



## Testimony

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

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# VA PRIMARY CARE

## Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care

Statement of Randall B. Williamson,  
Director, Health Care

Accessible Version

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

I am pleased to be here today to discuss our report on the provision and oversight of primary care services at Department of Veterans Affairs (VA) medical facilities, which is being publicly released today.<sup>1</sup> As you know, primary care services are often the entry point to the VA health care system for most veterans, including an aging veteran population and a growing number of younger veterans returning from military operations in Afghanistan and Iraq. Veterans may obtain primary care services at VA's 150 medical facilities, which include medical centers and more than 800 community based outpatient clinics (CBOC).<sup>2</sup> Primary care services are delivered through patient aligned care teams consisting of a primary care provider and support staff—a nurse care manager, clinical associate, and administrative clerk.<sup>3</sup> When other services are needed to meet patient goals and needs, these teams oversee and coordinate that care. VA's medical facilities are overseen by 21 Veterans Integrated Service Networks—called networks—and by VA's Central Office, which oversees the entire VA health care system.<sup>4</sup>

In recent years, VA has emphasized providing primary care as the way to enhance health care delivery to meet veterans' needs. In support of this emphasis, VA has detailed guidelines regarding how primary care is to be provided and staffed, including a requirement that medical facilities record and report data on primary care panel size—that is, the number of patients for whom a patient aligned care team delivers primary care services.<sup>5</sup> According to VA, panel size is an important factor in helping VA determine the total number of patients that can be cared for in the VA

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<sup>1</sup>GAO, *VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care*, [GAO-16-83](#) (Washington, D.C.: Oct. 8, 2015).

<sup>2</sup>VA medical facilities manage primary care clinics located within their respective medical centers and associated CBOCs. CBOCs provide outpatient primary care and general mental health services on site.

<sup>3</sup>Primary care providers are physicians, nurse practitioners, or physician assistants.

<sup>4</sup>VA's 21 Veterans Integrated Service Networks oversee the day-to-day functions of facilities that are within their network.

<sup>5</sup>See VHA Handbook 1101.02, *Primary Care Management Module (PCMM)* (April 29, 2009) and VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook* (February 5, 2014).

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health care system; moreover, maintaining appropriate panel sizes helps ensure that providers will be able to offer quality care in a timely manner to a reasonable number of patients. Panel sizes that are too high may lead to veterans experiencing delays in obtaining care among other negative effects, while panel sizes that are too low may be associated with inefficiency and wasted resources. Reliable data on panel size can also help VA facilities manage and VA Central Office and networks oversee VA's primary care program. In addition to data on panel sizes, VA policy also requires facilities to record and report data on primary care encounters—that is, the number and types of visits to a primary care provider—and expenditures for delivering primary care. According to VA officials, data on encounters and expenditures may help VA oversee its primary care program by identifying potential inefficiencies.

In this context, my testimony today discusses the findings from our report analyzing VA's panel size, encounter, and expenditure data. Accordingly, this testimony addresses (1) what VA's panel size data show across facilities and how VA Central Office and networks use these data to oversee primary care, and (2) what VA's encounter and expenditure data show across facilities and how VA Central Office and networks use these data to oversee primary care. In addition, I will highlight two key actions that we recommended in our report that VA can take to improve the reliability of its primary care panel size data and improve VA Central Office and the networks' oversight of facilities' management of primary care.

To conduct our work, among other things, we analyzed fiscal year 2014 data for all VA facilities on 1) modeled panel size, which represents the number of patients on a primary care panel for whom a patient aligned care team is expected to deliver primary care, as projected by VA for each facility, 2) facility-reported panel size, which represents the average number of patients on a primary care panel; 3) the number of primary care patients, providers, support staff, and exam rooms reported by each facility; and 4) expenditures per primary care encounter. In addition, we conducted a more detailed, nongeneralizable examination of these data at seven VA facilities, which we selected based on geographic diversity

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and differences in facility complexity.<sup>6</sup> Our review revealed concerns about facilities' reported panel sizes and other data elements that were attributable to inaccuracies in how facilities recorded the data, which precluded us from using these data to report panel sizes across all VA facilities. As a result of these data inaccuracies, we calculated actual panel sizes for six of the seven selected facilities where we were able to use updated data provided by each facility and correct the data for inaccuracies.<sup>7</sup> In addition, we reviewed VA policy documents and interviewed officials from the Veterans Health Administration's (VHA) Primary Care Operations Office and Office of Finance, within VA Central Office, as well as officials from selected facilities and their associated networks.<sup>8</sup> We also assessed oversight activities for VA Central Office and across the networks we reviewed in the context of federal internal control standards for control environment, information and communication, and monitoring.<sup>9</sup> The work this statement is based on was performed in accordance with generally accepted government auditing standards. Further details on our scope and methodology are included in our report.

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<sup>6</sup>VA assigns each facility to one of five complexity groups (1a, 1b, 1c, 2, and 3) using a facility complexity model where level 1a facilities are the most complex and level 3 facilities are the least complex. VA's complexity model uses multiple variables to measure facility complexity in four categories: patient population served, clinical services offered, education and research complexity, and administrative complexity.

<sup>7</sup>We calculated actual panel sizes based on updated data each facility provided to us at the time of our review from November 2014 through March 2015. We verified the reliability of the data each facility provided us by checking for missing values and outliers as well as interviewing facility officials knowledgeable about the data. For one of the seven facilities, we were unable to correct for the inaccurate number of full-time equivalent providers. Therefore, we did not use or report on the panel sizes for this facility and instead report on six facilities.

<sup>8</sup>VA policy documents we reviewed included VA Handbook 1101.02, *Primary Care Management Module (PCMM)* (April 29, 2009) and VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook* (February 5, 2014). VHA's Primary Care Operations Office is responsible for executing policies related to primary care delivery and for monitoring primary care. VHA's Office of Finance develops policies related to the recording and reporting of primary care encounter and expenditure data.

<sup>9</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999) and GAO, *Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: August 2001).

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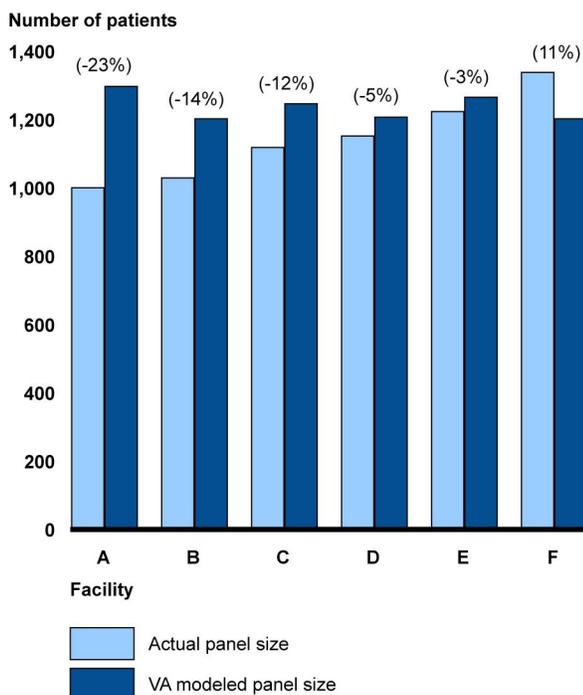
## VA Lacks Reliable Data on Medical Facilities' Primary Care Panel Sizes and Does Not Have Effective Oversight Processes to Verify and Use Facilities' Data to Monitor Primary Care

We found that VA data on primary care panel sizes are unreliable across VA's 150 medical facilities. Federal internal control standards state that reliable information is needed to determine whether an agency is meeting its goals for accountability for effective and efficient use of resources. However, in contrast with these standards, we found missing values and other inaccuracies in VA's 2014 data, such as values that appeared too high or too low. Officials from VHA's Primary Care Operations Office confirmed that facilities sometimes record and self-report these data inaccurately or in a manner that does not follow VA's policy and noted that this could result in the data reliability concerns we identified. Because some medical facilities' reported panel size data are unreliable, VA Central Office and network officials cannot readily determine each facility's average primary care panel size nor compare these panel sizes to each facility's modeled panel size to help ensure that care is being delivered in a timely manner to a reasonable number of patients.

Primary Care Operations Office officials told us that they intend to address data reliability issues over time. Specifically, the Primary Care Operations Office is in the process of implementing new software, called web-Primary Care Management Module (PCMM), which officials believe will address some concerns about the reliability of the data because the software features controls to help ensure that facilities record and report the data accurately and consistently. In preparation for the implementation of web-PCMM, Primary Care Operations Office officials said they have been training network and facility staff on the features and capabilities of the new software and instructing facility staff to review and correct their panel size data to help improve data accuracy. It is not yet known the extent to which the new software will address the data reliability issues we identified because facilities will continue to self-report data. The Primary Care Operations Office started piloting the new software at selected facilities in 2014 and had planned to implement it agency-wide after resolving software interoperability issues identified during the pilot. However, officials said that implementation is currently on hold because of a lack of funding, and the officials could not provide an updated timeframe for its system-wide implementation. According to these officials, VA has spent about \$8.8 million through July 2015 on the development and implementation of web-PCMM and requires an additional \$1.5 million to implement it agency-wide.

Although reliable data on reported panel sizes were not available for all of VA's facilities at the time of our review, we were able to obtain updated data from six of seven selected facilities and calculate the actual panel sizes for those six facilities.<sup>10</sup> We found that for these six facilities, the actual panel size varied from 23 percent below to 11 percent above the modeled panel size. (See fig. 1.) Such wide variation raises questions about whether veterans are receiving access to timely care and the appropriateness of the size of provider workload at these facilities. Officials we interviewed at the three facilities where actual panel sizes were the highest cited growing patient demand, staffing shortages, and exam room shortages as factors contributing to higher panel sizes.

**Figure 1: Comparison of Six Selected Department of Veterans Affairs (VA) Medical Facilities' Actual Primary Care Panel Sizes to Their Fiscal Year 2014 Modeled Panel Sizes**



Source: GAO analysis of six selected facilities' panel size data from November 2014 through March 2015. | GAO-16-114T

<sup>10</sup>We did not calculate the actual panel size for the remaining selected facility because we were unable to correct for inaccurate data on full-time equivalent providers reported by this facility.

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Note: We were unable to compare reported panel sizes to fiscal year 2014 modeled panel sizes at all VA facilities because of inaccuracies we identified in facilities' reported panel size data. For six selected facilities, we calculated actual panel sizes based on updated data obtained from each facility from November 2014 through March 2015 that we verified as reliable.

Moreover, we found that while VA's primary care panel management policy requires facilities to ensure the reliability of their panel size data, it does not assign responsibility to VA Central Office or networks for verifying the reliability of facilities' data or require the facilities to use the data for monitoring purposes. Primary Care Operations officials said that they have not validated facilities' reported panel size data or used the data to monitor primary care because the office has a limited number of staff and mainly relies on the networks and facilities to ensure that the data are recorded and reported correctly and that monitoring is conducted. This practice is inconsistent with federal internal control standards that call for agencies to clearly define key areas of authority and responsibility, ensure that reliable information is available, and use this information to assess the quality of performance over time. Primary Care Operations Office officials stated that VA Central Office is in the process of revising its policy for primary care panel management and is developing additional guidance to require VA Central Office and VA networks to verify reported panel size data in addition to other monitoring responsibilities. However, as the revised policy and guidance are still under development, it is unknown when they will be implemented and whether they will fully address the issues we identified.

In our report, we concluded that the absence of reliable panel size data and oversight processes could significantly inhibit VA's ability to ensure that facilities are providing veterans with timely, quality care that is delivered efficiently. To address these shortcomings, we recommended that VA incorporate in policy an oversight process for primary care panel management that assigns responsibility, as appropriate, to VA Central Office and networks for (1) verifying each facility's reported panel size data currently in PCMM—and in web-PCMM, if the software is rolled-out nationally—including such data as the number of primary care patients, providers, support staff, and exam rooms; and (2) monitoring facilities' reported panel sizes in relation to the modeled panel size and assisting facilities in taking steps to address situations where reported panel sizes vary widely from modeled panel sizes. VA agreed with this recommendation and said it plans to take steps to implement it, including issuing guidance by September 2016 clarifying VA Central Office and networks' oversight responsibilities with regard to primary care panel size data. Given the importance of these panel size data, we will continue to monitor VA's progress in implementing the recommendation.

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## VA's Encounter and Expenditure Data Show Wide Variation across Medical Facilities, and VA Central Office and Networks Do Not Use These Data to Monitor Primary Care

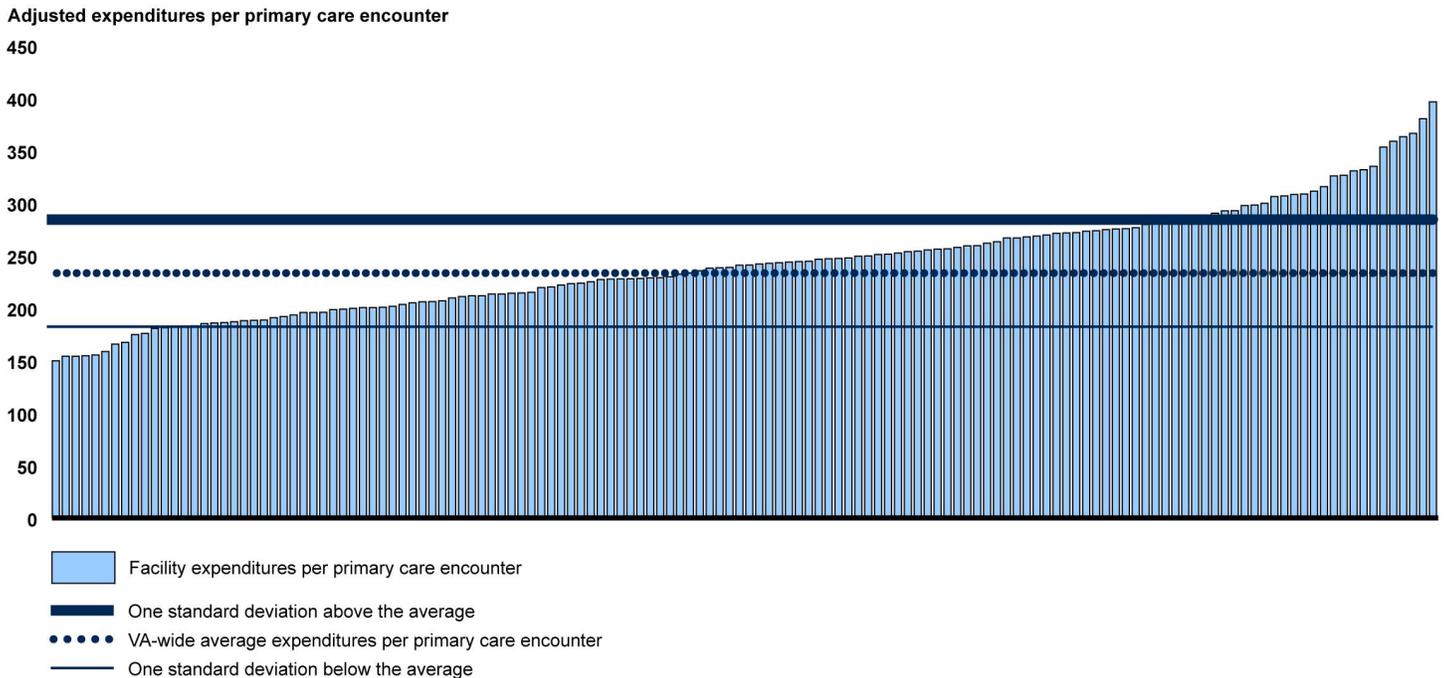
In contrast to VA's panel data, we found that primary care encounter and expenditure data reported by all VA medical facilities are reliable, although the data show wide variations across facilities.<sup>11</sup> For example, in fiscal year 2014, expenditures per primary care encounter ranged from a low of \$150 to a high of \$396 after adjusting to account for geographic differences in labor costs across facilities. (See fig. 2.) We also found that expenditures per encounter at about 40 facilities were potential outliers that VA Central Office and the networks may need to examine further.<sup>12</sup> We also analyzed expenditures per unique primary care patient—that is, a patient with at least one primary care encounter in fiscal year 2014—and found similar variation across VA's facilities. Such wide variations may indicate that services are being delivered inefficiently at some facilities with relatively higher per encounter costs compared to other facilities.

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<sup>11</sup>Data for some of VA's 150 facilities that are part of a larger hospital system were combined with another facility's data. As a result, the expenditure and encounter data that VA provided included 140 facilities. The analysis includes expenditure and encounter data for traditional and telephone primary care.

<sup>12</sup>According to officials from VHA's Office of Finance, one standard deviation is typically used to identify potential outliers when examining encounter and expenditure data. Our analysis found that expenditures per encounter at 20 facilities were at least one standard deviation above the average and at 23 facilities were at least one standard deviation below the average.

**Figure 2: Department of Veterans Affairs (VA) Expenditures per Encounter by Facility Adjusted for Geographic Variance in Labor Costs, Fiscal Year 2014**



Source: GAO analysis of VA data. | GAO-16-114T

Note: Data for some of VA's 150 facilities that are part of a larger hospital system were combined with another facility's data. As a result, the expenditure and encounter data that VA provided included 140 facilities. The analysis includes expenditure and encounter data for traditional and telephone primary care.

While VA verifies and uses these data for cost accounting and budgetary purposes, VA's policies governing primary care do not require the use of the data to monitor facilities' management of primary care. In contrast, federal internal control standards state that agencies need both operational and financial data to determine whether they are meeting strategic goals and should use such data to assess the quality of performance over time. By not using available encounter and expenditure data in this manner, we concluded that VA is missing an opportunity to potentially identify inefficient practices or processes at facilities and improve the overall efficiency of primary care service delivery. Using panel size data in conjunction with encounter and expenditure data would allow VA to assess facilities' capacity to provide primary care services and the efficiency of their care delivery.

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To address this shortcoming, our report recommended that VA review and document how to use encounter and expenditure data in conjunction with panel size data to strengthen monitoring of facilities' management of primary care. VA concurred with this recommendation and said it plans to take steps to fully implement it with a target completion date for presenting its findings and decisions by September 2018. Given the significant lead time that VA has indicated it needs to implement this recommendation, we will continue to actively monitor its progress.

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

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## GAO Contacts & Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 ([williamsonr@gao.gov](mailto:williamsonr@gao.gov)). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Rashmi Agarwal, Assistant Director; Aaron Holling; and Michael Zose.

# Appendix I: Accessible Data

## Data Tables

**Figure 1: Comparison of Six Selected Department of Veterans Affairs (VA) Medical Facilities' Actual Primary Care Panel Sizes to Their Fiscal Year 2014 Modeled Panel Sizes**

Facility	Actual panel size	VA modeled panel size
A	1000	1297
B	1029	1202
C	1118	1246
D	1152	1207
E	1223	1265
F	1338	1202

**Figure 2: Department of Veterans Affairs (VA) Expenditures per Encounter by Facility Adjusted for Geographic Variance in Labor Costs, Fiscal Year 2014**

One standard deviation below the average	\$ 191.52	T149
VA-wide average expenditures per primary care encounter	\$ 242.49	T146
One standard deviation above the average	\$ 293.45	T148

T5-T144

Expenditure per encounter
\$ 149.58
\$ 153.90
\$ 153.93
\$ 154.26
\$ 155.11
\$ 158.31
\$ 165.34
\$ 167.13
\$ 174.55
\$ 175.65
\$ 180.36
\$ 180.94
\$ 181.41
\$ 182.18
\$ 182.80
\$ 184.96
\$ 185.53
\$ 185.90
\$ 186.69

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\$ 187.70

\$ 187.99

\$ 188.42

\$ 190.64

\$ 191.60

\$ 193.09

\$ 195.60

\$ 195.61

\$ 195.74

\$ 198.29

\$ 198.69

\$ 199.47

\$ 200.16

\$ 200.22

\$ 200.47

\$ 201.41

\$ 203.14

\$ 204.64

\$ 205.77

\$ 205.96

\$ 206.61

\$ 209.41

\$ 210.70

\$ 211.43

\$ 211.51

\$ 213.09

\$ 213.18

\$ 213.91

\$ 214.18

\$ 214.74

\$ 219.22

\$ 219.90

\$ 221.61

\$ 223.06

\$ 223.40

\$ 224.82

\$ 226.98

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\$ 227.32

\$ 227.47

\$ 227.71

\$ 227.99

\$ 228.59

\$ 228.78

\$ 229.66

\$ 231.96

\$ 233.25

\$ 235.26

\$ 237.76

\$ 238.11

\$ 238.50

\$ 240.53

\$ 240.71

\$ 241.79

\$ 242.38

\$ 243.01

\$ 243.61

\$ 244.04

\$ 244.26

\$ 246.28

\$ 246.70

\$ 247.06

\$ 247.46

\$ 249.15

\$ 249.46

\$ 250.71

\$ 251.07

\$ 252.10

\$ 253.43

\$ 253.89

\$ 255.11

\$ 255.81

\$ 256.18

\$ 257.54

\$ 259.00

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\$ 259.18
\$ 261.56
\$ 262.85
\$ 266.57
\$ 266.58
\$ 267.54
\$ 268.28
\$ 269.31
\$ 271.01
\$ 271.24
\$ 271.58
\$ 273.02
\$ 273.38
\$ 274.48
\$ 275.03
\$ 275.38
\$ 276.33
\$ 279.22
\$ 280.18
\$ 285.02
\$ 285.15
\$ 285.44
\$ 285.46
\$ 287.91
\$ 290.02
\$ 292.25
\$ 292.53
\$ 297.38
\$ 297.91
\$ 299.47
\$ 305.96
\$ 306.60
\$ 307.89
\$ 308.37
\$ 311.08
\$ 315.42
\$ 325.63

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\$ 326.15

\$ 330.37

\$ 331.41

\$ 334.73

\$ 353.05

\$ 358.61

\$ 363.03

\$ 366.08

\$ 380.13

\$ 396.18

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