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BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

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

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

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

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

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

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

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

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

that appropriate resources are available to care for the patients on the panel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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