United States Government Accountability Office

Testimony

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

For Release on Delivery
Expected at 10:30 a.m. ET
Thursday, June 21, 2018

VETERANS HEALTH ADMINISTRATION

Steps Taken to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain

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GAO-18-623T

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

Thank you for the opportunity to participate in today's hearing on the ability of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) to recruit and retain high-quality physicians. A strong clinical workforce capable of providing quality and timely care to our nation's veterans is critical to the success of VHA, which operates one of the largest health care systems in the United States, providing care at 1,252 facilities, including 170 VA medical centers (VAMC).[1] As the demand for VHA's services grows—due in part to increasing demand from servicemembers returning from the United States' military operations in Afghanistan and Iraq, and the growing needs of an aging veteran population—attracting, hiring, and retaining top talent is critical to VHA's mission to provide high-quality and timely health care for our nation's veterans.

Physicians—who provide and supervise a broad range of care, including primary and specialty care—serve an integral role in VHA's mission. VHA indicated that physicians occupy a top spot on its annual list of mission-critical occupations, as a result of factors including the time frames needed for VHA's hiring process, a limited supply of candidates, and competition for candidates.[2] Within the physician category, VHA has also identified the top five physician occupations that are the hardest to recruit and retain. We use the term "mission-critical physician occupations" to refer to the top five physician occupations VHA identified in fiscal year 2016 as most in need of staffing: primary care, mental health, gastroenterology, orthopedic surgery, and emergency medicine. VHA hires more than 2,800 mission-critical physicians annually. Yet, physicians have consistently been identified by VHA as a critical staffing priority due to recruitment and retention concerns.

Over the past two decades, we and others have expressed concerns about VHA's ability to ensure that it has the appropriate clinical workforce

[1]In addition to the 170 VAMCs, VHA also operates 1,082 outpatient sites of care, such as health care centers and community-based outpatient clinics.

[2]VHA obtains data from its Veterans Integrated Service Networks and VAMCs on which occupations are the highest priority for recruitment and retention based on known recruitment and retention concerns, among other factors. See U.S. Department of Veterans Affairs, Veterans Health Administration, Mission-Critical Occupation Report (2016).

to meet the current and future needs of veterans.[3] A 2015 independent assessment found that if VHA does not increase its total number of clinical employees, including physicians, it will be difficult for it to meet the projected demand for services.[4] Further, in July 2016, we found that the number of physicians who leave VHA had steadily increased from fiscal years 2011 through 2015. During this time, physicians were among the 10 occupations with the highest rates of attrition each year.[5] The attrition was primarily due to voluntary resignations and retirements.

My statement today is based on our October 2017 report examining VHA physician staffing, recruitment, and retention strategies.[6] In particular, my statement focuses on (1) VHA information on how many mission-critical physicians provided care at VAMCs; (2) VHA guidance for determining its physician staffing needs; and (3) the strategies VHA used to support the recruitment and retention of physicians at VAMCs, and the extent to which it has evaluated these strategies to determine their effectiveness. As part of that work, we made several recommendations for VHA to improve staffing, recruitment, and retention strategies for physicians.

To do the work for our October 2017 report, we reviewed key documents and interviewed knowledgeable officials from VHA in headquarters offices, as well as in six VAMCs across the country. More detailed information on the objectives, scope, and methodology for our 2017 report can be found in that report. For this statement, we obtained information from VHA officials in June 2018 about any steps they have taken to implement our 2017 recommendations.

[3]We and the VA Office of the Inspector General have issued at least 16 reports between 1981 and 2017 that raised a variety of concerns about VHA's workforce. Recent GAO reports include, GAO, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment and Retention Strategies,* GAO-18-124 (Washington, D.C.: Oct. 19, 2017); *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges,* GAO-17-30 (Washington, D.C.: Dec. 23, 2016); and *Veterans Health Administration: Personnel Data Show Losses Increased for Clinical Occupations from Fiscal Year 2011 through 2015, Driven by Voluntary Resignations and Retirements,* GAO-16-666R (Washington, D.C.: July 29, 2016).

[4]See RAND Corporation, Assessment B (Health Care Capabilities), (Santa Monica, Calif: Sept. 1, 2015).

[5]See GAO-16-666R.

[6]See GAO-18-124.

This statement is based on work conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The attrition among VHA physicians has been of particular concern given that the Health Resources and Services Administration (HRSA) anticipates that by 2025 the national demand for physician services will exceed supply. HRSA's Office of Rural Health Policy reported, in 2017, that physician shortages were exacerbated in rural areas, where communities struggle to attract and keep well-trained providers.[7] This difficulty has posed a particular challenge for VHA, as approximately one in four VAMCs is located in a rural area.

Most physicians providing care at VAMCs are employed by VHA. VHA also supplements the capacity of its employed physician staff by acquiring additional physician services through fee-basis arrangements or contracts. Under fee-basis arrangements, providers are paid a pre-agreed-upon amount for each service provided. Under contracts, physician services may be obtained on a short-term basis; for example, through sole-source contracts with academic affiliates.[8] VAMCs may also use physicians who volunteer their time, who are referred to as work-without-compensation providers.

[7]Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Areas Statistic*, HRSA Data Warehouse, accessed May 31, 2017.

[8]The term academic affiliate describes any of the following three entities in a partnership with a VAMC: (1) a university medical school, (2) a university hospital, or (3) a university affiliated physician practice group. If VA requires heath care resources—such as physician services, medical equipment usage, or clinical space—and intends to acquire these resources from its affiliate due to its connection with a residency program, VA can enter into a non-competitive contract with that affiliate. See 38 U.S.C. § 8153(a)(3)(A).These sole source contracts are available only to VAMCs and their affiliates, and allow a VAMC to obtain physician services directly from the affiliate without competition if those services are necessary to support learning opportunities for physicians during their residency training in VAMCs. See Department of Veterans Affairs, *Health Care Resources Contracting—Buying, Title 38 U.S.C. 8153*, VA Directive 1663 (Aug. 10, 2006).

In addition to VHA-employed, contract, and fee-basis physicians, VAMCs often supplement their capacity by using physician trainees, who include medical residents and advanced fellows.[9] In 2016, 135 of the 170 VAMCs had active physician training programs. According to VHA officials, there were 43,768 medical residents who trained at a VAMC in 2016. VHA has been expanding its physician training program, as directed by the Veterans Access, Choice, and Accountability Act of 2014, as amended.[10] In 2017, VHA added 175 physician trainee positions across VAMCs nationwide, including 3 VAMCs that did not have physician trainees prior to this expansion. VHA's objective is to add 953 additional physician trainee positions to its VAMCs by 2025 in order to improve access and hire additional physicians. Further, VHA officials told us they want to continue to add new positions that would eventually allow all VAMCs access to physician trainees.

[9]A medical resident or fellow is a physician who practices medicine under the direct or indirect supervision of an attending physician. Successful completion of a residency program is a requirement to obtaining an unrestricted license to practice medicine. Advanced fellows are individuals who have completed all desired residency training (including fellowships) and have stayed in VHA for additional training.

[10]Pub. L. No, 113-146, § 301(b)(2), 128 Stat. 1754, 1785 (2014), as amended by Pub. L. No. 114-315, § 617(a), 113 Stat. 1536, 1577 (2016) (codified at 38 U.S.C. § 7302 note).

VHA Lacked Information on the Total Number of Mission-Critical Physicians Who Provided Care at VAMCs and Does Not Plan to Collect this Information

In our October 2017 report, we found that VHA's data on physicians who provided care at VAMCs were incomplete. Specifically, we found that VHA had data on the number of mission-critical physicians it employed (more than 11,000) and who provided services on a fee-basis (about 2,800), but lacked data on the number of contract physicians and physician trainees. As a result, VHA did not have data on the extent to which VAMCs used these arrangements and thus, underestimated its physician use overall. Therefore, VHA was unable to ensure that its workforce planning processes sufficiently addressed any gaps in staffing.

All six VAMCs included in our review used at least one type of arrangement other than employment for physicians, and five of the six used contract physicians or physician trainees. (See fig. 1.) On average, contract and fee-basis physicians made up 5 to 40 percent of the physicians in a given mission-critical physician occupation at each VAMC in our review.[11] For example, officials from a large, highly complex VAMC told us that, in March 2017, they augmented the 86 employed primary care physicians with eight contract and three fee-basis physicians, which represented about 16 percent of their primary care physician workforce.[12] Further, this VAMC also had about 64 primary care physician trainees providing certain medical services under the supervision of a senior physician.

[11]Officials from one of the six VAMCs we reviewed told us that they used both contract and fee-basis physicians, but they were not able to determine if these physicians worked in mission-critical physician occupations. Also, because physicians who are compensated on a fee-basis do not have an assigned full-time equivalent (FTE), we were unable to calculate the percentage of FTEs that contract and fee-basis physicians contribute to a VAMC. VAMC officials told us that, in order to ensure a physician is on-call 24 hours a day, 7 days a week, they may have a number of physicians on contract that only provide a limited amount of care.

[12]The contract and fee-basis physicians constituted approximately 6 percent of the VAMC's primary care FTE positions, which is lower because contract primary care physicians were often used on a part-time basis. Officials from this VAMC told us that employed primary care physicians filled 85 FTE positions, while contract physicians filled 3, and fee-basis physicians filled about 1 FTE.

Figure 1: VAMCs' Use of Contract Physicians, Fee-Basis Physicians, and Physician Trainees for Mission-Critical Physician Occupations at the Six VAMCs Reviewed for Our October 2017 Report

Facility	Contract physicians	Fee-basis physicians	Physician trainees
A	✓	✓	○
B	✓	✓	✓
C	✓	✓	✓
D	○	✓	○
E	✓	✓	✓
F	✓	✓	✓

✓ Facility used arrangement

○ Facility did not use arrangement

Source: GAO analysis of Department of Veterans Affairs Medical Centers' (VAMC) data. | GAO-18-623T

During the course of our work for the October 2017 report, VHA officials told us that its personnel databases were designed to manage VHA's payroll systems, but that these databases did not contain information on contract physicians or physician trainees. VHA officials told us they were working to include information on physician trainees in a new human resources (HR) database—HR Smart—which at the time of our review, was scheduled to be implemented in 2017. However, these officials were not aware of plans to add information to the database on contract physicians. Instead, VAMC leaders used locally devised methods to identify and track contract physicians, fee-basis physicians, and physician trainees. For example, one VAMC in our October 2017 review used a locally maintained spreadsheet to track its physicians under arrangements other than employment, while another VAMC asked department leaders to identify how many of these provided care within their respective departments. At each of the six VAMCs in our review, we found that department leaders were generally knowledgeable about the total number of physicians that provided care within the departments they managed. However, this locally maintained information was not readily accessible by VHA officials.

To address the limitations in VHA's data, we recommended in our October 2017 report that VHA develop and implement a process to accurately count all physicians providing care at each of its VAMCs, including physicians not employed by VHA. VHA did not concur with this recommendation, stating that it uses other tools for workforce planning. However, a VHA official acknowledged that data sources used for workforce planning may not include all types of contract physicians or work-without-compensation physicians.

As we discussed in our prior report, implementing such a systematic process would eliminate the need for individual VAMCs to use their own mechanisms, such as a locally developed and maintained spreadsheet to track its physician workforce, as was done by one VAMC in our prior review. Further, local mechanisms may not be readily accessible to VHA officials engaged in workforce planning, resulting in incomplete information for decision-making purposes.

Since our report, VHA officials told us that they have completed implementation of HR Smart, which provides the capability to track every position with a unique position number, and each employee's full employment history. However, VHA officials told us they do not plan to enhance the capability of HR Smart to track contractors.

We continue to believe that having a systematic and consistent process to account for all physicians who provide care across VAMCs, including physicians not employed by VHA, would help address concerns that VHA is unable to identify all physicians providing care at its VAMCs.

VHA Has Begun to Develop Guidance for Determining Its Staffing Needs for All Physicians

In our October 2017 report, we found that VHA gave responsibility for determining staffing needs to its VAMCs and provided its facilities with guidance, through policies and directives, on how to determine the number of physicians and support staff needed for some physician occupations. Specifically, VHA provided this guidance for primary care, mental health, and emergency medicine, but lacked sufficient guidance for its medical and surgical specialties, including occupations such as gastroenterology and orthopedic surgery. For these occupations, VHA provided guidance on the minimum number of physicians, but did not provide information on how to determine appropriate staffing levels for physicians or support staff based on the need for care.

Specifically, the VHA guidance available at the time set a minimum requirement that VAMCs of a certain complexity level have at least one

gastroenterologist and one orthopedic surgeon that is available within 15 minutes by phone or 60 minutes in person 24 hours a day, 7 days a week.[13] VHA guidance did not include information on how to use data, such as workload data, to manage the demand for care or help inform staffing levels for these physician occupations beyond this minimum requirement. Officials from four of the six VAMCs we reviewed for our October 2017 report told us that because they lacked (1) guidance on how to determine the number of physicians and support staff needed, and (2) data on how their staffing levels compared with those of similar VAMCs, they were sometimes unsure whether their staffing levels were adequate.

In our October 2017 report, we discussed that VHA had previously established, in 2016, a specialty physician staffing workgroup that examined the relationships between staffing levels, provider workload and productivity, veterans' access, and cost across VAMCs for its medical and surgical specialties, including gastroenterology and orthopedic surgery. This group's work culminated in a January 2017 report that found VHA was unable to assess and report on the staffing at each VAMC, as required by the Veterans Access, Choice, and Accountability Act of 2014, because a staffing model for specialty care had not been established and applied across VAMCs. This report made a number of recommendations, including that VHA provide guidance to its VAMCs on what level of staffing is appropriate for its mission-critical physician occupations. However, as we noted in our October 2017 report, VHA leadership had not yet taken steps to develop such staffing guidance. We reported that, according to a VHA official, other priorities were taking precedence and continued work in this area had not yet been approved by VHA leadership. Although VHA officials agreed that further steps should be taken, they did not indicate when these would occur. In our report, we concluded that until VHA issues guidance on staffing levels for certain physician occupations that provide specialty care to veterans, there would continue to be ambiguity for VAMCs on how to determine appropriate staffing levels.

[13]VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity. There are three complexity levels with level 1 representing the most complex facilities and level 3 the least complex. Level 1 is further subdivided into categories 1a, 1b, and 1c. Therefore, VAMCs that are categorized as level 1a would offer the most advanced and complex medical treatment within VHA's medical care system.

To address this, we recommended that VHA develop and issue guidance to VAMCs on determining appropriate staffing levels for all mission-critical physician occupations. VHA concurred with our recommendation and reported it would evaluate and develop staffing guidance for its medical and surgical specialties.

Since our report, VHA officials told us that on November 27, 2017, the Executive-in-Charge for VHA signed the specialty care workgroup charter. The primary goal of the workgroup is to develop a specialty care staffing model that will include staffing information for all specialty care. VHA anticipates completing its work and issuing staffing guidance by December 2018.

VHA Used Multiple Strategies for Physician Recruitment and Retention, but Has Not Comprehensively Evaluated Them to Assess Effectiveness

In our October 2017 report, we found that VHA used various strategies to recruit and retain its physician workforce, including providing assistance recruiting for mission-critical physician occupations through the National Recruitment Program; policies and guidance; financial incentives to enhance hiring and retention offers; and a national physician training program. (See table 1.)

Table 1: VHA Physician Recruitment and Retention Strategies

Providing assistance recruiting for mission-critical physician occupations	VHA operates the National Recruitment Program that provides direct physician recruitment services to Veterans Affairs medical centers (VAMC) for hard-to-recruit positions, including physicians. This program, which had 19 physician recruiters as of May 2017, according to officials, represents VHA at medical conferences, screens résumés, and develops marketing materials, among other things, to identify and refer physician candidates to VAMCs.
Policies and guidance	VHA administers the policies and guidance developed by VA that provide the basic framework for hiring, paying, promoting, and retaining physicians. Using in-person and webcast sessions, VHA also provides basic and advanced training to VHA staff on personnel policies.
Financial incentives	VHA provides financial incentives to strengthen efforts to recruit and retain physicians and help to narrow the differences between VHA salary offers and those of private sector employers. VAMCs adjust market pay, one component of physician compensation, to reflect a physician's training, experience, and prevailing pay levels in the local medical community. Additionally, VHA may offer other types of financial incentives such as the Education Debt Reduction Program, which reimburses qualifying education loan debt for employees, including physicians, in hard-to-recruit positions.
Physician training program	VHA's physician training program provides VAMC officials with the ability to regularly interact with trainees and identify top-performing physicians who would be a "good fit" for permanent employment. According to officials, access to this pool of potential hires serves as an important recruitment resource.

Source: Veterans Health Administration (VHA) | GAO-18-623T

In our October 2017 report, we found that VHA faced challenges using its strategies for recruiting and retaining physicians. For example, according to VHA officials, budget shortfalls in the Education Debt Reduction Program—which reimburses qualifying education loan debt for employees, including physicians, in hard-to-recruit positions—reduced VAMCs' ability to offer this recruitment incentive to physician candidates. In addition, the relatively small number of physician recruiters in VHA's National Recruitment Program—19 recruiters for the 170 VAMCs at the time of our report—limited their ability to understand the particular nuances of some markets, particularly in rural areas.

Further, despite VHA's large and expanding graduate medical training program, VAMCs experienced difficulties hiring physicians who received training through its residency and fellowship programs. VHA did not track the number of physician trainees who were hired following graduation, but officials told us that the number was small in comparison to the almost 44,000 physician trainees educated at VAMCs each year.

We found that VAMCs faced challenges hiring physician trainees, in part, because VHA did not share information on graduating physician trainees for recruitment purposes with VAMCs across the system. VHA officials

told us that recruitment efforts could be improved by developing and maintaining a database of physician trainees, but said that VHA had no such database. According to VHA officials, information sharing could help both VAMCs in geographically remote locations that do not have a residency program and help identify trainees who want to work at VHA after graduating, but who received no offers from the VAMC they trained at due to the lack of vacancies in their specialty.

We also reported in October 2017 that VHA did not have complete information on whether its recruitment and retention strategies were meeting its needs. VHA had gathered feedback on barriers VAMCs face when offering financial incentives to physician candidates through its Education Debt Reduction Program and created a workgroup to look at its overall use of physician retention strategies, although it had not completed a comprehensive review of its recruitment and retention strategies to identify any areas for improvement. As a result, VHA did not have complete information on the underlying causes of the difficulties VAMCs faced or whether its recruitment and retention strategies met its objective of having a robust physician workforce to meet the health care needs of veterans.

To address these issues, we recommended that VHA (1) establish a system-wide method to share information about physician trainees to help fill vacancies across VAMCs, and (2) conduct a comprehensive, system-wide evaluation of its physician recruitment and retention efforts, and establish an ongoing monitoring program. VHA concurred with our recommendations, and reported it planned to enhance its personnel database, HR Smart, to include physician trainees. Additionally, VHA said it planned to complete a comprehensive, system-wide evaluation of the physician recruitment and retention strategies.

Since our report, VHA reported taking some steps to address these recommendations. Specifically, officials told us they are working to include information in the newly implemented HR Smart database on work-without-compensation employees, such as physician trainees, and anticipate conducting pilot projects at various sites before fully implementing this capability by September 30, 2019. Additionally, officials said that they are in the process of completing a review of physician recruitment and retention incentives. Furthermore, according to VHA officials, beginning in October 2017, VHA's Office of Workforce Management and Consulting partnered with the Partnered Evidence-based Policy Resource Center—an internal VHA resource center—to evaluate and recommend a systematic approach for allocating workforce

management resources, such as the Education Debt Reduction Program. VHA expects to complete its efforts by September 2018.

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

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Key contributors to this statement were Janina Austin (Assistant Director), Sarah Harvey (Analyst-in-Charge), Jennie Apter, Frederick Caison, Alexander Cattran, and Krister Friday.

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