

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Veterans Health Administration

*Audit of  
Physician Staffing  
Levels for Specialty  
Care Services*

December 27, 2012  
11-01827-36

## ACRONYMS AND ABBREVIATIONS

FTE	Full-Time Equivalent
GAO	Government Accountability Office
OIG	Office of Inspector General
RVU	Relative Value Unit
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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# Report Highlights: Audit of VHA's Physician Staffing Levels for Specialty Care Services

## Why We Did This Audit

In January 2002, Public Law 107-135 mandated that VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. However, audits and inspections continued to identify the need for the Veterans Health Administration (VHA) to improve their staffing methodology by implementing productivity standards.

To evaluate VHA's progress in implementing a policy on physician staffing levels, we assessed whether VHA had an effective methodology for determining physician staffing levels for 33 of VHA's specialty care services. VHA did not collect workload data on some specialty care services, such as podiatry, thus we did not include those in our audit.

## What We Found

VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for all specialties and VA medical facility management did not develop staffing plans. This occurred because there is a lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans.

As a result, VHA's lack of productivity standards and staffing plans limit the ability

of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care.

## What We Recommended

We recommended the Under Secretary for Health establish productivity standards for at least five specialty care services by the end of FY 2013 and approve a plan that ensures all specialty care services have productivity standards within 3 years. We also recommended that the Under Secretary provide medical facility management with specific guidance on development and annual review of staffing plans.

## Agency Comments

The Under Secretary for Health agreed in principle with our finding and recommendations. We will monitor implementation of their planned actions.

A handwritten signature in black ink that reads "Linda A. Halliday".

LINDA A. HALLIDAY  
Assistant Inspector General  
for Audits and Evaluations

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## INTRODUCTION

**Objective** This Office of Inspector General (OIG) audit assessed whether the Veterans Health Administration (VHA) had an effective methodology for determining physician staffing levels for specialty care services.

**Public Law** In January 2002, Public Law 107-135 mandated that VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. Specifically, VA medical facilities should consider staffing levels and a mixture of staffing skills required for the range of care and services provided to veterans.

**VHA Memorandum** In a memorandum dated January 25, 2005, the Deputy Under Secretary for Health for Operations and Management directed VHA to continue the development of a productivity-based model for specialty care services using the Relative Value Unit (RVU) measure. An RVU is a value assigned to a service (such as a medical procedure) that establishes work relative to the value assigned to another service. For example, a service with an RVU of “2” accounts for twice as much physician work as a service with an RVU of “1.” It is determined by assigning weight to factors such as the:

- Time required to perform the service
- Technical skill and physical effort
- Mental effort and judgment
- Psychological stress associated with the service and risk to patient

The goal of this RVU-related directive was to explore the feasibility of developing a productivity-based staffing methodology. In response, VHA's Office of Productivity, Efficiency, and Staffing conducted studies of 14 specialties during 2006 and recommended VHA develop RVU productivity standards and staffing guidance for the field.

## RESULTS AND RECOMMENDATIONS

### Finding **VHA Needs To Develop an Effective Staffing Methodology for Specialty Care Services**

VHA did not have an effective staffing methodology to ensure appropriate physician staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for 31 of 33 specialty care services we reviewed, and VA medical facility management did not develop staffing plans. These conditions occurred because of a lack of agreement within VHA about which methodology to use to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans. As a result, VHA's lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care.

#### **VHA's Reluctance To Establish a Staffing Methodology**

The need for VHA to develop a staffing methodology is not a recent issue. In 1981, the Government Accountability Office (GAO) recommended that VHA develop a methodology to measure physician productivity. Since then, six VA OIG and GAO reports have made similar recommendations. (Appendix B contains a list of oversight reports and relevant recommendations.)

#### **Productivity Standards Not Established**

VHA's lack of established productivity standards for specialty care services limited the ability of medical facility officials to determine the appropriate number of specialty physicians needed to meet patient care needs and to measure productivity of specialty care services. The GAO's *Standards for Internal Control in the Federal Government* states that controls are an integral part of an organization's planning, implementing, reviewing, and accounting for government resources and achieving effective results. Organizations need to establish performance measures to make comparisons and assessments of different data and analyze their relationships to be able to take appropriate action.

In 2006, VHA's Office of Productivity, Efficiency, and Staffing conducted studies of 14 specialty care services, which resulted in 9 recommendations. One of the nine was to have VHA develop RVU productivity standards and staffing guidance for the field. However, VHA did not fully implement this recommendation. VHA has established productivity standards for only 2 of 33 specialties we reviewed—ophthalmology and radiology. The annual standard for ophthalmology is between 6,000 to 6,900 RVUs per clinical full-time equivalent (FTE), and the annual radiology standard is 5,000 RVUs per clinical FTE. In April 2012, VHA assigned a physician to lead the development of productivity standards and staffing plans for 10 specialties.

To assist medical facility managers, the Office of Productivity, Efficiency, and Staffing created the Physician Productivity Cube, which is a tool that captures physician productivity workload for most specialties. The tool measures workload by RVUs, number of encounters, and number of unique patients. It also provides medical facilities with the capability to assess their productivity and compare themselves to VHA's national medians, similar medical facilities, and private sector benchmarks. However, none of the five medical facilities we visited used the Physician Productivity Cube to monitor productivity. While some medical facility personnel were unaware of its availability, others did not monitor productivity because there was no reporting requirement, and access to the Physician Productivity Cube was limited.

*Reason  
Productivity  
Standards Not  
Established*

VHA agreed with the need to develop a methodology to measure productivity. However, a lack of agreement exists within VHA on which methodology to use to measure productivity. Some VHA officials believed the RVU-based productivity model is not a good measure as a stand-alone component for staffing. Other VHA senior officials from the Office of Patient Care Services and medical facility officials stated that based on data availability, the RVU model is the best method currently available to measure productivity.

VHA officials were also concerned that its National Patient Care Database did not capture all of the physician workload needed for use in productivity-based staffing models. For example, VHA officials told us that physicians who supervise residents accomplish less workload than their peers who do not supervise residents because the residents will get credit for the work completed. While this may be valid if VHA is trying to establish individual physician productivity, it is not a valid concern when developing a productivity standard for a specific specialty within similar medical facilities.

To determine an approximate measure of current physician specialty productivity, we established a rudimentary standard by identifying VHA's RVU median for each specialty care service. The national median is the middle value among each specialty care service. Using that median, we analyzed the collective group of specialty physicians at all medical facilities and determined that 12 percent (824 of 7,011) of physician FTEs did not perform to the standard. (Appendix C lists the physician specialties.) The 824 physician FTEs represented approximately \$221 million in physician salaries during FY 2011. Although we did not analyze the productivity of individual physicians, our results support the need for an in-depth evaluation of staffing.

If VHA decides not to use RVUs as the productivity standard, VHA can explore other options, such as panel size or other types of productivity-based workload measures. Panel size, used in primary care services, is the maximum number of active patients under the care of a specific provider.

VHA currently collects data, such as the number of encounters and unique patients, which they could use to develop a productivity-based methodology.

We recognize the challenge in establishing standards for all specialties, but VHA needs to initiate a plan by the end of FY 2013 that ensures all specialty care services have productivity standards within 3 years. The plan should include the establishment of productivity standards for at least five specialty care services by the end of FY 2013 and ensure medical facility personnel compare physician specialty workloads against these standards.

*Opportunities  
To Identify Best  
Practices  
Missed*

VHA does not have an internal measure to benchmark physician productivity within a specialty. Another tenet of *Standards for Internal Control in the Federal Government* is the organization's comparison of actual performance to results and the analysis of significant differences within that organization. For example, we compared the staffing levels to the amount of work performed by each specialty care service at the five medical facilities. Specifically, we compared the workload output per clinical FTE for each specialty care service and found significant differences in workload.

- A medical facility classified as "1a" by the Facility Complexity Level Model had 1 FTE providing infectious disease care to 316 unique patients for a total of 603 encounters. During the same period, a medical facility also classified as "1a" had 1.4 FTE that provided infectious disease care to 1,868 unique patients for a total of 3,476 encounters. Although the latter medical facility had about 40 percent more in staff, the medical facility provided over five times more encounters to 1,552 more patients.
- A medical facility classified as "1a" had .8 FTE providing endocrinology care to 1,053 unique patients for a total of 1,627 encounters.\* During the same period, a medical facility also classified as "1a" had .4 FTE that provided endocrinology care to 1,347 unique patients for a total of 2,286 encounters. Although the latter medical facility had about 50 percent less staff, the medical facility provided 41 percent more encounters.

Although evaluating the productivity of individual physicians has value, the message of this report is that VHA needs to implement productivity standards to measure and compare the collective productivity of physicians within a specialty care service at VA medical facilities. By measuring and comparing internal productivity and staffing, VHA can identify best practices and those practices that should be changed or eliminated.

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\* The Facility Complexity Model classifies VA medical facilities at levels 1a, 1b, 1c, 2, or 3. Level-1a facilities are the most complex and level-3 facilities are the least complex. VHA determines complexity levels by three categories—patient population, clinical services complexity, and education and research.

**Staffing Plans  
Not Prepared**

Staffing plans are an important control to ensure effective and efficient use of funds by providing some certainty that medical facility officials conduct periodic assessments of their staffing needs. VHA policy requires medical facilities to develop staffing plans that address performance measures, patient outcomes, and other indicators of accessibility and quality of care. These assessments determine if staffing levels need an adjustment—up or down—to meet current or projected patient outcomes, clinical effectiveness, and efficiency.

None of the five medical facilities could provide a staffing plan that addressed the facilities' mission, structure, workforce, recruitment, and retention issues to meet current or projected patient outcomes, clinical effectiveness, and efficiency. Medical facility officials stated that when requesting additional staff or filling a vacancy, they provide a workload analysis to justify the personnel action. However, medical facility officials could not always provide documentation or an adequate workload analysis to justify the need for additional staff.

For example, one medical facility provided us with the justification used to replace a part-time surgeon. It showed the surgeon was responsible for 13 percent of the work performed by the specialty care service. In the justification, the requesting official concluded the remaining two full-time surgeons would not be able to absorb the departing surgeon's patient care responsibilities. However, the requesting official provided no other information such as total workload, anticipated workload increases or decreases, or an analytical review of the other surgeons' ability to handle more workload.

This occurred because current VHA policy does not provide sufficient detail for medical facilities to develop their staffing plans. Officials from all five medical facilities stated they were not sure what was required to implement a staffing plan. According to VHA officials, the staffing policy was intentionally general in nature because medical facility officials determine staffing levels on various factors, such as the needs of each medical service, the number of residents, and the types of care provided. Without detailed staffing plans, VHA lacks assurance that medical facility officials are making informed business decisions that best ensure efficient use of financial resources in determining the appropriate number of specialty care physicians.

**Conclusion**

VHA needs to develop an effective staffing methodology for specialty care services. Specifically, VHA has not established productivity standards for all specialties because of indecision on how to measure physician productivity. Instead of focusing on the difficulties of measuring productivity, VHA needs to focus on the benefits of discovering medical facilities that might have a best practice and identify practices that should be changed or eliminated. This would maximize the use of physician resources while increasing access and quality of care to more veterans.

## Recommendations

1. We recommended that the Under Secretary for Health approve a plan by the end of FY 2013 that ensures all specialty care services have productivity standards within 3 years.
2. We recommended that the Under Secretary for Health establish productivity standards for at least five specialty care services by the end of FY 2013 and ensure medical facility personnel compare physician workload against these standards.
3. We recommended that the Under Secretary for Health provide medical facility directors with more specific guidance on how to develop staffing plans and ensure medical facility management review them at least annually to ensure optimal efficiency.

### **Management Comments and OIG Response**

The Under Secretary for Health agreed in principle with our finding and recommendations. In June 2012, the Under Secretary established the Specialty Care Physician Productivity and Staffing Plan Task Force to develop a methodology for VHA specialty care physician productivity and staffing. The plan is to examine available VHA physician productivity data and identify a productivity evaluation tool. The plan also includes determining how best to establish an activity-based staffing and productivity model.

VHA will work to establish appropriate activity-based staffing and productivity models for five specialties by the end of FY 2013. In the next 3 years, VHA will continue to refine and develop additional individualized specialty care models.

The Specialty Care Physician Productivity and Staffing Plan Task Force will also update the staffing directive and development of a communication and training plan. VHA is considering an annual review of all data that feeds the activity-based staffing and productivity model, as well as training requirements that will be used as a basis for resource discussions at the facility level.

We consider the planned actions acceptable. We will consider the recommendations implemented once productivity standards have been established for at least five specialty care services, a plan is in place that ensures all specialty care services have productivity standards within 3 years, and medical facility management receive specific guidance for development and annual review of staffing plans. Appendix D contains the full text of the Under Secretary's comments.

## Appendix A Scope and Methodology

### Scope

We conducted our audit work from August 2011 through October 2012. During FY 2011, VA employed 9,655 specialty physician FTEs at 140 VA medical facilities that equated to salary costs of approximately \$2.59 billion. Of the 9,655 physician FTEs, 7,011 (73 percent) provided patient care services. This represents the physician FTEs assigned to clinical duties for 33 specialties (excludes inpatient services for non-surgical specialties, such as medicine and mental health). The remaining 2,644 (27 percent) physician FTEs performed nonclinical duties, such as research and teaching. To accomplish our objective, we focused on the clinical portion of the activities of specialty physicians, which according to the Physician Productivity Cube, totaled approximately 7,011 physician FTEs.

Since VHA did not collect workload data on some specialty care services at the time of our audit, such as podiatry, our audit universe consisted of 33 specialty care services. From the audit universe, we selected eight specialty care services at five medical facilities. Specifically, we randomly selected seven specialty care services based on total FTEs and purposely selected Obstetrics and Gynecology due to the low number of total FTEs within that specialty care service. The eight specialty care services were:

- Cardiology
- Endocrinology
- Infectious Disease
- Obstetrics and Gynecology
- Ophthalmology
- Physical Medicine and Rehabilitation
- Psychiatry
- Surgery

The site visits included VA medical facilities in: (1) Augusta, GA; (2) Boston, MA; (3) Houston, TX; (4) Indianapolis, IN; and (5) Philadelphia, PA.

### Methodology

We identified and reviewed applicable Federal laws and regulations, previous OIG and GAO audit and inspection reports, and VHA policies. Additionally, we interviewed VHA officials and medical facility management and staff. Specifically, we discussed physician FTEs with medical facility management and staff concerning the duties of physicians.

We obtained initial clinical FTEs for each physician within the eight specialties from the Physician Productivity Cube and compared them to statements from medical facility staff. We accepted adjusted clinical FTEs

that resulted in less than a .2 FTE difference. We validated those with significant differences by obtaining schedules (from clinics or operating rooms) or support for nonclinical activities.

For nonclinical activities with .2 FTE and above, we accepted:

- Research time supported by a research project
- Teaching time supported by recurring training or classes
- Administrative time supported by the physician's position

***Reliability of  
Computer-  
Processed  
Data***

To address our audit objective, we assessed the reliability of the Physician Productivity Cube data based on physician FTEs and RVUs. We validated and reconciled the data through a statistical sample of physician work at five medical facilities. Although we found FTE differences at individual physician levels, the sample results supported the total number of physician FTEs that fell below VHA's national median for all specialty care services reported in the Physician Productivity Cube. As a result, we determined that the data was sufficiently reliable to accomplish the audit objective.

***Compliance  
With  
Government  
Audit  
Standards***

Our assessment of internal controls focused on those controls relating to our audit objective. We conducted this performance audit in accordance with generally accepted government auditing standards. These 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

**Appendix B Prior Audits and Inspections**

Year	By	Report Title	Finding	Recommendation	Concur	VHA's Response
1981	GAO	<i>VA Needs a Single System To Measure Hospital Productivity</i>	VHA lacked a uniform, centrally coordinated system to measure productivity.	Establish a schedule for developing an adequate, single, hospital productivity measurement system for Medicine and Surgery using one of the systems currently being developed as a basis.	Yes	VHA demonstrated agreement with the recommendations by supporting and stressing many internal projects concerning improved productivity and management, establishment of standards while fostering developmental efforts, resource tracking methods, flexible staffing patterns, and programs to train VA staff in the value and use of productivity measures.
1995	VAOIG	<i>Audit of VHA Resource Allocation Issues: Physician Staffing Levels</i>	VA medical centers needed guidance on physician staffing due to the significant disparities in physician staffing levels among VA medical centers with similar missions and levels of affiliation with medical schools.	Develop and implement a "most efficient organization" benchmarking process for physician staffing.	No	VHA had objections about the audit methodology and indicated the desire to have non-VA "technical experts" review the audit report. However, VHA implemented changes to include a more equitable distribution of resources, such as a task force on physician pay and a 5-year plan identifying the levels and types of services to be provided at each Veterans Integrated Services Network (VISN), which will require an assessment of staffing resources in each VISN. The goal of the physician task force is to develop a system whereby physicians will be paid based on performance and productivity, which would have an effect on the distribution of physician resources.
				Bring physician staffing levels at the lower patient-to-physician ratio VA medical centers to normal ranges for similar VA medical centers.	No	
				Set goals to encourage all VA medical centers to move their physician staffing levels closer to "most efficient organization" benchmark levels.	No	
1997	GAO	<i>VA Health Care. VA Is Adopting Managed Care Practices to Better Manage Physician Resources</i>	VA is changing physician monitoring by emphasizing standardized productivity and clinical care outcome measures to monitor the efficiency and effectiveness of physician performance.		Yes	
			VA expects to change physician practice patterns and improve service delivery efficiencies by workload rather than according to historic funding patterns.			

**Appendix B Prior Audits and Inspections (cont'd)**

Year	By	Report Title	Finding	Recommendation	Concur	VHA's Response
2003	VAOIG	<i>Audit of VHA's Part-Time Physician Time and Attendance</i>	VHA did not have effective procedures to align physician staffing levels with workload requirements. Specifically, VHA had not established or provided guidance to VA medical centers to determine appropriate physician staffing levels.	Publish policy and guidance that incorporates the use of workload analysis to determine the number of physicians needed to provide timely, cost effective, and quality service to veterans seeking care from VA.	Yes	Develop a physician productivity model for the four key outpatient areas of primary care, urology, cardiology, and ophthalmology. From this, VHA plans to develop productivity standards and identify staffing levels that accurately address workload demands. The model will apply to full-time and part-time physicians and may be applied beyond the four areas at a future date.
				Require VA medical centers to review staffing structures and determine if these appointments are appropriate to the needs of the VA medical center.	Yes	VHA Directive 2003-001, Part-Time Physician Time and Attendance, requires that VA medical center directors review the types of appointment and tour of duty of each part-time physician to determine if the appointment and tour meet VA's needs for patient care and other workload demand requirements.
				Require directors to reassess staffing requirements annually and certify their staffing decisions to VHA's Deputy Under Secretary for Operations and Management.	No	Rather than an annual assessment, it seems more feasible to assess needs as vacancies arise and thus be able to relocate staff immediately as needs required.
2004	VAOIG	<i>Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)</i>	Absence of productivity standards contributed to clinical backlogs. Specifically, radiologist productivity was not monitored.	Develop and implement productivity standards for physicians as directed by Public Law 107-135.	Yes	VHA will work on the productivity model for specialty care providers and will evaluate available models. Currently, VHA is evaluating a model that directly measures clinical work using standard RVUs as the numerator and physician FTE employees as the denominator. VHA is also exploring the feasibility of using a population-based model developed by the U.S. Army Medical Command. Significant software engineering will have to be completed to automate necessary data for the specialty care physician productivity project.

**Appendix B Prior Audits and Inspections (cont'd)**

Year	By	Report Title	Finding	Recommendation	Concur	VHA's Response
2006	VAOIG	<i>Review of Selected Financial and Administrative Operations at VISN 1 Medical Facilities</i>	VISN management could enhance productivity and reduce the costs of radiologist's services by monitoring radiologist's productivity and costs on both a VISN-wide and facility basis.	Conduct review of radiologist costs and productivity to identify opportunities to leverage radiologist resources.	Yes	
2006	VAOIG	<i>Follow-Up Evaluation of Clinical and Administrative Issues Bay Pines Health Care System Bay Pines, Florida</i>	Collected data on radiology productivity was not used to evaluate the productivity or radiologists or their workload.	Monitor and evaluate productivity to ensure that assets are appropriately managed.	Yes	An RVU report detailing the productivity of radiologists will be reviewed by the Chief of Staff weekly.

Source: VA OIG

**Appendix C List of Physician Specialties That Did Not Perform to VHA's National RVU Median**

Specialties <sup>†</sup>	Total Clinical FTEs	Clinical FTEs Below Median	Percent of Clinical FTEs Below Median
Anesthesiology	475.97	96.03	20%
Infectious Disease	89.72	17.75	20%
Pathology	269.90	54.20	20%
Preventive Medicine	23.05	4.20	18%
Critical Care/Pulmonary Disease	187.08	32.48	17%
Rheumatology	79.42	13.84	17%
Clinical Cardiac Electrophysiology	21.66	3.43	16%
Dermatology	105.02	17.22	16%
Nephrology	125.45	20.51	16%
Hematology-Oncology	178.14	26.01	15%
Plastic Surgery	61.99	9.41	15%
Allergy and Immunology	18.53	2.68	14%
Cardiology	271.00	37.58	14%
Neurological Surgery	46.70	6.33	14%
Obstetrics and Gynecology	52.06	7.32	14%
Endocrinology	101.03	13.27	13%
Geriatric Medicine	168.13	21.47	13%
Neurology	267.54	34.55	13%
Pain Medicine	41.10	5.50	13%
Thoracic Surgery	82.25	10.54	13%
Gastroenterology	251.42	30.11	12%
Interventional Cardiology	48.21	5.95	12%
Orthopedic Surgery	235.01	28.05	12%
Otolaryngology	115.66	13.35	12%
Radiation Oncology	26.51	3.12	12%
Ophthalmology	250.52	27.36	11%
Physical Medicine and Rehabilitation	263.36	27.67	11%
Vascular Surgery	89.89	9.36	10%
Emergency Medicine	311.89	27.23	9%
Surgery	354.89	32.70	9%
Psychiatry	1,548.68	117.60	8%
Radiology	652.58	50.41	8%
Urology	196.47	16.55	8%
<b>TOTAL</b>	<b>7,010.83</b>	<b>823.78</b>	<b>12%</b>

Source: VHA's Physician Productivity Cube

<sup>†</sup> Of the 33 specialty care services, our sample consisted of the 8 services highlighted in yellow.

## Appendix D Under Secretary for Health Comments

### Department of Veterans Affairs

# Memorandum

**Date:** December 6, 2012

**From:** Under Secretary for Health (10)

**Subj:** OIG Draft Report Response, Audit of Physician Staffing Levels for Specialty Care Services

**To:** Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and agree about the importance of ensuring that Department of Veterans Affairs (VA) medical facilities have adequate staff to provide appropriate, high-quality care and services.
2. OIG's audit correctly points out the complexity of the issue of measuring productivity in a health care setting. This is especially true in VA facilities where we provide clinical care, but also have additional statutory missions of research, education, and emergency operations. Even though this will be a complicated task, VHA understands the importance of measuring our effectiveness and productivity in achieving all of these missions.
3. I have already taken action to address the findings of this audit. Medical facility officials need reliable and accurate data to improve their ability to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care. In June 2012, I established a task force to examine available VHA physician productivity data and identify whether a productivity evaluation tool could be developed. The task force is continuing its analysis to determine how best to establish a population-based, staffing and productivity model.
4. VHA will work to establish appropriate population-based, staffing and productivity models for five specialties by the end of fiscal year (FY) 2013. In the next three years, VHA will continue to refine and develop additional individualized specialty care models.
5. Thank you for the opportunity to review the draft report. A complete action plan is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10AR) at (202) 461-7014.

*(original signed by:)*

Robert A. Petzel, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)  
Action Plan**

**OIG Draft Report, Audit of Physician Staffing Levels for Specialty Care Services**

**Date of Draft Report: October 9, 2012**

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<b>Recommendations/ Actions</b>	<b>Status</b>	<b>Completion Date</b>
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**Recommendation 1. The Office of Inspector General recommends that the Under Secretary for Health approve a plan by the end of FY 2013 that ensures all specialty care services have productivity standards within 3 years.**

VHA Comments

Concur in principle

In June 2012, the Under Secretary for Health (USH) established the Specialty Care Physician Productivity and Staffing Plan Task Force to develop a methodology for VHA specialty care physician productivity and staffing. The plan is to examine available VHA physician productivity data and identify whether a productivity evaluation tool could be developed and to determine how best to establish an activity-based staffing and productivity model. The charter outlines the following as deliverables:

1. Develop models to evaluate the impact of changes of care delivery on productivity and staffing.
2. Update the current Staffing Directive to reflect new models and requirements to ensure accuracy of the model.
3. Develop a communication and training plan for the new staffing model.
4. Identify the top 5-7 specialty services and establish a staffing model that includes productivity standards and other criteria for a full robust model to address overall staffing needs.

In process

September 30, 2013

**Recommendation 2. The Office of Inspector General recommends that the Under Secretary for Health establish productivity standards for at least five specialty care services by the end of FY 2013 and ensure medical facility personnel compare physician workload against these standards.**

VHA Comments

Concur in principle

In June 2012, the Under Secretary for Health (USH) established the Specialty Care Physician Productivity and Staffing Plan Task Force to develop a methodology for VHA specialty care physician staffing and productivity. The plan is to examine available VHA physician productivity data and identify whether a productivity evaluation tool could be developed and to determine how best to establish a population-based, staffing and productivity model that includes consideration for clinical, academic and research missions of VHA.

VHA will work to establish appropriate population-based, staffing and productivity models for five specialties by the end of fiscal year (FY) 2013 and have a plan to implement use of these standards.

In process

September 30, 2013

**Recommendation 3. The Office of Inspector General recommends that the Under Secretary for Health provide medical facility directors with more specific guidance on how to develop staffing plans and ensure medical facility management review them at least annually to ensure optimal efficiency.**

VHA Comments

Concur in principle

In June 2012, the Under Secretary for Health (USH) established the Specialty Care Physician Productivity and Staffing Plan Task Force to develop a methodology for VHA specialty care physician staffing and productivity. The charter for this workgroup includes a deliverable for updating the staffing directive and development of a communication and training plan. An annual review of all data that feeds the population based staffing and productivity model is being considered and would be outlined in the updated Staffing Directive, as well as the training requirements that will be used as a basis for resource discussions at the facility level. Any annual review of facility staffing will include consideration for all four of VHA's missions.

In process

September 30, 2013

Veterans Health Administration  
December 2012

## Appendix E Office of Inspector General Contact and Staff Acknowledgments

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Larry Reinkemeyer, Director Joseph Janasz, Audit Manager Robin Frazier Lee Giesbrecht Timothy Halpin Brad Lewis Daniel Morris Dao Pham Carla Reid Lynn Scheffner Nelvy Viguera Butler
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## **Appendix F Report Distribution**

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Veterans Benefits Administration  
National Cemetery Administration  
Assistant Secretaries  
Office of General Counsel

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans  
Affairs, and Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction, Veterans  
Affairs, and Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget

This report will be available in the near future on the OIG's Web site at <http://www.va.gov/oig/publications/default.asp>. This report will remain on the OIG Web site for at least 2 fiscal years.