# PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Directive defines the policy for monitoring and assessing specialty provider group practice productivity and associated staffing. For the purpose of this Directive and the associated VHA Handbook 1065.01 this policy excludes Mental Health and Emergency Medicine, which have individual policies regarding productivity and staffing.

**2. SUMMARY OF CONTENT:** This is a new VHA directive that sets forth policy for productivity and staffing for Specialty Group Practice providers.

**3. RELATED ISSUES:** VHA Handbook 1065.01, Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015, or subsequent policy.

**4. RESPONSIBLE OFFICE:** The Assistant Deputy Under Secretary for Health for Patient Care Services (10P4) and the Assistant Deputy Under Secretary for Health for Clinical Operations (10NC) are responsible for the contents of this directive. Questions may be directed to 202-461-7120.

**5. RESCISSIONS:** VHA Directive 2009-055, dated November 2, 2009 and VHA Directive 2008-009, dated February 7, 2008 are rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of May, 2020. This VHA directive will continue to serve as VHA policy until it is rescinded or recertified.

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# PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE

## 1. PURPOSE

This Veterans Health Administration (VHA) directive defines the policy for monitoring and assessing specialty provider group practice (see VHA Handbook 1065.01 section 4. (7)) productivity and staffing. This policy excludes Mental Health and Emergency Medicine, which have individual policies regarding productivity. **AUTHORITY:** 38 U.S.C. 8110(a)(3)(C).

## 2. POLICY

It is VHA policy that each VA medical facility Director monitors and assesses specialty care provider group practice productivity and staffing on an annual basis, at a minimum, using standardized methods. ***NOTE:*** *See VHA Handbook 1065.01, Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015, or subsequent policy.*

## 3. RESPONSIBILITIES

a. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health Operations and Management, supported by the policy developed by Deputy Under Secretary for Health for Policy and Services, is responsible for ensuring all medical facilities review and utilize the Fiscal Year (FY) Physician Specialty Workforce Report, developed by Office of Informatics (OIA), Office of Productivity, Efficiency and Staffing (OPES), on productivity and staffing data to inform and optimize their specialty provider group practice productivity and staffing workforce.

b. **Deputy Under Secretary for Health for Policy and Services.** Deputy Under Secretary for Health for Policy and Services is responsible for providing policy to ensure all VA medical facilities perform an annual review of the specialty provider group practice workforce productivity and staffing. The policy will be used to support the Deputy Under Secretary for Health for Operations and Management's operational oversight to ensure all VA medical facilities use the OIA, OPES, FY Physician Specialty Workforce Report on productivity and staffing.

c. **Office of Informatics and Analytics.** OIA, OPES is responsible for conducting an annual study of the specialty provider group practice workforce productivity and staffing report, captured by the "Physician Productivity, Benchmarks & Study Data" and the "Specialty Physician Productivity Report." The report is developed in conjunction with the policy developed by the Deputy Under Secretary for Health for Policy and Services and the operational oversight of the Deputy Under Secretary for Health Operations and Management. The information gathered will be used to ensure all specialty group practice providers are meeting the standards for specialty group practice productivity and staffing levels. (See VHA Handbook 1065.01, Productivity and

Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015, or subsequent policy.)

***NOTE:*** *The* Specialty Provider Workforce Report*, http://opes.vssc.med.va.gov/Pages/SpecialtyPhysicianWorkforce.aspx, provides a comprehensive review of specialty provider group practice staffing levels, productivity, population staffing ratios and specialty provider group practice support staff ratios. The Specialty Provider Productivity Standards Performance & Outlier Report, http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fOPES%2fSpecialtyProductivityReport%2fProd_Stats&rs:Command=Render, provides a comprehensive suite of productivity performance reporting including productivity targets and thresholds, trends and measurement to the established targets. Productivity targets will be updated at least every 2 years and will be reviewed by the by Deputy Under Secretary for Health for Policy and Management and Deputy Under Secretary for Health for Clinical Operations. The median will be used for comparison to applicable external benchmarks and for resource determination. Updates and potential improvements to the report will be continuously evaluated by Office of Productivity Efficiently and Staffing. Such improvements may include new data elements to move VHA towards an efficiency model, as is appropriate for a Health Maintenance Organization (HMO) type practice. The RVU model used in the private sector has been relevant for fee for service practice; whereas VHA and other HMOs (Kaiser Permanente®) may be better served by a focus on efficiencies. The Specialty Access Report and Quadrant Tool (SPARQ), http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fOPES%2fSPARQ%2fSpecialtyQuadrant&rs:Command=Render, provides data to assist sites in making informed resource decisions on practice infrastructure and other important practice characteristics to improve the efficiency of their specialty practice.*

d. **Assistant Deputy Under Secretary for Clinical Operations and the Assistant Deputy Under Secretary for Health for Patient Care Services.** Assistant Deputy Under Secretary for Health for Clinical Operations Assistant and the Deputy Under Secretary for Health for PCS are responsible for the following:

(1) Collaborating with OPES on the Physician Productivity, Benchmarks & Study Data to provide subject matter experts as needed for analysis;

(2) Balancing optimal standards of concurrence and support of the implementation of productivity and staffing standards. Considerations for balancing optimal standards include;

(a) Productivity performance;

(b) The team composition including support staffing ratios per provider in the various specialty practices; and

(c) The approval of the standards by Under Secretary for Health.

e. **Veterans Integrated Service Network Director.** Each Veteran Integrated System Network (VISN) Director is responsible for reviewing the FY Physician Specialty Workforce Report in seeking to optimize specialty provider group practice productivity and staffing at their VA medical facilities with the assistance of the VISN Leadership, including the Chief Medical Officer (CMO).

f. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Documenting the Specialty Provider Group Practices that the VA medical facility delivers from the specialty provider group practice definition (See VHA Handbook 1065.01, paragraph 3.i).

(2) Ensuring that the VA medical facility Chief of Staff (COS), other clinical leaders, and all relevant specialty Service Chiefs engage in assessment activities (See VHA Handbook 1065.01) including the yearly review, at a minimum. (Reviews of data inputs, such as labor mapping etc., may be warranted more frequently as shifts in work assignment (i.e. research grants) may occur at any time).

(3) Certifying specialty provider group practice labor mapping assignments according to the Physician and Dentist Labor Mapping found in VA Financial Policy, Volume XIII, Chapter 3, Appendix D, https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIIIChapter03.pdf).

(4) Reviewing the productivity reports of their various specialty provider group practices; and

(5) Utilizing the Physician Productivity, Benchmarks & Study Data and the Specialty Physician Productivity Reports to inform resource decisions for their specialty provider group practices. When practices are out of range (high/low) remediation plans should be implemented, reviewed, and forwarded to VISN leadership (as required by VISN leadership procedures), to improve specialty physician group practice productivity.

***NOTE:*** *Remediation plans are appropriate for specialty provider group practice services where the specialty practice productivity level is below the minimum productivity threshold for its specialty and peer grouping.*

g. **Department of Veterans Affairs Medical Center Chief of Staff.** The VA medical facility Chief of Staff (COS) is responsible for coordinating the activities of the relevant specialty providers group practice Service Chiefs in assessing and measuring productivity and staffing on a minimum of yearly basis, including performing needs assessments for the hiring of contract practitioners in their services by:

(1) Defining productivity source data as identified by the applicable directives (such as the Physician and Dentist Labor Mapping (found in VA Financial Policy, Volume XIII, Chapter 3, Appendix D), VHA Directive 2012-003, Person Class File Taxonomy dated January 12, 2012, ) and VHA Directive 1085, Patient Data Capture Directive, DATED March 24, 2015, or subsequent policies, to include:

(a) Appropriate person class designations;

(b) Consistency between labor mapping of specialty group practice providers and relevant business rules.

(c) Identification of the attending physician as the primary provider when residents are involved in the clinical encounter.

(2) Ensuring all specialty provider group practices are monitoring activities for measuring team member activities, workload, and contracting.

***NOTE:*** *Non-VA Paid providers are not covered in the VHA Handbook subject to productivity measurement; rather, they are to be in compliance with the applicable arrangements of their appointment.*

(3) Determining specialty practice productivity levels based on the Physician Productivity, Benchmarks and Study Data and the Specialty Physician Productivity Reports.

(4) Analysis begins with any specialty that falls below the $25^{th}$ percentile productivity standard or above the $75^{th}$ percentile for a specific specialty and peer group; the service must undergo a local review which addresses data inputs (See VHA Handbook 1065.01). If a specialty practice productivity level is below the minimum productivity threshold and provided the review of data inputs are valid and rectified if applicable, a specialty Section Chief will then work with the Service Chief to develop a remediation plan to improve that specialty provider group practice productivity. The remediation plan would include addressing any lack of supporting infrastructure. Upon receipt of a remediation plan, the facility COS is responsible for endorsing and forwarding the plan to the VA medical facility Director (via the local Resource Management Board (RMC), if desired by the Director) and then to the VISN for review and concurrence.

***NOTE:*** *Consideration should be given to the influence of productivity modifiers when assessing practices.* ***NOTE:*** *See VHA Handbook 1065.01.*

## 4. REFERENCES

a. Title 38 U.S.C. 8153 Sharing of Health-Care Resources.

b. VA Financial Policy, Volume XIII, Chapter 3, Appendix D, https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIIIChapter03.pdf.

c. VHA Directive 1101.05(02), Emergency Medicine, dated September 2, 2016, or subsequent policy.

d. VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015, or subsequent policy.

e. VHA Directive 2012-003, Person Class File Taxonomy, dated January 12, 2012, or subsequent policy.

f. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016, or subsequent policy.

g. VHA Handbook 1006.02, VHA Site Classification and Definitions, dated December 30, 2013, or subsequent policy.

h. VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009, or subsequent policy.

i. VHA Handbook 1400.10, Health Care Resources Contracting: Educational Costs of Physician and Dentist Resident Training Pursuant to Title 38 United States Code 8153, dated November 16, 2012, or subsequent policy.

j. VHA Notice 2017-72, Rescission of VHA Directive 2011-009 Physician and Dentist Labor Mapping, dated October 26, 2017.

k. Physician Specialty Practice Management Web link: http://opes.vssc.med.va.gov/Pages/PracticeManagement.aspx

l. OPES http://opes.vssc.med.va.gov/Pages/Default.aspx

## 5. DEFINITIONS

a. **Acceptable Group Practice Range of Productivity.** The productivity within the Interquartile Range (25th to 75th percentile) is considered an acceptable range of productivity, taking care not to compromise quality and patient access standards. Productivity above the 75th percentile is considered a best practice, after review of mapping and other data inputs confirm accuracy. Productivity below the the minimum productivity threshold ( is considered a practice requiring a remediation plan.

b. **Clinical Care Time.** Clinical care time is defined as any time spent to prepare, provide for, and follow-up on the clinical care needs of patients. Clinical care time is time not occupied by administrative duties, teaching, or research.

c. **Current Procedural Terminology.** Current Procedural Terminology (CPT) is a numerical code for each specialty provider group practice service or procedure performed by a specialty provider group practice physician, as defined by the American Medical Association.

***NOTE:*** *In VHA, these codes are assigned to a procedure at the time the study is performed or to any specified clinical care activity, and in accordance with the nature and scope of the study or patient care activity.*

d. **Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO) FTE(c).** Physician Allopathic Doctor, Doctor of Osteopathic Medicine FTE (c) are individuals who are the worked (removing leave) portion of a FTEE provider which is devoted to clinical care time as assigned in MCAO labor mapping.

***NOTE:*** *A detailed definition of these duties, and how to account for them in MCAO, is provided in Physician and Dentist Labor Mapping (VHA Directive 2011-009).*

e. **Relative Value Unit.** Relative Value Unit (RVU) is a measure of the difficulty and expense of a professional service. The number of RVUs associated with each CPT code is determined by the Centers for Medicare and Medicaid Services (CMS) as published in the CMS Medicare Fee Schedule supplemented with Ingenix Gap Code. RVUs are primarily designed for reimbursement purposes, but have been widely employed to measure physician work effort/ workload as well. The total RVU consists of three components: physician work (wRVU), practice expense (peRVU) and malpractice expense (mpRVU). RVU tables may be obtained from the Office of Productivity, Efficiency & Staffing staff upon request. For productivity measurement, only the wRVU is utilized.

***NOTE:*** *The RVU used in this Handbook and by CMS differ from those defined by the MCAO.*

f. **Remediation Plans.** If a specialty practice productivity level is below the minimum productivity threshold, Facility Chief of Staff in conjunction with local Service Chiefs, will work with the specialty provider group practice to develop a remediation plan.

g. **Specialty Provider Group Practice.** A specialty provider group practice is defined as the specialty provider group practice service in a VA medical facility and its clinics that are appointed to a service or service line and are privileged to perform specialty patient clinical care activities and/or procedures.

h. **Specialty Provider Group Practice Practitioner.** Specialty provider group practice practitioner is a Medicine, Surgery, or other specialty practitioner outside of Primary Care (PC). Mental Health and Emergency Medicine have individual policies regarding productivity with specific training (board certification or eligibility) and are analyzed separately.

i. **Specialty Provider Group Practice Productivity.** Specialty provider group practice productivity is the ratio of total Relative Value Unit (RVU) for the entire specialty group practice service Full Time Equivalent Employees (FTEE) [(RVU)/ (Clinical FTEE)]. (See Office of Productivity, Efficiency & Staffing (OPES) Cube Leadership Provider Productivity Dashboard https://bioffice.pa.cdw.va.gov/default.aspx?bookid=8169780b-509a-4893-b9f8-f651af6cc333|ispasFalse|report2856f0da-4e07-4cab-8418-040c04b0d6cc|ws1|wsb0|isDisabledAnalyticsFalse|isDashboardPanelOnTrue. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

j. **Specialty Provider Group Practice Support Staff.** For the purpose of this Handbook, specialty provider group practice support staff includes Nurses, and all allied health professionals such as Clinical Pharmacists, Technologists, Clerks, Transcriptionists, Automated Data Processing Application Coordinators (ADPACS), and Service Managers assigned to the specialty provider group practice service. Support

staff positions are defined by their Budget Object Code (BOC) utilized in VHA PAID data.

k. **VA Medical Facility.** For purposes of this Directive, a VA medical facility is a VA point of service that provides at least two categories of care (inpatient, outpatient, residential, or institutional extended care). For the purposes of this Directive and associated Handbook (VHA Handbook 1065.01) Vet Centers are not assigned a category of care, and do not affect site classification. (See VHA Handbook 1006.02, VHA Site Classifications & Definitions).

l. **Work RVU.** Work (wRVU) for purposes of physician productivity measurement, only the physician work component of the RVU value is utilized.