than counterproductive additional work.

Ms. BROWNLEY. Thank you.

I yield back.

Mr. WENSTRUP. Dr. Dunn, you are now recognized for 5 minutes.

Mr. DUNN. Thank you, Mr. Chairman.

I want to note that this particular topic, productivity, efficiency, quality, these determine value, and this very subject is going to occupy the attention of this Committee and I think the larger Committee, as it has for years. It is going to be a real focus going forward, and we are going to try to finally find the light on this subject, I hope. And I am grateful, by the way, to have such an august group of consultants that we can ask for input on this difficult subject.

Mr. Ambrose, your findings, between the productivity of private practitioners and the VHA were intriguing. They are able to measure productivity with the cost of deliverables, and the cost of delivering, like the cost of delivering an office visit, surgery, drugs and so on. You agree that this is a rational and effective way to measure productivity?

Mr. AMBROSE. Well, thank you for the question, Congressman. If I understood your question correctly, cost is certainly a component, both at the episodic level as well as the patient level that should be looked at. And I believe VA has the ability to measure cost, just like other provider systems do. We did not in our study—

Mr. DUNN. I noticed you didn't, but I was hoping that that was the next thing. I read your study.

Mr. AMBROSE. Yes. So we did not have a discussion nor did we analyze that data.

Mr. DUNN. Do you think there is a way we can get to that data, quickly, easily?

Mr. AMBROSE. Well, I believe VA has a cost accounting system that assigns costs to encounters for patients and by provider. So I do believe that there is a way to analyze that data.

Mr. DUNN. I was thinking of you, in your role as an auditor, would you just take that data or would you—you would be auditing that, right?

Mr. AMBROSE. Well, I think the way we normally approach things is we look at data, but then we also look at it in the context of—

Mr. DUNN. How it is gathered.

Mr. AMBROSE [continued]. —the environment. We talk to the physicians, the management, to understand what the data represents, how it is collected, to make sure that we are able—

Mr. DUNN. Because we are so short on time, I am going to cut you off. But I want to say that the cost of deliverables is a number that is important, I think. It is important to me, and I think it is important to the VA as well.

Dr. PERLIN, you highlighted that some of the biggest challenges the VA faces are with external benchmarking, and I thank you also for your testimony. And I would be remiss if I didn't slip a kudos in for you for my partner—Mr. Poliquin, the Member from Maine who usually sits on my right side.

The comment on prompt payment of external providers is of concern and would be something where legislative relief would be helpful. Do you have a quick answer on legislative relief that you would recommend for that?

Dr. PERLIN. Thank you very much for that question. Right now, the VA is grappling with eight, as I understand it, different payment mechanisms for care outside of the VA. As well, it is really administered as a benefits program, not a reimbursement program, as most of the transactions are, whether they are with Medicaid and other governmental payers or whether they are with commercial insurance.

So giving VA the tools to actually work more in that domain would be inherently more efficient and would allow that interaction to be much more seamless, and I believe as a derivative of that would—

Mr. DUNN. I would love to hear your comments offline perhaps separately about what we can do to really relieve that problem, because we are all anxious to relieve that problem, along with many others.

You also said that there are times when it is inefficient or inappropriate for the VA to internally produce all the care veterans need, whether for geographic, wait times, capacity, or demonstrated clinical performance excellence or technology that just wasn't available in the local VA. Does this sound like the Choice Program to you?

Dr. PERLIN. I think those are elements of the Choice Program, but really, those are the Secretary's words that relate to the reasons to get care outside. No health system can be all things to all

people perfectly in all places. VA is remarkable in terms of caring for incredibly complex vulnerable patients. It provides glue and continuity, but certain services clearly would be more efficient in other environments.

Mr. DUNN. Thank you. As it relates to the external benchmarking—I love that part of your testimony—you said it is obligatory to look at productivity and quality simultaneously. And I would like that also, you know, the external benchmarking to be kind of marched over to that area as well, because I have worked in VAs and HCAs, and I see differences.

Mr. Chairman, I yield back. Thank you.

Mr. WENSTRUP. Mr. Takano, you are now recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

I have a question for the GAO. The GAO's report highlighted the VA Central Office that the VA Central Office does not require the VA Medical Centers to monitor efficiency models or to address inefficiencies identified by them. It only encourages them to do so.

Mr. Williamson, can you talk a bit about the challenges that this creates?

Dr. PERLIN. Sure. Oversight and accountability seem to be endemic in VA for a lot of areas. This is certainly one of them. We have OPES reports, data on efficiency, for example, and VAMCs basically, at least the ones we visited are basically ignoring that, because there is no incentive for them. Nobody is held accountable to provide any remediation plans. It is data that is out there, and those facilities that take it seriously probably do something. But, again, there is a raft of data that OPES puts out there, and a lot of the VAMCs don't have the capability, the technical capability, or the capacity to do that.

But incentivizing it—a good example is the SAIL data, which you are familiar with. There is a star rating system. There are five things that are measured, in terms of quality, access, patient satisfaction, productivity and efficiency. Productivity and efficiency are excluded from that star rating, so they are not part of that data. The data is there, and it is recorded, but it is not—and that star rating system is, in part, used for performance pay for the leadership of each VAMC. So it is a serious problem.

Mr. TAKANO. The VA does have—the Central Office does have the authority—well, that is my question. It has the authority to go further than encouraging them? Does it have the authority to mandate it or to direct them to do that?

Dr. PERLIN. They have that authority. I would hope that Deputy Under Secretary for Health for Operations has that authority. And I think that, in Dr. Clancy's testimony, that she indicated they are going to take more of a role in that. But I would like to see that.

Mr. TAKANO. The GAO also observed that the Central Office does not have a systemic process in place to monitor these efforts, that the medical centers and the VISNs are not required to submit remediation plans to the Central Office, nor does the policy state that VISNs or the Central Office must monitor the implementation of the remediation plans.

In your opinion, without direct oversight from the VA Central Office, are best practices being identified, actually?

Dr. PERLIN. I don't think so. I think it could be better because, without some kind of clearinghouse beyond the VISN level that allows you to share best practices, it is very difficult.

And, you know, VA talks about weekly meetings and monthly meetings where they talk about these things, but a lot of times those may not be well attended. There is no assurance that those best practices are out there. It probably needs to be a little more formalized, in my opinion.

Mr. TAKANO. All right. Well, I am kind of interested to see this amazing sort of relationship between the Central Office and the medical centers. I am kind of surprised myself to learn this.

But I yield back. Mr. Chairman.

Mr. WENSTRUP. Mr. Bilirakis, you are now recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much.

And thank you to the panel for your testimony as well.

A lot of my questions were already answered, but, Dr. Clancy, you testified that the VA is in the midst of developing standards for advanced practice providers. When can you expect those standards to be released?

Dr. CLANCY. I believe we have committed to it later this year. I want to just emphasize that this is an area where we don't have external benchmarks to refer to very easily because historically the work of physician assistants, advanced practice nurses, and so forth has been subsumed under the billing by physician. So we can't easily turn to another large system and say, what are the standards? So, to some extent, we will be, I think, as the Ranking Member noted earlier, in the lead on this particular area and may end up being a reference for others.

Mr. BILIRAKIS. Can you please follow up with that with me? I would appreciate that.

Let me ask a question, Dr. Perlin, with regard to medical scribes. You are familiar, obviously, with medical scribes. Are you using medical scribes within the HCA system?

Dr. PERLIN. We have scribes in certain environments. It is not consistent, but it is part of certain practices.

Mr. BILIRAKIS. Would you recommend that they be used within the VA? Now, I know to a certain extent—I want to ask this question to the VA too. Are we using medical scribes within the VA, and to what extent?

Dr. CLANCY. I know we are using them in some facilities. I would have to get back to you with a more robust answer in terms of—

Mr. BILIRAKIS. Why wouldn't be they be widespread in the system? I know there are several advantages to that. Are there any drawbacks? Why don't we have them in place within the entire system? And I want you to elaborate also, Dr. Perlin, on what the use, how beneficial they are.

Dr. PERLIN. Let me maybe start by providing context. They sometimes relieve the physician or other provider of the burden of entering the information. It is an individual choice. There are providers who are very proficient with electronic health records, myself included, for whom it actually it would be an inefficiency in terms of working through someone else.

The other inefficiency that they can offer is that one of the best parts of electronic records is that they can provide decision support, and that decision support is kind of hard to intermediate by someone who tells you: Oh, we got this warning for this.

So there may be circumstances where efficiency can be increased, certainly for some surgical specialties where someone can serve that function as well. There may be situations in which advanced practitioners who accompany those surgeons or other providers may add that efficiency.

But I think the broader question, the one you are getting at that I think is so important, is, how do you just increase the efficiency of both the individual provider as well as the overall team?

Mr. BILIRAKIS. Right. Dr. Clancy, again, if a physician within the VA requests a scribe, are they readily available, and why not, if they are not available?

Dr. CLANCY. So I would agree with Dr. Perlin that scribes are one very specific and very helpful tool for increasing efficiency. In other cases, there is a whole lot of else that we could be doing in a practice.

In one of our networks, the network that includes most of Pennsylvania, they have recently begun using scribes and have seen dramatic increases in efficiency and are actually going to be bringing their lessons learned back to share with others.

In one recent thing that we did—and I have to look at the other Chairman for a moment—recently was to actually go through our view alerts and figure out how could we get rid of some of those that are actually a huge distraction and preventing physicians from seeing the most important messages. And as a result of this system-wide effort, we were actually able to give back about an hour and a half a week to primary care physicians, which, again, is another increase in efficiency and, frankly, decrease in sort of irritation, if you will.

So I would be happy to make sure that we get you better information on how the scribes are used. I think, as Dr. Perlin said, it is often an individual choice and may be competing with resources for other types of support for the team and the practice.

Do you use them at Cleveland?

Dr. ALTOSE. No. Very, very little. There is very little use in Cleveland of scribes. The providers will record it on the electronic medical record. And we extensively use voice recognition software so that reports can be dictated by the providers.

Mr. BILIRAKIS. Thank you very much.

I yield back. Mr. Chairman.

Mr. WENSTRUP. I am going to indulge Chairman Roe. If we may, we will have one more round of questions—time with Mr. Correa will be recognized. But I know this room is going to be occupied shortly.

Mr. ROE. It will be quick.

Mr. WENSTRUP. It will be quick. Mr. Correa, you are now recognized.

Mr. CORREA. Dr. Roe, if you would like to go, go ahead, sir. You said "quick"?

Mr. ROE. You go ahead.

Mr. CORREA. Please.

Mr. ROE. I think Dr. Wenstrup and others, and Dr. Dunn, those who have practiced medicine for a long time have seen a lot of the joy leave medicine, and most it is checking boxes. I call that polyboxia, where you just check all these boxes. And if you check the right boxes, you are a good doctor; and if you don't, you are a bad doctor, no matter how your patient actually ends up. It is a great source of frustration, both inside the VA—and you mentioned, Dr. Clancy, the number of prompts that my friends who are at the VA, sometimes 200 a day. That is so distracting; you can't possibly practice if you are doing that.

I think that we are going to see the use of medical scribes more and more, and certainly, in some places, they can be very efficient. I talked to a group of ophthalmologists in a community not too far from mine where there were five of them. They all use one or two scribes. Five doctors see 55,000 patients a year.

And I know that when we put an electronic health record in our office, it slowed me down. I saw less patients and extended my day. That was really wonderful. And I couldn't tell much benefit. I think it has gotten better. I think the EHRs have gotten better.

But certainly, at the VA, and I have heard Dr. Wenstrup say this many, many times about, if we only saw as few patients as most primary care doctors do at the VA, we could just lock the door and leave, because you couldn't pay your bills. And in private practice, that is the case. I believe I am right. And that is what he has tried to get out about how much does it cost you to actually see a patient at the VA? And, quite frankly, it is hard for anybody to quantify that, but we could pretty much tell you in our practice, because at the end of the year, if we paid our bills, how much I got paid. That is not the case at the VA.

So we have a bill and Dr. Wenstrup and I have this bill we are going to mark up on Monday I think it is that is going to get a pilot program for scribes. I will tell you, in all of the studies I have read—and I have read several of them—in urology, general surgery, and others, where they have to see a lot of patients in a day, it has made their practice more enjoyable, and it has made it more efficient. And they have actually done a better job of coding than the doctors do. I did a lousy job of it. I know I did. I didn't like it, and so I didn't do a very good job of it.

I think the other thing that you will be able to do is, with this, with better data going in, I think you are going to be able to better manage populations and get better patient outcomes. I really think you will be able to do that.

And is the VA willing to go ahead—I guess I will ask Dr. Clancy this—if we pass this bill and it gets through the Senate, implement a scribe program? And hopefully in the next year or so, we will have an answer, because it shouldn't be hard to get these people hired.

Dr. CLANCY. Absolutely. And, you know, frankly, building on what we have already started to see in Pennsylvania, I think it would be terrific.

Mr. ROE. I will yield back.

Mr. WENSTRUP. Mr. Correa, you are now recognized.

Mr. CORREA. Thank you, Mr. Chairman.

A general question to the panel. As we rush to transform the VA better, leaner, more responsive, we talk about terms such as productivity, efficiency, quality, looking at off-the-shelf systems to try to integrate them. A question to each and every one of you is: System integration, information systems, as we look at the Kaisers of the world and we look at the private sector—a big challenge in the private sector, of course, is those information systems are not integrated so the information here does not flow to here, so on and so forth. What attention, what are you doing to assure that the VA itself, as you transform it to something better, whatever that may mean, is fully integrated to be responsive to the needs of the patient?

Dr. CLANCY. So I think you have—Congressman, it is a great question and you have put your finger on two very, very important issues.

A third game-changer I believe for access and for being responsive to patients is telehealth. Now, we use this a lot in very different ways. We use it for everything from virtual visits to good old-fashioned telephone visits to video encounters with specialists and so forth. And ultimately, I think that we will be doing this in patients' homes. And we do that in some States right now. How much nicer for a patient with PTSD to get his counseling and therapy from his own home rather than driving 3, 3-1/2 hours to the nearest medical center and so forth. And that has been very, very successful.

Historically, at VA, it has been really wonderful but sort of separate from all of our other systems. And increasingly in the past year, year and a half, we have been integrating that with all of our efforts to make sure that we address our top priority of access to care.

So I think that is going to be a game-changer, because in addition to making it much better and much more responsive to what veterans need and want—I mean, navigating our system or any health system is not a joy unto itself—it is also a terrific platform to extend the expertise of specialists, who tend to be at some of our larger, more complex medical centers, out to the outlying community-based outpatient clinics and so forth.

Mr. CORREA. If I may follow up, what are you doing to make sure that, as you come out with this productivity tool that will multiply your ability to reach out at these, you know, people that live out in areas that are difficult for them to come to the VA, what are we doing to make sure that they understand that this is something that is good and not just a cost-cutting measure and, therefore, maybe they may think, patients may think that you are sacrificing efficiency for cost savings? Are we following with some surveys, with some actual studies to make sure that, in the process to deliver these services, quality is not being sacrificed?

Dr. CLANCY. Yes. We are actually surveying veterans to see how well this works for them. In fact, a big fundamental linchpin of our same-day access for urgent mental health or primary care needs has been that that may be a face-to-face visit, it may be a virtual visit, or a phone call, or some other way that we are helping you resolve your problem today. But the point is we are not going to be forcing this on people who don't want it. But, by and large, I

would say industry experience has been that people for the most part really like it a great deal. So you see the Kaisers of the world doing more and more of it.

Mr. CORREA. Thank you very much.

I yield the remainder of my time.

Mr. WENSTRUP. As you can tell by the crowd outside, our rent is due and the new tenants are ready to move in. So we are going to have to conclude, and I would encourage anyone, if they have any further questions, to please submit them for the record.

So, at this time, the panel is now excused.

And I ask unanimous consent that all Members have 5 legislative days to revise and extend remarks and include extraneous material.

Without objection, so ordered.

And the hearing is now adjourned, and I thank you all for being with us today.

[Whereupon, at 4:28 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of C. Sharif Ambrose

Good afternoon Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee. Thank you for the opportunity to discuss Grant Thornton's 2015 findings and analyses that focused on VA Provider Staffing and Productivity. My name is Sharif Ambrose and I am a Principal at Grant Thornton LLP where I lead our Public Sector Healthcare Practice that provides contracted consulting services to government clients, including the U.S. Department of Veterans Affairs. I am accompanied by Erik Shannon, a fellow Partner at Grant Thornton who leads our commercial healthcare advisory practice and who also contributed to the 2015 Independent Assessment.

Grant Thornton is one of the largest professional services firms in the world and we provide our clients across all major industries with advice on strategic, operational, financial, and technology issues to help them achieve their missions. Our health care practioners serve commercial and government health providers, health plans, and life sciences clients to create, protect, and transform value across their organization. It has been our distinct privilege and honor to support the U.S. Department of Veterans Affairs (VA) and the Veterans it serves for the past 20 years.

Grant Thornton's involvement in this assessment began after Congress enacted and President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146) ("Veterans Choice Act").[1] This law was intended to improve access to timely, high-quality health care for Veterans. Under Title II - "Health Care Administrative Matters," Section 201 called for an Independent Assessment of 12 areas of VA's health care delivery systems and management processes.

VA engaged the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare (CAMH) to serve as the program integrator and as primary developer of 11 of the Veterans Choice Act independent assessments. CAMH is a federally funded research and development center (FFRDC) operated by The MITRE Corporation, a not-for-profit company chartered to work in the public interest. CAMH subcontracted with 3 firms with technical and industry expertise - Grant Thornton, McKinsey & Company, and the RAND Corporation - to conduct 10 independent assessments as specified in Section 201, with CAMH conducting the 11th assessment. Part G of Section 201 required an independent assessment of "the staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics."

To address this requirement under Part G, Grant Thornton conducted an assessment during the winter and spring of 2015 of current provider staffing levels, caseload, and productivity, in comparison to health care industry benchmarks. This included an in-depth assessment of nurse staff resource allocation, decision-making, and processes which impact provider productivity and efficiency.

- Our team interviewed VHA policy leaders and subject matter experts from the major specialties as well as the leaders of the program offices responsible for reporting VHA staffing levels and provider productivity.
- We obtained staffing, workload, and time allocation data of VHA providers from VHA for fiscal year 2014.
- In coordination with other Choice Act independent assessment teams, we visited 24 VA Medical Centers and community-based outpatient clinics (CBOCs). The purpose of the site visits was to interview local facility leaders and providers to understand the local management practices, staffing, caseload and productivity levels across VA.

[1] This law was later amended by the Department of Veterans Affairs (VA) Expiring Authorities Act of 2014 (Public Law 113–175).

Our report, along with the other independent assessments, were provided to the Secretary for Veterans Affairs, the House Committee on Veterans' Affairs, the Senate Committee on Veterans' Affairs, and the Commission on Care in September 2015.

Provider Staffing Findings

Grant Thornton's assessment found VA medical centers face issues with provider vacancies, lengthy hiring processes, and competitive compensation, each of which can contribute to provider shortages. Assessment G noted three primary findings.

Finding 1: VHA specialties with the highest provider full-time equivalent (FTE) levels include medicine specialties, mental health, and primary care, consistent with VHA's care model and the needs of the Veteran population.

Finding 2: VHA does not systematically track fee-based provider productivity, and does not capture FTE level information for fee-based care providers.

Finding 3: VHA physician staffing levels per patient population are, in most specialties, lower than industry ratios. These ratios, however, are not sufficient to establish whether VHA is staffed to meet demand because of factors that make it difficult to measure clinical workload at VHA and to compare VHA performance to industry benchmarks. For instance, VHA uses Advanced Practice Providers (APPs) extensively but the FTE for these types of providers are not included in VA's data.

Provider Productivity Findings

In comparing VHA providers to providers in the private sector, our assessment used several common health care industry productivity measures:

- encounters (count of direct provider-patient interactions in which the provider diagnoses, evaluates, or treats the patient's condition),
- work relative value units (wRVUs-a measure of a provider's output which takes into account the relative amount of time, skill, and intensity required to complete a given procedure), and
- primary care panel size (the number of unique patients for whom a care team is responsible).

Our team considered VHA's care model, benchmarked providers accordingly, and considered the barriers VHA faces in delivering care at a rate of productivity that matches health care systems in the private sector. In comparing the productivity of VHA providers to industry benchmarks, our analysis supports two key findings:

1)The number of patients assigned to VHA general primary care providers is 12 percent lower than the private sector benchmark for patients of a similar acuity.

2)With respect to specialty providers, our analysis shows that VHA specialists are less productive than their private sector counterparts on two industry measures - encounters and work relative value units (wRVUs). Many specialties fall in the 50th percentile of private sector providers; others are as low as the 25th percentile. However, when encounters (visits) are used as a measure, the gap shrinks and VHA specialty care compares more favorably to the private sector. In a system as large and varied as VHA, we did find variation in the relative productivity of providers. For instance, specialty care providers at the most complex facilities were found to be more productive than their peers, and the most productive VHA providers (those at the 75th percentile of VHA providers) are often more productive than the private sector. Mental health provider productivity at VHA was calculated to be in the 100th and 72nd percentiles as measured by both wRVUs and encounters, compared to industry benchmarks.

Root Causes

Our team examined the various drivers of VHA provider productivity, and found there are several factors that limit the ability of providers to optimize productivity. For example:

We found VHA providers have a lower room-to-patient ratio than the private sector. Private sector room-to-provider ratios are typically 3-to-1 and we found VHA providers typically only have a 1-to-1 ratio, which does not allow them to see as many patients as their private sector counterparts. Similarly, VHA providers have significantly fewer nurses and administrative support staff, which means the providers cannot be as efficient as they otherwise could be. Insufficient clinical and administrative support staff results in providers and clinical support staff not working to the top of their licensure.

Another challenge is VHA does not effectively manage nurse absences (using nurse float pools), resulting in unplanned staff shortages and fewer patients who can be treated.

While there has been widespread implementation of the Patient Aligned Care Team (PACT) model in primary care clinics and the National Nurse Staffing Methodology in many areas of inpatient care, there are no current VHA standards for staffing levels and/or mix in specialty clinics, with the exception of eye clinics.

Based upon our team's observations and the findings of Assessment F (Clinical Workflow), we have concerns providers may not be properly documenting all of their workload, which may explain some of the difference in productivity across all facilities. During site visits and interviews with VHA Central Office leaders, we consistently heard concerns that providers do not fully document and accurately code all of their clinical workload.

Grant Thornton's Recommendations

In formulating our recommendations in 2015, our team considered the findings and recommendations of the other Veterans Choice Act Assessments, prior reports by the VA Office of the Inspector General (OIG), the Government Accountability Office (GAO) and other government bodies available at the time.

In our report we offered five overarching recommendations to VHA along with the supporting evidence for each recommendation, relevant promising or best practices, and potential near-term actions or next steps. We also provide a discussion of cross-cutting implementation considerations that may be used to develop, enhance, or speed implementation of the recommendations. By implementing these recommendations, along with the recommendations of the other Veterans Choice Act Assessments, VHA can - with the support of Congress - evolve into a consistently high performing health system, enabling access to high quality care in an efficient and cost effective manner.

Recommendation 1: VHA should improve staffing models and performance measurement.

VA should evaluate the design and implementation of current VHA staffing models to determine the extent to which they are sufficient to meet the goals of VHA's population health focused model and ensure all eligible Veterans have access to high quality, timely care. VHA should conduct a program review of the implementation of the PACT staffing model in primary care to identify the causes of the productivity shortfalls and the impacts of these performance gaps on access to quality care. VHA should develop and implement staffing models for outpatient specialty care services and improve existing performance measurement systems to realize the benefits of specialty care staffing models. VHA should refine and implement the National Nurse Staffing Methodology across inpatient services and improve the performance measurement system to realize the benefits of the methodology.

To improve staffing and productivity measurement and better determine the capacity of VHA specialty clinics, Grant Thornton's assessment recommended the VHA gather data and assess the productivity of fee-based providers, as well as conduct a work measurement study (or verify existing workload data) to determine the volume and distribution of workload each year to better match staffing requirements to demand.

Recommendation #2: VA Medical Centers should create the role of clinic manager and drive more coordination and integration among providers and support staff.

VA has an opportunity to increase the level of teamwork and accountability among all outpatient clinic staff, especially in specialty care services. This might be achieved by creating multidisciplinary management teams for specialty clinics that include a physician leader, nurse leader, and business administrator. Alternatively, specialty clinics might establish a single or dual reporting line and operating a model for providers and their clinical and non-clinical support staff, so all of the members of the specialty clinic team have more accountability to each other and the Service Chief of the specialty.

Recommendation #3: VA Medical Centers should implement strategies for improving management of daily staff variances, and include a replacement factor for all specialties, including PACT.

With respect to managing staff absences, VA can improve the management of daily staffing variances by implementing several strategies that include intermittent float pools of support staff and the inclusion of a replacement factor across all staffing methodologies/models, to include PACT.

Recommendation #4: VA Medical Centers should implement local best practices that mitigate space shortages within specialty clinics.

VA medical facilities should further study opportunities to mitigate space shortages within specialty clinics. These include strategies such as: standardized schedule templates, expanded clinic hours, increased use of non-face-to-face encounters for follow-up consults by specialty care, and system redesign initiatives to improve patient flow within clinics.

Recommendation #5: VHA should improve the accuracy of workload capture.

VHA should conduct an audit of health record documentation and current procedural terminology (CPTr) coding accuracy and reliability to validate physician productivity measurement and that if the results support it, evaluate the ability of commercially available computer assisted coding (CAC) applications to assist providers with coding. The creation of the role of clinic manager for Specialty Care clinics should also be used to improve clinic management and coding practices.

Closing

In a health system comprised of more than 150 hospitals and nearly 1,400 community-based outpatient clinics - among other care settings - determining the staffing levels, caseload, and productivity required of VA providers to meet the needs of more than 9 million enrolled Veterans is a complex task. Adequate provider staffing levels and a health care system that enables its clinicians to be productive in delivering VHA's population-health focused model of care are essential to meeting the goals of timely, high quality care for our nation's Veterans. I applaud this committee, the Department and the often overlooked dedication from the VA health care providers and support staff who have chosen to serve our nations' Veterans. Grant Thornton is grateful for the opportunity to address this committee and to offer our analysis of the challenges facing VA.

Prepared Statement of of Randall B. Williamson

VA HEALTH CARE

Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency

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

I am pleased to be here today to discuss our report on clinical productivity and efficiency at the Department of Veterans Affairs (VA).[1] As you know, VA's total budgetary resources for its Veterans Health Administration (VHA) have increased substantially over the last decade, rising from $37.8 billion in fiscal year 2006 to $91.2 billion in fiscal year 2016. As VA's funding levels increase, it is increasingly important that the department spend these funds wisely and ensure that VA attains high levels of productivity among its clinical services and operational efficiency to maximize veterans' access to care and minimize costs.

Beginning in fiscal year 2013, VA began implementing clinical productivity metrics to measure physician providers' time and effort to deliver various procedures in 32 clinical specialties.[2] In addition, VA developed 12 statistical models to measure clinical efficiency at VA's medical centers (VAMC). Under the models, VA calculates each VAMC's utilization and expenditures for different high volume or high expenditure components of health care delivery, such as emergency department and urgent care, and determines the extent to which utilization and expenditures differ from expected levels. The Office of Productivity, Efficiency, and Staffing (OPES), within VA Central Office, is responsible for calculating both the provider productivity metrics and the VAMC efficiency models.

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[1] GAO, VA Health Care: Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency, GAO 17 480 (Washington, D.C.: May 24, 2017).

[2] In 2012, VA's Office of Inspector General (OIG) recommended that the department establish clinical productivity metrics for providers at VA's medical centers. VA OIG, Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services. 11–01827–36. (Washington, D.C.: Dec. 27, 2012). Clinical productivity refers to the workload performed by VA's clinical providers over a given time period.

My testimony today summarizes the findings from our recent report analyzing VA's clinical productivity metrics and efficiency models. Accordingly, this testimony addresses (1) whether VA's clinical productivity metrics and efficiency models provide complete and accurate information on provider productivity and VAMC efficiency and (2) VA's efforts to monitor and improve clinical productivity and efficiency. In addition, I will highlight four key actions that we recommended in our report that VA can take to improve the completeness and accuracy of VA's productivity metrics and efficiency models and strengthen the monitoring of clinical productivity and efficiency across VA.

To conduct the work for our report, we examined the types of providers and the clinical services captured in the underlying clinical workload and staffing data that inform VA's metrics and models, as well as the processes used to record these data. We reviewed VA documentation and interviewed officials from VA Central Office and six VAMCs, which we selected based on geographic diversity, differences in facility complexity, and variation in their providers' performance on VA's productivity metrics as well as variation in the VAMCs' performance on VA's efficiency models for fiscal year 2015.[3] We examined the monitoring and any related improvement efforts of VA Central Office, the six selected VAMCs, and the Veterans Integrated Service Networks (VISN) that are responsible for overseeing the six VAMCs.[4] We reviewed VA documentation and interviewed VA Central Office, VISN, and VAMC officials. As part of our review, we assessed the completeness and accuracy of the information provided by VA's clinical productivity metrics and efficiency models using federal standards for internal control related to information, and we assessed VA's monitoring efforts using federal standards for internal control for information and monitoring.[5] Further details on our scope and methodology are included in our report. The work this statement is based on was performed in accordance with generally accepted government auditing standards.

VA's Metrics and Models May Not Provide Complete and Accurate Information on Clinical Productivity and VAMC Efficiency

We found that VA's productivity metrics and efficiency models may not provide complete and accurate information on provider productivity and VAMC efficiency. To the extent that VA's productivity metrics and efficiency models do not provide complete and accurate information, they may misrepresent the true level of productivity and efficiency across VAMCs and limit VA's ability to determine the extent to which its resources are being used effectively to provide health care services to veterans.

Specifically, we identified the following limitations with VA's metrics and models:

- Productivity metrics are not complete because they do not account for all providers or clinical services. Due to systems limitations, the metrics do not capture all types of providers who deliver care at VAMCs, including contract physicians and advanced practice providers, such as nurse practitioners, serving as sole providers. VA Central Office officials explained that VA data system limitations and other factors have made it difficult for VA's productivity metrics to capture the workload for all types of providers. In addition, the metrics do not capture providers' workload evaluating and managing hospitalized patients because VA's data systems are not designed to fully capture providers' workload delivering inpatient services that do not involve procedures-in particular, evaluating and managing patients who are hospitalized.
- Productivity metrics may not accurately reflect the intensity of clinical workload. A 2016 VA audit shows that VA providers do not always accurately code the intensity-that is, the amount of effort needed to perform-of clinical procedures or services. As a result, VA's productivity metrics may not accurately reflect provider productivity, as differences between providers may represent coding inaccuracies rather than true productivity differences.
- Productivity metrics may not accurately reflect providers' clinical staffing levels. Officials at five of the six selected VAMCs we visited reported that providers do not always accurately record the amount of time they spend performing clin-

[3] The six VAMCs we selected are located in Atlanta, Georgia; Baltimore, Maryland; Harlingen, Texas; Las Vegas, Nevada; Saginaw, Michigan; and Salem, Virginia.

[4] VA Central Office is responsible for managing and overseeing the VA health care system and delegates certain responsibilities to its VISNs.

[5] GAO, Standards for Internal Control in the Federal Government, GAO/AIMD 00 21.3.1 (Washington, D.C.: November 1999) and Standards for Internal Control in the Federal Government, GAO 14 704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

ical duties, as distinct from other duties. VA's productivity metrics are calculated for providers' clinical duties only.

- Efficiency models may also be adversely affected by inaccurate workload and staffing data. To the extent that the intensity and amount of providers' clinical workload are inaccurately recorded, some of VA's efficiency models examining VAMC utilization and expenditures may also be inaccurate. For example, the model that examines administrative efficiency requires accurate data on the amount of time VA providers spend on administrative tasks; if the time providers allocate to clinical, administrative, and other tasks is incorrect, the model may overstate or understate administrative efficiency.

To improve the completeness VA's productivity metrics, we recommended that VA expand existing productivity metrics to track the productivity of all providers of care to veterans by, for example, including contract physicians who are not VA employees as well as advance practice providers acting as sole providers. VA agreed in principle with our recommendation and stated that it plans to establish productivity performance standards for advanced practice providers, using available productivity data, by October 2017. In its response, however, VA did not provide information on whether it plans to expand its productivity metrics to include providers who are not employed by VA, such as contract physicians.

In addition, to improve the accuracy of VA's productivity metrics and efficiency models, we recommended that VA help ensure the accuracy of underlying workload and staffing data by, for example, developing training for all providers on coding clinical procedures. VA agreed in principle with our recommendation and reiterated its existing efforts to improve clinical coding accuracy. It also said that the department would reissue existing policy to VAMCs by June 2017 as well as continue to provide need-based, focused coding training to providers, as appropriate. However, VA did not provide information on how it plans to improve the accuracy of provider staffing data, which inform VA's productivity metrics and efficiency models.

VA Central Office Has Taken Steps to Help VAMCs Monitor and Improve Clinical Productivity, but Does Not Systematically Oversee Productivity and Efficiency across VA

We found that VA Central Office has taken steps to help VAMCs monitor and improve provider clinical productivity but does not systematically monitor VAMCs' clinical productivity remediation plans and does not require and monitor remediation plans for addressing clinical inefficiency. As a result, VA cannot ensure that low productivity and inefficiencies are identified and addressed across VA. Nor can VA systematically identify both the factors VAMCs commonly identify as contributing to low productivity and inefficiencies as well as best practices VAMCs have developed for addressing these issues.[6]

In December 2016, VA Central Office began developing a comprehensive analytical tool to help VAMCs identify the causes of low productivity at their facilities, a process that would likely occur after VA's productivity metrics have identified low productivity in one or more clinical specialty at the facility. According to VA Central Office officials, the comprehensive analytical tool VA is developing-in the form of a data dashboard-is intended to centralize relevant data sources, including data on clinic utilization, veterans' access to care, and provider workload, and thereby allow VAMC officials to more easily examine the factors contributing to low productivity. The officials told us that they expect the data dashboard to be developed in stages and rolled out to all VAMCs and VISNs over the course of 2017.

While VAMCs are required to monitor VA's productivity metrics and may take steps to improve clinical productivity, VA Central office does not have an ongoing process to systematically oversee these efforts. VA policy requires VAMCs to develop remediation plans to address any low productivity identified in their clinical specialties and submit these plans to their VISN. Our review found that three of the six selected VAMCs in our study were required to develop remediation plans, and officials from these VAMCs stated that they submitted these plans to their respective VISNs for review. However, we found that VA's policy does not stipulate that VAMCs or VISNs are to submit approved remediation plans to VA Central Office; nor does the policy stipulate that VISNs or VA Central Office must monitor the implementation of these remediation plans to ensure their success. As a result, for ex-

[6] In its 2012 report, the VA OIG noted that information on productivity can help VA identify best practices and those practices that should be changed or eliminated. See VA OIG, Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services. 11–01827–36. (Washington, D.C.: Dec. 27, 2012).

ample, officials at one of the VISNs we interviewed told us the VISN does not monitor the implementation of VAMCs' remediation plans to address low productivity.

Regarding VA's efforts to monitor efficiency, we found that while VA Central Office officials encourage VAMCs to monitor and take steps to improve clinical inefficiency at their facilities, VA policy does not require VAMCs to use VA's efficiency models and address any inefficiencies identified by them. In particular, VA has not established performance standards based on these models and does not require VAMCs to develop remediation plans to address inefficiencies.[7] According to VA Central Office officials, VA has not required VAMCs to monitor these models and address any inefficiencies because VA officials view the models solely as a tool to guide VAMCs in managing their resources. In the absence of a monitoring requirement, we found that two of the six VAMCs we visited had not taken steps to address inefficiencies identified by VA's efficiency models.

Based on our findings, we recommended that VA develop a policy requiring VAMCs to monitor and improve clinical inefficiency through a standard process, such as establishing performance standards based on VA's efficiency models, and develop remediation plans for addressing clinical inefficiencies. VA concurred in principle with this recommendation, stating that it would require VAMCs to develop remediation plans. We also recommended that VA establish an ongoing process to systematically review VAMCs' remediation plans and ensure that VAMCs and VISNs are successfully implementing remediation plans for addressing low clinical productivity and inefficiency. VA concurred with our recommendation and told us it plans to review, twice a year, the progress VAMCs are making in addressing low productivity and inefficiency.

Chairman Wenstrup, 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; Michael Zose, Analyst in Charge; Krister Friday; Hannah Grow; and Jacquelyn Hamilton.

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[7] VA's efficiency models are used to track VAMC utilization and expenditures for various health care services and compare these expenditures to expected levels.

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Prepared Statement of Jonathan B. Perlin, MD, PhD

"CLINICAL PRODUCTIVITY AND EFFICIENCY IN THE DEPARTMENT OF VETERANS' AFFAIRS HEALTHCARE SYSTEM"

Good afternoon. I'm Dr. Jonathan Perlin, President of Clinical Services and Chief Medical Officer for Nashville, Tennessee-based HCA Healthcare. I would like to thank Committee Chairman Roe, Subcommittee Chair Wenstrup, ranking member Brownley, and members of the Subcommittee for this opportunity to comment on VHA Clinical Productivity and Efficiency.

We are the nation's largest private healthcare provider, and have the privilege of caring for patients through 28 million clinical encounters annually. These include approximately 1.65 million hospitalizations, 8.5 million emergency room visits, and more than 220,000 deliveries. We number about 241,000 employees, of whom approximately 80,000 are nurses. These numbers are exclusive of nearly 37,000 voluntary physicians. We see patients at 168 hospitals and more than 1,200 other sites of care, including surgical centers, free-standing emergency rooms, urgent care, and physician offices across 42 markets in 21 states. In other words, we are similarly-sized to the Veterans Health Administration.

We are proud to acknowledge that included in our dedicated healthcare workforce are many Veterans and military spouses. We invest in employing service members, and in 2016 alone, we hired more than 5,400 military Veterans and 1,100 military spouses. In 2015, the U.S. Chamber of Commerce Foundation awarded HCA the "Hiring Our Heroes Lee Anderson Veteran and Military Spouse Employment Award."

I believe that I have a unique perspective to offer the Committee, having served as Chief Quality Officer, Deputy Under Secretary and Under Secretary for Health, as well as - like the Secretary, Dr. Shulkin - as a VA physician during my tenure in these roles.

I appreciate the opportunity to support the work of the Committee and the Department in providing the most effective and efficient care for America's Veterans. In his 100-day briefing at the White House, Secretary Shulkin offered 13 observations on areas he considered risks for VA. He and his team came to these conclusions from both a business and clinical perspective. While there is no need for me to recount them here, a few are worth noting, as they are directly responsive to some of the concerns that the GAO report identifies. I will augment his observations

with mine, bringing current private-sector perspective on how we manage productivity within our organization.

Dr. Shulkin's first diagnosis of risk concerned access. I will not recount all of the statistics, but would note that his comments identify substantial progress overall, increased same-day access for primary and certain specialty services and some remaining opportunities for improvement. Obviously, increases in provider efficiency are an important means for creating additional capacity and access.

The second area of concern involves prompt payment of external providers. This is an area in which legislative relief would be helpful. Consolidation of disparate models for obtaining services outside of VA and, frankly, comportment with Medicare or private insurer reimbursement models would facilitate provider participation and Veteran access to services. The complexity of the different models imposes statutory inefficiencies in VA's overall management of care within and outside of VA.

The third area noted by Dr. Shulkin was quality. VA is to be commended for making their star ratings public. VA is increasingly benchmarking against private sector, and in many instances, VA performance is as good, if not better. I note these areas because they are salient to GAO's central observations on VA provider productivity.

-GAO first notes that "Productivity metrics are not complete because they do not account for all providers or clinical services." Secretary Shulkin's recent expansion of scope-of-practice for advanced practitioners will both increase productivity and present an increasing challenge in recording and benchmarking productivity. Indeed, VA is apt to become the reference point for advanced practitioner productivity, to the extent that data systems can attribute the work performed to advanced practitioners individually or in the aggregate.

-GAO further notes that "metrics do not capture providers' workload evaluating and managing hospitalized patients." This is a challenge for all entities that provide team-based care. The attribution of workload to certain members of the team, beyond the attending physician, is notoriously complex, as has been demonstrated in long-standing debate regarding attribution of quality and safety metrics. This is demonstrated by, for example, contention over who receives credit for a positive quality outcome (for example, a care episode without a vascular catheter infection) or blame for a safety breach (for example, a hospital-acquired infection). This is problematic because many hands touch the patient, and data systems don't capture every touch. While data systems could be designed for attribution of effort, workload needs to be captured as a by-product of work, otherwise it would be inefficient, requiring providers to spend as much time designating their work, as doing their work.

-GAO's next observation that "Productivity metrics may not accurately reflect the intensity of clinical workload" has roots to some degree in the same phenomenon - does extra effort required for coding workload compete with actual work and productivity? On the other hand, as VA has announced the decision to re-platform its electronic record, this would be an ideal time to consider how to embed tracers of workflow that can transparently capture productivity. I would note that in our organization, when we think about the care of hospitalized patients, rather trying to capture every individual's action, we summarize by looking at "employee equivalents per occupied bed."

- The GAO Report further notes that "A 2016 VA audit shows that VA providers do not always accurately code the intensity of . . . clinical procedures or services. As a result, VA's productivity metrics may not accurately reflect provider productivity, as differences between providers may represent coding inaccuracies rather than true productivity differences." Again, documentation improvement to capture the patient's service intensity requirement is something that private sector has become highly proficient in doing, as it is simultaneously the basis for clinical risk adjustment, as well as the basis for graduated payment levels. Similarly, this - and "recording (clinician) time performing clinical duties" - are area that VA's new electronic health record should assist with improving.

-I would agree prima facie with the statement that "efficiency models may also be adversely affected by inaccurate workload and staffing data" and that the impact may lead to either understating or overstating efficiency.

-On the basis of my experience with VA management systems of more than a decade ago, as well as my research in preparing for this hearing, I would also agree with GAO's finding "that VA Central Office has taken steps to help VAMCs monitor provider productivity by developing a comprehensive analytical tool VAMCs can use to identify the drivers of low productivity."

-GAO's exhortation to "systematically oversee VAMCs' efforts to monitor clinical productivity and efficiency . . . and systematically identify best practices to address low productivity and inefficiency" is a central challenge for management of multi-

facility health systems across the United States. Certainly, it is a central focus for our organization and, in this regard, VA and HCA share an operating advantage: Both systems are large enough to look for positive variation. If the underpinnings of better performance can be understood, replicated and scaled, it becomes the means to elevate the performance of the entire system.

-Understanding variation within the system and comparison with external performance standards is why both internal and external benchmarking are necessary: Internal benchmarking allows systems to tap into the data that they have to identify both positive and negative variation. Internal benchmarking is a tool for learning and management. It can function as one part of a control system for facility, VISN and VACO leadership to manage performance. External benchmarking is necessary to understand whether internal performance is superior, consistent with or inferior to external organizations. External benchmarking is limited by differences in data availability and data definitions among organizations.

-VA's "SAIL" system provides elements for both internal and external benchmarking, and I would again agree with GAO's assessment that this is a useful management tool for all of the reasons I've noted.

I would note that the biggest challenges to external benchmarking are not related to data, but rather certain inherent features of VA and the patients it serves:

First, Veterans using VA are systematically more complex patients than commercially-insured or even mixed commercial/government-covered (i.e., general Medicare or Medicaid) populations. So, some of the external references, such as the MGMA (Medical Group Management Association) benchmarks may need to be tempered. Better reference environments may be safety net providers, in terms of patient complexity, as well as academic health systems that - like VA - have a simultaneous teaching responsibility.

Second, the VA benefits package is systematically different that either commercial insurance or other government programs, like Medicare or Medicaid. VA's breadth of services means that there are more things that a provider can, should and must do during a clinical encounter. In a capitated system, it is rational to take all necessary actions for preventive services or other interventions that reduce the need for future services or subsequent interventions. Again, the tension between work and recording work arises.

Third, RVU's were developed for fee-for-service environments and, as such, are intended to make provider compensation proportional to recorded effort. This obviously incentivizes both work and the recording of work. Private sector enjoys different flexibility in provider compensation models, so when clinicians are employed by a provider organization, provider compensation can be calibrated to productivity. In our organization, we always look at productivity, compensation and quality together. While provider performance on quality is a non-negotiable expectation, we can calibrate compensation appropriately.

Fourth, in our organization, our physical plants and adjunctive staffing models are oriented to enhancing productivity. It is systematically inefficient for a clinical provider to operate from only one or two exam rooms and with one or fewer support staff. My understanding is that despite some spectacular new facilities, VA still has opportunity to improve its aged plants and associated staffing models.

Fifth, there may be times when it is inefficient or inappropriate for VA to internally produce all of the care Veterans need. I agree with the Secretary's perspective to use private sector services when geographic access, wait times, capacity, demonstrated clinical performance excellence or technology are not available in VA. On the other hand, VA has demonstrated excellence in serving as a medical and health home for the most complex of patients. Indeed, many Veterans using VA are patients with multiple medical and social challenges - such as serious mental illness, advanced physical illness, poverty and other vulnerabilities directly related to their statutory eligibility for VA care - that challenge private-sector performance and distinguish VA. That continuity-of-care and coordination of services (including medical and social) that VA provides is not only special, but not directly replicable in private sector.

Finally, and in closing, it is obligatory to look at productivity and quality simultaneously. Quality and safety are always most efficient: rework for breaches in either is neither efficient, nor consistent with the performance excellence that taxpayers deserve and that Veterans should expect and have earned through their service and sacrifice. Again, my thanks to the Subcommittee for this opportunity, and we look forward to working with you and Secretary Shulkin to accomplish these objectives.

Prepared Statement of Carolyn Clancy, M.D.

Good afternoon, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to discuss the clinical efficiency and productivity of providers in VA. I am accompanied today by Dr. Murray Altose, Chief of Staff for the Louis Stokes VA Medical Center (VAMC) in Cleveland, Ohio.

VA's mission is to provide Veterans with the best healthcare they have earned and deserve. However, we also must be good stewards of taxpayer dollars, which fund this care. This means making sure that our facilities and systems are organized to facilitate optimal productivity and efficiency, particularly on the front lines of care. Clinical productivity is the sum of both clinical activity and the effectiveness of the team supporting that clinician. This means that a productive and efficient facility has both high-performing clinicians and support staff.

In 2013, we implemented clinical productivity metrics to measure physician providers' time and effort to deliver procedures. VA also developed statistical models to track clinical efficiency at VAMCs. Data collected under the metrics and models are used to identify clinical productivity and efficiency levels. Reports are designed to provide leaders in our facilities and networks with essential tools to understand which clinics are working under, at, or over capacity.

Physician Staffing and Productivity Standards

VA has adopted an activity-based productivity and staffing model for specialty physicians. Utilizing an industry accepted Relative Value Unit (RVU)-based model, specialty physician productivity standards have been developed and implemented. In fiscal year (FY) 2013, productivity standards for six specialties (dermatology, neurology, gastroenterology, orthopedics, urology, and ophthalmology) were developed, piloted in four Veteran Integrated Service Networks (VISN) and then implemented nationwide.

A critical component of the productivity and staffing standard implementation is the Specialty Productivity-Access Report and Quadrant (SPARQ) tool that provides an algorithm for the effective management of VHA's specialty physician practices. This tool is designed to assess specialty physician practice business strategies and drive performance improvement in Veterans' access to specialty care. This tool was recognized as one of the most important managerial tools developed in support of physician productivity and staffing standards and its ability to go beyond standard implementation to ultimately drive system performance.

The SPARQ tool includes important measures, such as support staff ratios for specialty physicians so as to maximize physician efficiency. The SPARQ tool measures the care team, including advanced practice providers such as Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists, and their RVU contribution. The SPARQ tool also measures specialty physician value in the form of "compensation per RVU" so as to demonstrate our ability to be good stewards of public healthcare resources.

We are pleased to report measurable progress as demonstrated by increased RVUs. VHA's system-wide focus on improving access to care, prioritizing urgent clinical needs and achieving same-day access for Veterans with urgent primary care or mental health needs, has resulted in increased clinical output (clinical workload up 13 percent) with a concurrent increase in RVUs per clinical employee of 9 percent.

Government Accountability Office (GAO) Report

On June 23, 2017, the GAO released a report (GAO–17–480) titled "Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency." GAO identified limitations with VA's metrics and models that limit VA's ability to assess whether resources are being used effectively.

GAO found that productivity metrics are not complete because they do not account for all providers or clinical services due to data systems limitations. The metrics also do not capture providers' workload evaluating and managing hospitalized patients. Also, productivity metrics may not accurately reflect the intensity (the amount of effort needed to perform) of clinical workload. As a result, VA's productivity metrics may not accurately reflect provider productivity, as differences between providers may represent coding inaccuracies rather than true productivity differences. Furthermore, productivity metrics may not accurately reflect providers' clinical staffing levels. GAO found that providers do not always accurately record the amount of time they spend performing clinical duties. In turn, efficiency models may also be adversely affected by this inaccurate workload and staffing data. GAO made four recommendations and VA concurred with each:

1.Expand existing productivity metrics to track the productivity of all providers of care to Veterans by, for example, including contract physicians who are not employees as well as advance practice providers acting as sole providers;

2.Help ensure the accuracy of underlying staffing and workload data by, for example, developing training to all providers on coding clinical procedures;

3.Develop a policy requiring VAMCs to monitor and improve clinical efficiency through a standard process, such as establishing performance standards based on VA's efficiency models and developing a remediation plan for addressing clinical inefficiency; and

4.Establish an ongoing process to systematically review VAMCs' remediation plans and ensure that VAMCs and VISNs are successfully implementing remediation plans for addressing low clinical productivity and inefficiency.

VA Response to Recommendations

VA concurred with GAO's recommendations and is already working to complete them. We have already expanded productivity measurement to include Advanced Practice Providers (APP) and will establish productivity performance targets for them. Since 2014, the Office of Productivity, Efficiency and Staffing (OPES) has maintained a comprehensive database of the APP workforce and workload. This database, the APP Cube, provides detailed information by discipline about the APP staffing levels, clinical workload, and productivity for each VAMC. We collect this data and post it on the VHA Support Service Center (VSSC) website. We are currently in the process of establishing standards for these advanced practice providers, for whom we recently expanded practice authority across the system.

We recognize that our current productivity and efficiency monitoring does not represent a 100-percent solution, but it does move VHA toward our goal of ready access to high-quality, efficient healthcare for our Veterans. Significant work has been undertaken to improve productivity and efficiency. For example, data tools to assist local VAMCs are readily available and are used with increasing frequency. As one indicator, the number of web hits on these productivity and efficiency tools within the system - which shows local managers are working on initiatives to improve productivity and efficiency - has increased by 37 percent (up from 462,742 to 631,912) from the second quarter of FY 2016 to the same time in FY 2017.

VA concurred in principle with the second recommendation, to develop coding training for all providers. VA utilizes appropriate needs-based, focused training to minimize the impact on access to care. In May 2016, VHA's Health Information Management (HIM) program office, in conjunction with the Office of Compliance and Business Integrity, developed and implemented a process to improve coding accuracy and report monitoring of clinical coders and providers and monitoring productivity of coders. The process includes the appropriate sample size of billable and non-billable events per facility along with a standardized data collection tool. The facility chief of HIM collects appropriate data, reports results to the facility Compliance Committee and, as appropriate, develops a causation and corrective action plan for facility implementation to include focused provider training as deemed necessary. Regular presentations by the Compliance Committee assure leadership visibility of progress in improving productivity and efficiency. The HIM program office examines data to identify patterns across VHA sites and develops education remediation efforts. This is then reissued to the field.

We have also undertaken a comprehensive education and communication plan about the specialty physician productivity and staffing standards. We have held national calls to actively engage our specialty physician workforce. Our specialty physicians are committed to demonstrating and improving specialty productivity and access. We have also held national calls with medical center leadership in an effort to communicate clearly the expectations of full implementation of specialty physician productivity and staffing standards. All medical centers have been provided with access to a variety of tools that permit productivity and staffing measurement at the individual physician and specialty practice level. Our national and local specialty leaders have been trained on the business strategies and tools available to assist them in managing their specialty practices with the goal of ready access to quality specialty care for our Veterans.

VA also concurred in principle with the third recommendation, to monitor and improve efficiency through a standard process. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will develop a more comprehensive strategy regarding VAMC clinical efficiency by leveraging current clinical efficiency models. The DUSHOM's preferred approach is to continue our present course of enhancing and updating tools that highlight potential opportunities to improve clinical

efficiency, and to strengthen the organization's capacity to disseminate proven, strong practices from high performers and, for struggling sites, to provide personalized, on-site assistance. Currently, staff from the DUSHOM's office sits down weekly with field colleagues to identify outlier facilities for follow-up who may have reported unusual increases or decreases in productivity. Plans for improving clinical efficiency must be developed at the VAMC. Remediation plans should be tracked at both the facility and VISN. The DUSHOM will review the progress VAMCs are making on the remediation plans for addressing low clinical productivity twice a year with the VISN. The target completion date for this is March 2018.

Finally, VA concurred with GAO's recommendation to establish an ongoing process to review and ensure success of these remediation plans. OPES already provides ongoing reporting of productivity performance to the VAMC leadership. In addition, the DUSHOM will review the progress VAMCs are making on the remediation plans for addressing low clinical productivity and efficiency twice a year with the VISN. The target completion date for this is October 2017.

We are currently exploring a productivity measurement system and performance targets for Physician Assistants and Nurse Practitioners. This is a complicated matter and involves deliberation with multiple stakeholders who are less accustomed to workload documentation than our physicians. Our current Veterans Information Systems and Technology Architecture (VistA) data architecture was never designed to capture data related to billing type, so a variety of complex workarounds are needed to assemble an approximation of RVUs. These workarounds introduce a risk of reporting inaccurate numbers; and we magnify that risk by expanding the scope of measurement. We are encouraged by the fact that the anticipated Cerner system is better configured for workload capture and billing using private-sector standards, and could help embed workflow indicators that transparently capture data regarding productivity and minimize inaccuracies due to our current workarounds. Many private hospitals now rely on integrated applications to reduce coding errors and inefficiency. Capturing the productivity of contract physicians is currently not possible because, while we can track workload, we do not have any centralized data for total effort or time.

The 2015 Independent Assessment

In 2015, the Independent Assessment required by Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 made five similar recommendations regarding productivity and efficiency: (1) VHA should improve staffing models and performance measurement; (2) VAMCs should create the role of clinic manager and drive more coordination and integration among providers and support staff; (3) VAMCs should implement strategies for improving management of daily staff variances, and include a replacement factor for all specialties, including Patient Aligned Care Teams; (4) VAMCs should implement local best practices that mitigate space shortages within specialty clinics; and (5) VHA should improve the accuracy of workload capture.

In response to the Independent Assessment, VA has taken several steps described below to ensure increased efficiency and productivity and therefore improve access to care and better use of taxpayer dollars. As a result, VA has made great improvements since the publication of the Independent Assessment to improve overall productivity and efficiency.

As previously mentioned, the SPARQ tool provides data to assist leadership with local resource decisions. This includes data on the practice infrastructure and projected clinical workload from the Enrollee Healthcare Projection Model. VHA reports provider productivity by specialty and medical center complexity group. Specialty practices not meeting productivity targets are required to identify a remediation plan, with VA Central Office and VISN leadership actively involved in this review. Similarly, Specialty Practice Triggers are in place to identify significant changes in clinical workload volume and productivity.

As a result of the Veterans Access, Choice, and Accountability Act of 2014, we have Group Practice Managers (GPM) at all of our facilities who oversee staffing and clinic flow. They represent one of the most exciting initiatives that VHA has implemented recently. The GPMs are charged with specialty practice management and have quickly and adeptly begun addressing the myriad issues in optimizing our clinic practice in real time.

Conclusion

VA appreciates our colleagues at GAO's efforts and the efforts of others to improve clinical efficiency and productivity. VHA's top priority is improving access to care for our Veterans; improving productivity and efficiency is a means to that end.

Mr. Chairman, I am proud of the healthcare our employees provide to our Nation's Veterans. Together with Congress, I look forward to making sure that VA will be a good steward of taxpayer dollars, while providing this care in a productive and efficient manner. Our Veterans deserve this care and our taxpayers deserve to know we are providing it in the most efficient and productive manner. Thank you for the opportunity to testify before this Subcommittee. I look forward to your questions.