STATEMENT OF
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U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
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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.