

**STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
MEETING PATIENT CARE NEEDS: MEASURING THE VALUE OF
VA PHYSICIAN STAFFING STANDARDS
MARCH 13, 2013**

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss our report, *Audit of Physician Staffing Levels for Specialty Services*, that was issued in December 2012. I am accompanied by Mr. Larry Reinkemeyer, Director of the Office of Inspector General (OIG) Kansas City Audit Operations Division, who directed the team conducting this audit.

BACKGROUND

The need for the Veterans Health Administration (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 OIG and GAO reports have made similar recommendations.¹

In January 2002, Public Law 107-135, Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, 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. Organizations also need to establish performance measures to make comparisons and assessments of different data to be able to take appropriate action.

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

¹ *Audit of VHA Resource Allocation Issues: Physician Staffing Levels* (1995); *Audit of VHA's Part-Time Physician Time and Attendance* (2003); *Issues at VA Medical Center Bay Pines, Florida, and Procurement and Deployment of the Core Financial and Logistics System* (2004); *Review of Selected Financial and Administrative Operations at VISN 1 Medical Facilities* (2006); *Follow-up Evaluation of Clinical and Administrative Issues Bay Pines Health Care System, Bay Pines, Florida* (2006).

example, a service with an RVU of “2,” counts 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

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.

AUDIT OF VHA’S PHYSICIAN STAFFING LEVELS FOR SPECIALITY CARE

In order to evaluate VHA’s progress in implementing the policy on the physician staffing levels, we assessed whether VHA had an effective methodology for determining physician staffing levels for 33 of VHA’s specialty care services. Generally, we found that while there is a consensus among VHA officials that VHA needs to develop a methodology to measure productivity, there is no agreement on how to accomplish it. There is a lack of agreement 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, while 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.

We were told VHA officials were 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 explained 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. Further, VHA can adjust the productivity standard for physicians whose other duties, such as resident supervision, results in the physician accomplishing less workload than their peers.

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, which is 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. While we do not endorse any one specific method to measure physician productivity, we do believe that VA needs to have measurable and comparable productivity standards in place to assist in determining the number of specialty physicians needed to meet patient care needs. Our concern is that VHA’s decision-process to implement productivity standards has been pending too long.

Productivity of VHA Specialty Physicians

In the absence of a productivity standard, we established a rudimentary, conservative standard by identifying VHA's RVU median for each specialty care service to determine an approximate measure of current physician specialty productivity. 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 full-time equivalents (FTEs) did not perform to the standard. The 824 physician FTEs represented approximately \$221 million in physician salaries during fiscal year 2011. Although we did not analyze the productivity of individual physicians, our results support the need for an in-depth evaluation of staffing.

Opportunities to Identify Best Practices

VHA does not have an internal measure to benchmark physician productivity within a specialty. GAO's *Standards for Internal Control in the Federal Government*² requires an organization to compare actual performance to results and analyze significant differences within that organization. We compared the staffing levels to the amount of work performed by eight specialty care services³ at the five medical facilities⁴ we visited. Specifically, we compared the workload output per clinical FTE for each specialty care service and found significant differences in workload.

- One 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.⁵ During the same period, another 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. The latter medical facility provided over 500 percent more encounters with .4 FTE or 40 percent more in staff.
- One 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 dedicated FTE, the medical facility provided 41 percent more encounters.

VHA needs to implement productivity standards to measure and compare the collective productivity of physicians within a specialty care service at similar VA medical facilities.

² The Federal Managers' Financial Integrity Act of 1982 requires GAO to issue standards for internal control in Government. The standards provide the overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges and areas at greatest risk of fraud, waste, abuse, and mismanagement.

³ We reviewed the following specialty care services: cardiology, endocrinology, infectious disease, obstetrics and gynecology, ophthalmology, physical medicine and rehabilitation, psychiatry, and surgery.

⁴ VA Medical Centers in Augusta, GA; Boston, MA; Houston, TX; Indianapolis, IN; and Philadelphia, PA.

⁵ 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.

By measuring and comparing internal productivity and staffing, VHA can identify staffing shortages and excesses along with best practices and those practices that should be changed or eliminated.

Staffing Plans Were Not Prepared

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.

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. These plans also ensure medical facility directors have sufficient data to make sure staffing decisions address VHA's priority—providing quality patient care—along with their other missions such as teaching and research.

None of the five medical facilities we visited 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.

Recommendations

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.

The Under Secretary for Health agreed in principle with our finding and recommendations. We consider the planned action acceptable and will track progress.

CONCLUSION

Staffing for specialty care services is an expensive resource which needs to be managed effectively. VHA has not established productivity standards for all specialties because of indecision regarding 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.

Mr. Chairman, this concludes my statement. We would be pleased to answer any questions that you or other Members of the Subcommittee may have.