Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

| AMENDED |
| May 19, 2023 |

VHA DIRECTIVE 1065(1)
Transmittal Sheet
December 22, 2020

PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes national policy for monitoring and assessing specialty provider group practice productivity and associated staffing.

2. SUMMARY OF MAJOR CHANGES:

Amendment dated, May 19, 2023, updates Appendix A to include links to the Protected Time resources (see page A-1).

As published December 22, 2020, major changes to the directive included:

    a. Responsibilities for the Assistant Under Secretary for Health for Operations, Veterans Integrated Service Network (VISN) Directors, VISN Chief Medical Officers (CMOs) and the Office of Analytics and Performance Integration (API) (see paragraph 5).

    b. Additional standards for monitoring and assessing specialty provider group practice productivity and associated staffing.

3. RELATED ISSUES: VHA Directive 1066, Requirement for National Provider Identifier (NPI) and Taxonomy Codes, dated November 7, 2013; VHA Directive 1064, Pathology and Laboratory Medicine Services (P&LMS) Productivity and Staffing, dated September 17, 2018; VHA Directive 1082, Patient Care Data Capture, dated March 25, 2015; VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018; and VHA Directive 1161, Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers, dated June 7, 2013.

4. RESPONSIBLE OFFICE: The Office of the Assistant Under Secretary for Health for Quality and Patient Safety (17API4) is responsible for the contents of this directive. Questions may be directed to 202-461-5833

5. RESCISSIONS: VHA Handbook 1065.01, Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of December 2025. This VHA directive will continue to serve as VHA policy until it is rescinded or recertified.

                                      BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Gerard R. Cox, M.D.
Assistant Under Secretary for Health
for Quality and Patient Safety

NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

DISTRIBUTION: Emailed to the VHA Publications Distribution List on January 4, 2021 Amendment dated May 19, 2023 was emailed to the VHA Publications Distribution List on May 23, 2023.

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PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE

1. PURPOSE

This Veterans Health Administration (VHA) directive maintains policy for monitoring and assessing specialty provider group practice productivity and staffing. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 1706A, 8110(a)(3)(C).

2. BACKGROUND

a. This VHA directive fulfills the statutory requirement for nationwide policy on the staffing of Department of Veterans Affairs (VA) medical facilities in order to ensure that such facilities have adequate staff to provide Veterans with appropriate, high-quality care and services.

b. Starting in 1989, the Centers for Medicare and Medicaid Services (CMS) (then the Health Care Financing Administration (HCFA)) began reimbursing for health care procedures and services based on health care procedure codes. Each procedure code in the Healthcare Common Procedure Coding System (HCPCS), based on the American Medical Association's (AMA) Current Procedural Terminology (CPT) codes, is assigned a Relative Value Unit (RVU) which rank on a common scale the resources used to provide each service. RVUs associated with a procedure code represent the skill, effort, judgement and time required to deliver the service.

c. Due to the link between RVU production and CMS reimbursement, RVU workload monitoring quickly became the health care industry standard approach for workload measurement and productivity monitoring. VHA began RVU-based productivity measurement in 2003. Efforts to build the necessary data infrastructure to measure provider productivity resulted in the establishment of the VHA Office of Productivity Efficiency and Staffing (OPES) in 2008. Since 2008, OPES has developed tools for monitoring provider productivity and staffing that consider RVU-based workload volumes, clinical full-time equivalent (FTE) time and provider productivity (see Appendix A for details on Provider Productivity Calculation and Measurement).

d. Determining a reasonable amount of work per provider (i.e., a productivity standard) at a group practice level is a critical tool for understanding VHA's capacity to meet current and future patient demand. The goal is not to maximize productivity in isolation, but to optimize access, quality, Veteran experience, resource stewardship, and workforce strength. Starting in 2015, VHA established productivity and staffing guidance for specialty provider group practices based on the work from OPES. This directive maintains methodologies and approaches for measuring, monitoring, reviewing and improving provider productivity levels at the group practice level.

3. DEFINITIONS

a. **Acceptable Range of Productivity.** The acceptable range of productivity is established by VHA at the VA medical facility group practice level. The range of

productivity encompasses the set of acceptable group practice productivity values for a fiscal year. By default, specialty provider group practice productivity that falls within the interquartile range (25th to 75th percentile) of prior VHA internal experience is considered an acceptable range of productivity (see Appendix B). The acceptable range of productivity assumes that production does not compromise quality and patient access standards. The acceptable range of productivity may be set at different levels based on the input of the program offices responsible for providing policy guidance to the respective specialty.

a. **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, didactic education or research. Clinical time is measured in accordance with the principles set forth by the VHA Office of Finance - Managerial Cost Accounting Office (MCAO). *NOTE: This responsibility is detailed as a part of VA Financial Policy Volume XIII located at: https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIIIChapter03.pdf. Additional guidance can be found on the MCA website at: https://mcareports.va.gov/vhanlmt.aspx and http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp. These are internal VA websites that are not available to the public.*

b. **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 (AMA). *NOTE: In VHA, these codes are assigned to an encounter at the time that the service or procedure is performed or to any specified clinical care activity in accordance with the nature and scope of that patient care activity.*

c. **Minimum Productivity Threshold.** The minimum productivity threshold is, by default, the specialty provider (or discipline) group practice productivity of the specialty median productivity minus 1.25 standard deviations of prior VHA internal experience (see Appendix B). The specialty productivity standards specify both an acceptable range of productivity and a minimum productivity threshold. The minimum productivity threshold may be set at different levels based on the input of the responsible parties.

d. **Provider Full Time Equivalent (Clinical).** Provider Full Time Equivalent (Clinical) (FTE(C)) refers to both physician allopathic doctors (MD), Doctor of Osteopathic Medicine (DO) FTE and other licensed providers. Provider FTE(C) measures the worked (removing leave) portion of a provider's time that is devoted to clinical care time as assigned in Managerial Cost Accounting labor mapping. This portion of FTE is used in productivity calculations (see Appendix B). *NOTE: A detailed definition of these duties, and how to account for them can be found at MCA Labor Mapping Guidelines, https://mcareports.va.gov/vhanlmt.aspx. This is an internal VA website that is not available to the public. For more information on covered specialties and provider types, see the OPES Provider Specialty Practice Management website located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. This is an internal VA website that is not available to the public.*

e. **Relative Value Unit.** RVU is a measure of the time and intensity of a professional service. The number of RVUs associated with each CPT code is determined by CMS as published in the CMS Medicare Fee Schedule (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files) supplemented with Optum gap codes. ***NOTE:*** *The Optum gap codes provide RVU values for services that are not a part of the CMS Medicare Fee Schedule. RVUs were primarily designed for reimbursement purposes but have been widely employed to measure provider work effort and workload. The total RVU consists of three components: physician work (wRVU), practice expense (peRVU) and malpractice expense (mpRVU). RVU values are available in OPES provider productivity data cubes and reporting. For productivity measurement, only the wRVU is utilized. The RVU used in this directive and by CMS differ from those defined by MCAO.*

f. **Improvement Plans.** An improvement plan is a document that outlines the actions a VA medical facility will undertake to assist identified low productivity specialty practice to become more productive. An improvement plan is required if a specialty provider (or discipline) group practice productivity level is below the established minimum productivity threshold. ***NOTE:*** *See Appendix B for more information regarding the minimum productivity threshold and Appendix D for minimum requirements of what must be included in an improvement plan.*

g. **Specialty Provider Group Practice.** A specialty provider group practice is defined as a group of providers delivering clinical services in a VA medical facility and its clinics that have privileges to perform a clinical specialty, patient clinical care service(s) and/or procedure(s). "Specialty provider group practice" can refer to an entire discipline (*e.g.* advanced practice provider disciplines) for productivity measurement. For VHA productivity measurement, aggregate specialties for the specialty provider group practice are identified based on the person class taxonomy of the provider. See VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018. ***NOTE***: Specialty provider group practice does not include primary care in accordance with VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017.

h. **Specialty Provider Group Practice Productivity.** Specialty provider group practice productivity is the ratio of total RVU for the entire specialty group practice service (FTE) [(RVU)/Clinical FTE)]. ***NOTE:*** *For more information, see the OPES Provider Specialty Practice Management website located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. This is an internal VA website that is not available to the public.*

i. **Specialty Provider Group Practice Support Staff.** For the purpose of this directive, specialty provider group practice support staff includes the clinical team staff (*e.g.,* nurses, allied health professionals such as technicians and technologists) and administrative support (*e.g.,* medical support assistants (MSAs) assigned to the specialty provider group practice service). Support staff positions are defined by their

budget object code (BOC) used in VHA Personnel and Accounting Integrated Data (PAID) data.

    j. **Work RVU.** Work RVU (wRVU) is the principal measure of workload for purposes of provider productivity measurement. VHA productivity measures include only the work component (wRVU) of the total RVU value.

4. POLICY

    It is VHA policy that each VA medical facility monitors and assesses specialty and discipline provider group practice clinical productivity and staffing at least annually using standardized methods to ensure providers can deliver appropriate, high-quality and timely health care and services to Veterans.

5. RESPONSIBILITIES

    a. **Under Secretary for Health.** The Under Secretary for Health is responsible for overall VHA compliance with this directive.

    b. **Assistant Under Secretary for Health for Quality and Patient Safety.** The Assistant Under Secretary for Health for Quality and Patient Safety is responsible for supporting the implementation and oversight of this directive across VHA.

    c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

    (1) Communicating the contents of this directive to each of the VISNs.

    (2) Assisting VISN Directors to resolve implementation and compliance challenges.

    (3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

    (4) Providing notice of the annual productivity review and improvement process to Veterans Integrated Service Network (VISN) Directors in the form of an official memorandum.

    (5) Ensuring all the VISN Directors annually review specialty group practice provider productivity using the reports relating to productivity and staffing data that are developed by Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID) and OPES as documented on the OPES Provider Specialty Practice Management website, located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public. For further information on these reports, see paragraph 5.e.*

    (6) Ensuring that the VISN Directors who oversee specialty provider group practices whose annual productivity totals that fall below the established minimum productivity threshold for the specialty in question complete an improvement plan to ensure future

compliance with minimum productivity for the specialty (*see* Appendix D for general guidance on this process).

d. **Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services, for their respective subsidiary program offices, are responsible for:

(1) Collaborating with OPES on the annual study of specialty provider (or discipline) group practice productivity to provide subject matter experts as needed for analysis.

(2) Developing and approving specialty productivity standards in collaboration with OPES, including acceptable ranges of productivity and minimum productivity thresholds for specialty practice as required based on changes in the health care marketplace. Productivity standards are based on VHA actual internal historical performance within the target specialty. A description of the default process is available in Appendix B. *NOTE: Input on productivity standards are provided by specialty (and discipline) program offices in the Office of the Assistant Under Secretary for Health for Clinical Services and the Office of the Assistant Under Secretary for Health for Patient Care Services. Clinical specialties are responsible for developing their unique productivity standards, however ultimate responsibility is with the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services as supported by OPES.*

(3) When applicable, approving any additions or changes to productivity measurement that occur outside of the scope of the general productivity measurement description set forth in Appendix A (e.g., changes in RVU values based on operational differences between VHA and CMS productivity models).

(4) Approving, monitoring and evaluating the results of the annual productivity review and improvement process.

e. **Director, Office of Analytics and Performance Integration.** The Executive Director of API is responsible for ensuring that the Director of OPES has sufficient resources to implement this directive and for providing oversight of OPES to assure compliance with this directive, relevant standards and applicable regulations.

f. **Director, Office of Productivity, Efficiency and Staffing.** The Director OPES is responsible for:

(1) Developing and maintaining a process for measuring provider productivity based on industry-standard approaches to measuring provider workload and provider time. A general outline of the productivity measurement process is outlined in Appendix A.

(2) Coordinating with the Assistant Under Secretary for Health for Operations any changes to productivity measurement based on differences between VHA operations and CMS RVU policy as published in the CMS Medicare Fee Schedule, located at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.

(3) Developing and maintaining reports and tools to support monitoring specialty provider (or discipline) group practice productivity. A brief summary of currently supported monitoring tools is available in Appendix C.

(4) Conducting an annual study of specialty provider group practice productivity to provide descriptive information on the VA health care provider workforce and provider productivity across VA medical facilities.

(5) Continually tracking the validity of the existing productivity methodology and adapting VHA's productivity tracking methods in coordination with changes to VHA's data systems, changes in global health care policy and developments in providing value-based care.

(6) Developing and maintaining specialty productivity standards as needed in collaboration with the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services, including acceptable ranges of productivity and minimum productivity thresholds for specialty practice. Productivity standards are based on VHA actual internal historical performance within the target specialty. *NOTE: Clinical specialties are responsible for developing their unique productivity standards, however ultimate responsibility is with the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services as supported by OPES.*

(7) Supporting the Assistant Under Secretary for Health for Operations, the Assistant Under Secretary for Health for Clinical Services, and the Assistant Under Secretary for Health for Patient Care Services in executing the annual provider productivity review process and improvement plan process. A review of the annual review process is summarized in Appendix D.

(8) Developing and maintaining reports and tools to track productivity performance to ensure that improvement plans are successful in improving provider productivity above the minimum productivity threshold. A summary of improvement approaches is available in Appendix E.

(9) Providing VHA leadership with national real-time reporting (through reports, dashboards and other tools as required) on productivity and staffing resources available by specialty across the VHA health care system.

(10) Collecting the VISN attestation memoranda from the VISN Director (see paragraph 5.i.(4)). The final set of attestation memoranda must be submitted to the Assistant Under Secretary for Health for Operations for informational purposes in a final annual review package*.*

g. **Director, VHA Office of Finance - Managerial Cost Accounting Office.** The Director, VHA MCAO is responsible for providing guidance on provider and support staff

labor mapping per VA Financial Policy, Volume XIII, Chapter 3, Managerial Cost Accounting. *NOTE: This responsibility is detailed as a part of VA Financial Policy Volume XIII located at: https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIIIChapter03.pdf and is noted here only for clarity of where official guidance on labor mapping can be found.*

h. **Chief Research and Development Officer, VHA Office of Research and Development.** The CRADO of the VHA Office of Research and Development is responsible for providing VA medical facilities with guidance on protected research time required for various research activities (see Appendix A). Guidance will be posted on the OPES Provider Specialty Practice Management website at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public.*

i. **Chief Academic Affiliations Officer, VHA Office of Academic Affiliations.** The CAAO of the VHA Office of Academic Affiliations is responsible for providing VA medical facilities with guidance on protected time required for education and education administration activities (see Appendix A). Guidance will be posted at the OAA website at: https://dvagov.sharepoint.com/sites/VHAOAA/general/Public%20Document/Forms/AllItems.aspx?viewpath=%2Fsites%2FVHAOAA%2Fgeneral%2FPublic%20Document%2FForms%2FAllItems.aspx. Guidance will additionally be posted on the OPES Provider Specialty Practice Management website at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: These are internal VA websites that are not available to the public.*

j. **Director, VHA Office of Veterans Access to Care.** The Director VHA Office of Veterans Access to Care (OVAC) is responsible for providing VA medical facilities with guidance on standardizing core processes relating to ensuring timely provision of health care services to Veterans.

k. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Reviewing the RAPID and OPES productivity reports in order to optimize specialty and discipline provider group practice productivity and staffing at their VA medical facilities with the assistance of VISN leadership, including the VISN Chief Medical Officer (CMO).

(2) Reviewing and approving productivity improvement plans for specialties failing to meet the minimum productivity threshold developed during the annual provider productivity review process. *NOTE: VISN-level review is required for specialties failing to meet minimum standards (see Appendix D).*

(3) Ensuring VA medical facility compliance with specialty productivity standards. The VISN Director may choose to establish independent minimum productivity thresholds based on VISN actual internal historical performance within the target

specialty so long as those thresholds are higher than the established VHA standards for the target specialty. For more information see the OPES Provider Specialty Practice Management website at http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(4) Signing an attestation memorandum that attests each VA medical facility has complied with the directive's requirements on development of improvement plans at the specialty group practice level for submission to the Assistant Under Secretary for Health for Operations (see Appendix D).

l. **Veterans Integrated Service Network Chief Medical Officer and Veterans Integrated Service Network Chief Nursing Officer.** ***NOTE:*** *These two roles share responsibilities with the understanding that the VISN CMO addresses physician productivity and the VISN CNO addresses nursing discipline productivity.* The VISN CMO and the VISN CNO are responsible for assisting the VISN Director with reviewing the RAPID and OPES productivity reports and providing guidance and expertise to VA medical facility Service Chiefs, Chief of Staff (COS), and Associate Directors of Patient Care Services (ADPCS) on productivity improvement plans.

m. **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 based on this directive's definition of specialty provider group practice for specialties covered under this directive. Covered specialties will be hosted on the OPES Provider Specialty Practice Management website located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) Reviewing the RAPID and OPES productivity reports to optimize specialty and discipline provider group practice productivity and staffing at their VA medical facility with the assistance of the VA medical facility leadership, including the VA medical facility COS.

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

(4) Reviewing and approving productivity improvement plans developed during the annual provider productivity review process for specialty provider group practice services where the specialty practice productivity level is outside the acceptable range of productivity for the specialty.

(a) Improvement plans for specialties falling below the minimum productivity threshold must be forwarded to the VISN Director for final approval.

(b) Improvement plans for specialties with productivity above the minimum productivity threshold, but outside the acceptable range of productivity for the specialty only require VA medical facility Director approval.

(5) Using the Physician Productivity, Benchmarks & Study Data and the Specialty Physician Productivity Reports available on the OPES Provider Specialty Practice Management website located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public.*

n. **VA Medical Facility Chief of Staff and VA Medical Facility Associate Director of Patient Care Services.** *NOTE: These two roles share the same responsibilities with the understanding that the VA medical facility COS addresses physician productivity while the VA medical facility ADPCS addresses the nursing discipline productivity.* The VA medical facility COS and VA medical facility ADPCS are responsible for:

(1) Coordinating the activities of the relevant VA medical facility specialty service chiefs and specialty care nurse managers in assessing and measuring productivity and staffing at least annually, including performing needs assessments for hiring contract providers in their services (see Appendix E for more information).

(2) Validating and certifying productivity source data as identified by the applicable directives including:

(a) Appropriate person class designations as required by VHA Directive 1095.

(b) Consistency between labor mapping of specialty group practice providers and relevant MCA Labor Mapping Guidelines located at: https://mcareports.va.gov/vhanlmt.aspx. *NOTE: This is an internal VA website that is not available to the public.*

(c) Compliance with VHA patient data capture requirements, including identification of the attending physician as the primary provider when residents are involved in the clinical encounter as required by VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015.

(3) Ensuring all specialty provider group practices are monitoring provider productivity on an ongoing basis using OPES productivity tools and reports available on the OPES Provider Specialty Practice Management website located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public.*

(4) Completing the annual productivity review process and developing improvement plans for specialties with provider productivity outside of the acceptable range of productivity for the specialty in conjunction with the service chief of the specialty and applicable clinical leaders. Improvement plans for specialties that fail to meet the minimum productivity threshold for the VA medical facility must be approved by the VA medical facility Director prior to forwarding to the VISN Director for review and approval.

At a minimum, improvement plans for VA medical facilities failing to meet the minimum productivity threshold must address the following:

(a) A review of prior year data to determine if the failure to meet the minimum productivity threshold for the specialty is new to the current annual review or if the specialty has failed to meet the minimum standard in prior years. For specialties where the minimum threshold has not been met in multiple years, a summary of prior year efforts or issues should be addressed.

(b) A review and re-validation of the validity of the data inputs for the productivity analysis. This review should include a review of the relationship between physician and APP workload within the specialty.

(c) A review and discussion of any potential issues relating to lack of clinical and administrative support staff required for productivity improvement.

(d) A review and discussion of any potential issues relating to lack of supporting infrastructure or equipment required for productivity improvement.

o. **VA Medical Facility Specialty Service Chiefs and VA Medical Facility Nursing Chiefs.** *NOTE: These two roles share the same responsibilities with the understanding that the VA medical facility Specialty Service Chiefs address physician productivity while the VA medical facility Nursing Chiefs address the nursing discipline productivity.* The VA medical facility specialty Service Chiefs and VA medical facility Nursing Chiefs are responsible for:

(1) Ensuring that the providers in their service line or practice discipline meet the acceptable range of productivity for their specialty practice by monitoring of practice productivity on an ongoing basis using OPES productivity and staffing tools, recognizing that individual provider productivity expectations may vary due to the nature of their clinical work.

(2) Completing the annual productivity review process and developing productivity improvement plans for their specialty provider group practice services if the specialty practice productivity level is outside the acceptable range of productivity for their specialty. The improvement plan should be completed in collaboration with the VA medical facility COS.

(3) Reviewing data associated with productivity, including labor mapping, workload data capture and provider person class, on an ongoing basis as required by VHA Directive 1082 and VHA Directive 1095.

(4) Reviewing OPES practice management tools and reports to identify potential causes for productivity and staffing issues for the specialty. The productivity tools and reports are available on the OPES Provider Specialty Practice Management website located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public.*

6. STAFFING AND PRODUCTIVITY STANDARDS

a. The productivity goal of specialty provider (or discipline) group practices is to achieve a yearly clinical productivity value above the minimum productivity threshold of observed wRVU per Provider FTE(C) for all providers in the various individual specialty or discipline within their peer or national group. ***NOTE:*** *Other clinical units of workload may apply for select specialties or disciplines. For example, Anesthesiology specialty uses industry-standard American Society of Anesthesiologists (ASA) units.*

b. VHA uses actual internal historical performance to established productivity targets. Targets are established at the aggregate specialty or discipline peer or national group level and are updated at least every 2 years or as significant changes warrant. Productivity targets and thresholds are defined and employed using statistical methods to address outliers. The finalized targets and methodologies for specialties covered by this directive are published on the OPES Provider Specialty Practice Management website, located at: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public. Targets are not set at the individual provider level. When the productivity standards were developed, the monitoring was envisioned for the productivity at the specialty/discipline practice level (i.e., a specialty/discipline at the parent VA medical facility level). This was designed to allow for maximum flexibility at the VA medical facility level to assign workload across the specialty/discipline. Knowing that some specialties/disciplines have a wide variance in productivity at the sub-specialty level e.g., between a procedure based sub-specialty and an office visit based sub-specialty). By only monitoring the productivity at the specialty/discipline level, managers have the leeway to allow for productivity variance at the sub-specialty level, while holding the whole practice to the productivity standards. When VA medical facility leadership are considering individual provider productivity levels, for which they have authority, they must contextualize to the unique characteristics of their practice.*

c. While ultimate responsibility for establishing specialty group practice productivity standards is detailed in paragraph 5 of this directive, a default approach to developing specialty productivity standards is detailed in Appendix B. This approach is used as a baseline approach for establishing productivity standards based on VHA's actual internal historical performance.

7. TRAINING

There are no formal training requirements associated with this directive. OPES will provide education and training as consulted to review the productivity measurement process and tools available for monitoring and improving productivity (see Appendix D).

8. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control

Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

9. REFERENCES

a. 38 U.S.C. § 8153.

b. VA Financial Policy, Volume XIII, Chapter 3, Managerial Cost Accounting https://www.va.gov/finance/policy/pubs/volumeXIII.asp.

c. VHA Directive 1064, Pathology and Laboratory Medicine Services (P&LMS) Productivity and Staffing, dated September 17, 2018.

d. VHA Directive 1066, Requirement for National Provider Identifier (NPI) and Taxonomy Codes, dated November 7, 2013.

e. VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015.

f. VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018.

g. VHA Directive 1101.05(02), Emergency Medicine, dated September 2, 2016.

h. VHA Directive 1131(3) Management of Infectious Diseases and Infection Prevention and Control Programs, dated November 27, 2017.

i. VHA Directive 1161, Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers, dated April 28, 2020.

j. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016.

k. VHA Directive 1231, Outpatient Clinic Practice Management, dated October 18, 2019.

l. VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017.

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

n. 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.

o. MCA Labor Mapping Guidelines: https://mcareports.va.gov/vhanlmt.aspx.

p. MCA Labor Mapping Technical Guidance: http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp.

q. OPES Provider Specialty Practice Management website:
http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx.
NOTE: This is an internal VA website that is not available to the public.

r. OPES Website: http://opes.vssc.med.va.gov/Pages/Default.aspx. *NOTE: This is an internal VA website that is not available to the public.*

s. VHA Facility Complexity Model website:
http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. *NOTE: This is an internal VA website that is not available to the public.*

PROVIDER PRODUCTIVITY CALCULATION METHODOLOGY AND STAFFING ESTIMATES

Conceptually, productivity is a measurement of production within a specified amount of time. This appendix provides an overview of how productivity is measured for providers in Veterans Health Administration (VHA). Specific details associated with the measurement and monitoring of productivity are available through the data definitions associated with each productivity and staffing report.

1. PROVIDER PRODUCTIVITY COMPONENT MEASURES

In VHA provider productivity data, productivity is defined as workload (measured in relative value units (wRVUs)) divided by workforce (measured in Provider FTE(C)). The key components of productivity are defined as follows:

a. **Workload.** Relative value units (RVUs) are assigned to VHA workload by extracting Current Procedural Terminology (CPT) coding from the electronic health record (EHR). Each CPT code is converted to an RVU using the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File supplemented with Optum and/or limited internal gap code RVUs. *NOTE:* In addition to wRVUs, other clinical units of workload may be applicable for select specialties or disciplines. For example, Anesthesiology specialty uses an industry-standard American Society of Anesthesiologists (ASA) units.

(1) Capture of workload incorporates all inpatient and outpatient reported workload with CPT coding that passes workload capture data checks as defined in VHA Directive 1082, Patient Care Data Capture, dated March 25, 2015.

(2) Workload is assigned to the provider who completed the workload as noted on the encounter. Specialty/discipline classification of the workload is derived from the specialty/discipline group practice provider active person class code/taxonomy assignment of the workload-completing provider per VHA Directive 1095, Provider Person Class/Taxonomy File, dated July 18, 2018.

(3) Outpatient clinic and procedure professional workload is derived from specialty stop codes as defined by Stop Code guidance (http://vaww.dss.med.va.gov/programdocs/pd_oident.asp) per Department of Veterans Affairs (VA) Financial Policy, Volume XIII, Chapter 3, Managerial Cost Accounting. *NOTE: This is an internal VA website that is not available to the public.*

b. **Workforce.** The number of hours of clinical worked time (defined as Provider FTE(C)) is calculated based on the following:

(1) The provider's actual hours worked are reported on a pay period basis in the VA Personnel and Accounting Integrated Data (PAID) system or subsequent payroll database. Only worked hours are included in the productivity calculation; hours

associated with annual leave, sick leave or leave without pay are excluded from the worked hour count.

(2) The worked hours from PAID are linked to the National Labor Mapping Tool (NLMT) results and then passed to the Managerial Cost Accounting Office (MCAO) Clinic Workforce (WF) PAID and VCNV (VA Conversion) file. Only the clinical portion of the hours worked are considered. Hours associated with administration, research and education are excluded.

NOTE: The definition of the fraction of time the employee devotes to administration, teaching and research, are specified in Financial Policy Volume XIII, Cost Accounting Chapter 3 Managerial Cost Accounting and the current Managerial Cost Accounting (MCA) Labor Definitions located at: https://mcareports.va.gov/vhanlmt.aspx. This is an internal VA website that is not available to the public. Brief summary-level guidance on labor mapping categories are provided here for convenience but are not authoritative:

(a) Clinical time (MCA Direct Patient Care Time) includes time to prepare, to provide for and follow-up on the clinical care needs of patients. It is the time left when justifiable administrative, education and research hours have been subtracted.

(b) Administrative time includes activities such as scheduling employees, completing performance reviews, fulfilling hospital or national reporting requirements, managing a clinical program and participating on VA medical facility or national committees, advisory boards or professional societies. Operations Guidance: Protected Administrative Time for Clinicians: https://dvagov.sharepoint.com/sites/VHAOPES/Shared%20Documents/Operations%20Guidance%20Protected%20Admin.%20Time.pdf?web=1 *NOTE: This is an internal VA website that is not available to the public.*

(c) Education time is limited to the hours spent by VA clinical staff preparing and delivering classroom training, formal presentations or lectures as well as time spent managing a resident, fellow or other type of student teaching program. While MCA is responsible for the definition of education time, the Office of Academic Affiliations is responsible for providing guidance on appropriate time allotments for education and training activities. Office of Academic Affairs (OAA) Guidance: Protected Educational Time for Clinicians https://dvagov.sharepoint.com/sites/VHAOAA/public/OAA%20Approved%20Policies/Forms/AllItems.aspx?id=/sites/VHAOAA/public/OAA%20Approved%20Policies/OAA%20Protected-Education-Time-for-VA-Clinicans-October%202022.pdf&parent=/sites/VHAOAA/public/OAA%20Approved%20Policies *NOTE: This is an internal VA website that is not available to the public.*

(d) Research time is time spent working on research that is approved by the local VA medical facility Research and Development Committee and does not produce clinical workload in the EHR. Office of Research and Development (ORD) Protected Time for Research Staff https://www.research.va.gov/resources/policies/guidance/Guidance-for-Research-Protected-Time.pdf *NOTE: This is an internal VA website that is not available*

to the public. While MCA is responsible for the definition of research time, the Chief Research and Development Officer (CRADO), VHA Office of Research and Development is responsible for providing guidance on appropriate time allotments for education and training activities.

(3) Specialty and discipline provider group practice clinical time does not include inpatient daily evaluation and management services such as ward attending rotations unless such time is captured in an encounter and labor mapped accordingly (*see MCA Labor Mapping Guidelines* available at https://mcareports.va.gov/vhanlmt.aspx for more information on workload and non-workload capturing inpatient production units). ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) Total provider clinical hours worked are divided by the count of available worked hours in the time period to generate the Provider FTE(C) value. Provider FTE(C) totals are aggregated to the specialty level. Specialty/discipline classification of the Provider FTE(C) is derived from the specialty/discipline group practice provider active person class code/taxonomy assignment of the provider as provided by VHA Directive 1095.

2. CALCULATION OF PROVIDER PRODUCTIVITY

Provider productivity is calculated at the provider level by dividing the workload performed (in RVUs) by the hours worked (in Provider FTE(C)).

$$Productivity = \frac{Sum\ of\ wRVUs\ completed}{Provider\ FTE(C)}$$

a. While productivity is calculated at the provider level, productivity is designed as a monitor at the specialty group practice level within a given aggregate specialty. This allows for maximum flexibility at the VA medical facility level to assign workload across the specialty or discipline. By only monitoring the productivity at the specialty (or discipline) level, managers have the leeway to allow for planned productivity variance at the provider level, while holding the whole practice to the productivity standards.

b. While productivity is measured in wRVUs per Provider FTE(C) for all specialties, productivity values should not be compared across specialties. Different specialties have differing RVU values for their most commonly performed procedures which results in differences in average levels of productivity values across specialties.

c. Specialty group practice productivity levels must only be compared when there is relative homogeneity in the practice setting. Some factors associated with differences in productivity are: practice setting (Facility Complexity Level), teaching mission (residents), support staff ratios, use of advanced practice providers (Advance Practice Registered Nurses, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Physician Assistants) and access to certain capital infrastructure such as operating rooms, procedure areas and examination rooms.

3. CONTRACT FTE ESTIMATION

Non-VA PAID providers (including in-house fee providers, contract staff and without compensation (WOC) providers) are not covered in the process of productivity measurement because while workload information is available (in wRVUs completed), there is no source of data for clinical hours worked. Using the workload information and the productivity standards for the applicable specialty, VHA is able to estimate (impute) the FTE total of work received through in-house fee, contract staff and WOC workload. To impute the impact of these FTE on the specialty provider workforce, the total work completed by the contract staff is divided by the VHA national average productivity for VA PAID staff for the specialty of the providers.

$$Imputed\ Fee\ \&\ Contract\ FTE\ (C) = \frac{Sum\ of\ wRVUs\ completed\ by\ contract\ staff}{VHA\ National\ Average\ Productivity}$$

a. Workload associated with Non-VA PAID providers is not included in VHA's productivity calculations.

b. The imputed workforce estimates are included in the Provider Clinical FTE estimates in the Office of Productivity, Efficiency and Staffing (OPES) tools relating to counts of the provider workforce. When counting the total provider workforce within a given specialty in staffing tools, the total Provider Clinical FTE measure is the sum of VA PAID Provider FTE(C) and the imputed fee and contract FTE.

$$Provider\ Clinical\ FTE = Provider\ FTE(C) + Imputed\ Fee\ \&\ Contract\ FTE$$

4. SPECIALTY STAFFING PROFILES

Specialty staffing profiles are based on the data from the provider productivity calculations in combination with staffing data relating to different types of staff required for running a specialty clinic. Using this data on staffing in conjunction with specialty workload data, specialty practices can get a picture of how specialty specific staffing at a site compares with VHA, Veterans Integrated Service (VISN) and peer VA medical facility staffing for a given specialty. Specialty staffing profiles are available on the OPES Provider Specialty Practice Management website: http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public.* Relevant staffing ratios provided in the reporting a defined below.

a. **Residents.** The count of Graduate Medical Education (GME) resident slots Associated Health (AsocH) resident slots, and/or Allied Health (AH) slots for the specialty as defined by the Office of Academic Affiliations.

   b. **Advanced Practice Provider.** The physician extenders (e.g., nurse practitioners, physician assistants) with time mapped to the specialty. Advanced Practice Providers (APPs) are identified by budget object code (BOC).

   c. **Administrative Support Staff.** The administrative and clerical staff with time mapped to the specialty. Administrative Support Staff is identified by BOC.

   d. **Clinical Team Staff.** The clinical staff including nurses and clinical health technicians with time mapped to the specialty. Clinical Team Staff is identified by BOC.

   e. Detailed data definitions for the specialty staffing profiles are available in the OPES Specialty Provider Workforce Report Data Definitions located at: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=3708. A summary of how support staff are mapped to specialty is available as the OPES Support Staff White Paper. ***NOTE:*** *This is an internal VA website that is not available to the public.*

ESTABLISHING SPECIALTY PROVIDER GROUP PRACTICE PRODUCTIVITY STANDARDS

This appendix describes the process for establishing productivity benchmarks based on actual internal historical performance data. While productivity benchmarks must rely on internal performance data, the ultimate responsibility for establishing specialty group practice productivity standards lies with the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services for the respective program offices under their supervision (see paragraph 5.e). Note that the process may be altered by the responsible parties in order to accommodate specific circumstances and data. The baseline approach described in this appendix provides the general approach to establishing specialty group practice productivity standards that have been in place since 2013.

1. PRODUCTIVITY SPECIALTY/DISCIPLINE PROVIDER GROUP PRACTICE ALGORITHMS

The purpose of these productivity algorithms is to assist Department of Veterans Affairs (VA) medical facility leaders in the management of specialty (or discipline) group practices with resources and ensure appropriate staffing for these services across all VA medical facilities.

a. **Acceptable Group Practice Range of Productivity.** An acceptable range of productivity is a group practice productivity within the interquartile range within the selected peer group (25th to 75th percentile), taking care not to compromise quality and patient access standards.

b. **Peer Grouping.** Peer groupings are generally based on the Veterans Health Administration (VHA) Facility Complexity Model (model and results available at http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx). ***NOTE:*** *This is an internal VA website that is not available to the public.* Differences in facility complexity, including types of services provided by the facility, can impact overall productivity. The VHA Facility Complexity Model groups VA medical facilities into one of five complexity levels (Medical Center Groupings (MCG) 1a, 1b, 1c, 2 and 3) based on the relative complexity of the overall services provided by the VA medical facility at the administrative parent level.

(1) Where there is a sufficient count of facilities with the specialty in question at the MCG level, the complexity model peer group is used to define the acceptable group practice range of productivity (e.g*.,* MCG Level 1a has one standard while the MCG Level 1b, 1c, 2 and 3 standards are calculated independently).

(2) In certain cases, VA medical facility counts with a specialty are limited in the lower complexity MCG level facilities. When this occurs, complexity levels may be

combined to provide a joint threshold (e.g., MCG Level 2 and MCG Level 3 are combined to create a joint MCG Level 2 and 3 standard).

(3) When counts of facilities that provide a specialty are very low such that MCG groupings cannot be used, or when in the judgement of the subject matter experts there should not be a distinction between the MCG levels because of how the specialty operates, the VHA national data is used for developing the thresholds.

c. **Specialty/Discipline Group Practice Productivity Thresholds.** Thresholds both low and high for Specialty/Discipline Group Practice Productivity (recognizing the heterogeneity of individual contributions and associated wRVU and/or other clinical workload, i.e., American Society of Anesthesiologist (ASA) units are established based on the 25th and 75th percentile. This is generally referred to as the acceptable range of productivity for the specialty.

Minimum productivity thresholds are established at the median group practice provider productivity minus 1.25 standard deviations for the specialty's peer group:

$$Minimum\ Productivity\ Threshold = \\ Peer\ Group\ Median\ Productivity - (1.25 * Peer\ Group\ Standard\ Deviation)$$

2. ESTABLISHING SPECIALTY PROVIDER GROUP PRACTICE PRODUCTIVITY STANDARDS

Productivity standards are re-evaluated as needed by the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services. Re-evaluation must take place because as health care evolves over time, RVU values change and relative workloads shift. Productivity standards consist of the acceptable group practice range of productivity, the peer grouping and the minimum productivity threshold for the specialty. The productivity data used to establish the productivity standards is the same data developed by OPES as a part of their ongoing productivity reporting.

NOTE: *Specialty provider group practice does not include primary care in accordance with VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017.*

3. FACTORS FOR VARYING FROM PRODUCTIVITY ALGORITHMS

The offices responsible for establishing productivity standards may vary from the default approach for establishing productivity standards. Generally, variance occurs when one or more of the following situations are true (though final decision rests with the responsible parties):

a. Data quality issues related to workload capture for a given specialty.

b. Workload volume issues related to a given specialty (multiple years of data may be used).

c. Fundamental changes to the practice of a given specialty or fundamental changes to the RVU (i.e., reimbursement) rates for procedures within a given specialty.

d. Unexplained national workload volume decreases without a corresponding decrease in external benchmarks for productivity (prior year data may be used).

e. Changes to provider and support staffing that impact productivity levels such that additional analysis is required.
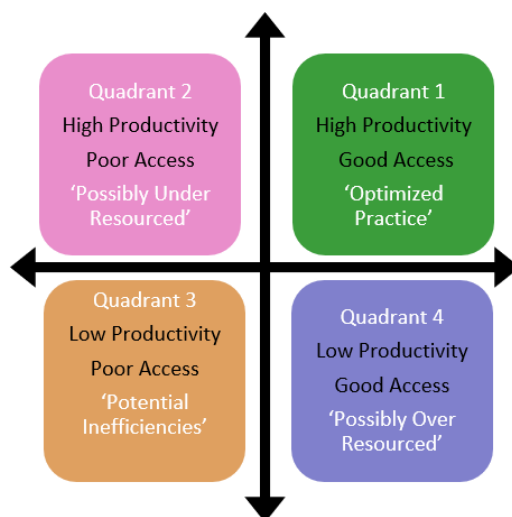
SPECIALTY PROVIDER GROUP PRACTICE PRODUCTIVITY AND STAFFING TOOLS

The Veterans Health Administration (VHA) Office of Productivity Efficiency and Staffing (OPES) has developed a series of reporting tools designed to monitor specialty provider group practice productivity and staffing. This appendix summarizes productivity tools available for the purposes of monitoring specialty group practice productivity and staffing. For more information please visit http://opes.vssc.med.va.gov/Pages/Provider-Specialty-Practice-Management.aspx. *NOTE: This is an internal VA website that is not available to the public.*

1. SPECIALTY PROVIDER GROUP PRACTICE PRODUCTIVITY ACCESS REPORT AND QUADRANT TOOL

a. Specialty Provider Group Practice Productivity Access Report and Quadrants (SPARQ) is a summary report from the VHA Office of Productivity, Efficiency and Staffing (OPES) that combines specialty physician productivity data with specialty access data. SPARQ provides the ability to compare a Department of Veterans Affairs (VA) medical facility's performance with other sites offering similar levels of complex care.

b. The SPARQ tool combines practice-level productivity and access metrics into an Importance-Performance Analysis (IPA) framework, a two-dimensional cartesian coordinate system divided by two axes that form four quadrants. Scores representing productivity are plotted on the vertical axis (y-axis) and scores representing access on the horizontal axis (x-axis). Group practice staffing needs can be thus identified.

c. The IPA framework in the SPARQ tool indicates an algorithm for identifying staffing needs at the specialty group practice level:

(1) Specialties with high productivity and good access (Quadrant 1) are presumed to be optimized.

(2) Specialties with high productivity and poor access (Quadrant 2) are possibly under-resourced (i.e., the practice is productive, but even with a productive staff, the current demand cannot be handled without an above average wait time).

(3) Specialties with low productivity and poor access (Quadrant 3) are potentially inefficient (i.e., the wait times may be able to be addressed by increasing the throughput/productivity of the existing staff).

(4) Specialties with low productivity and good access (Quadrant 4) are possibly over-resourced (i.e., demand for the service is satisfied such that wait times are low, but the staff have below-average productivity indicating an area that may require fewer resources to fill the demand).

d. The SPARQ tool also aggregates practice management data designed to provide VA medical facility specialty Service Chiefs and clinical leadership with views of various measures known to have a relationship with specialty group practice productivity, including:

(1) Facility level specialty utilization.

(2) Workforce supply.

(3) Workforce per population.

(4) Procedure suite-based workforce (for applicable specialties).

(5) Office-based clinic support staff.

(6) Advanced practice provider workforce.

(7) Provider productivity.

(8) Teaching mission.

(9) Practice management measures.

(10) Specialty workload measures.

(11) Employee turnover.

(12) Physician compensation.

2. SPECIALTY GROUP PRACTICE PRODUCTIVITY STANDARDS OUTLIER REVIEW REPORT

a. The Specialty Provider Productivity Standards Performance & Outlier Review report provides information on historic productivity in comparison to established productivity standards for the standards established for the selected fiscal year. Additionally, the outlier review report provides fiscal year to date (FYTD) productivity levels with a projection of whether the specialty group practice is on track to meet existing productivity standards or fail to meet existing minimum productivity thresholds.

b. The outlier report also provides the full set of specialty group practice productivity standards and the list of specialty group practices in need of improvement plans as described in this directive.

3. SPECIALTY PROVIDER WORKFORCE REPORT

a. The Specialty Provider Workforce Report delivers system level staffing norms by geographic location (Veterans Integrated Service (VISN)) and practice setting (Medical Center Groupings (MCG)). Staffing levels per population (core facility unique patients and specialty specific patients treated) are included in this report as well as provider productivity levels.

b. Additionally, the composition of the care team (physicians, Advanced Practice Providers (APPs) and support staff levels) are included. This report can be used to determine comparison staffing levels at the specialty level; however, VA medical facility managers must contextualize these data to their potentially unique characteristics such as patient reliance and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

4. PROVIDER PRODUCTIVITY LEADERSHIP DASHBOARD

a. The Provider Productivity Leadership Dashboard provides detailed information about the staffing levels, clinical workload and provider productivity for each VA medical facility at the specialty level. This analytic tool assists Veterans Health Administration (VHA) managers and leadership in effectively managing their specialty provider practices towards the goal of ready access to quality specialty services. VHA tracks specialty care practice and provider level productivity performance for over 30 areas of specialization as well as advanced practice providers.

b. The leadership dashboard provides a Chief of Staff dashboard with views of specialty provider productivity at the aggregate specialty level, views of APP productivity, views of rehabilitation provider specialty productivity and social work provider productivity at the facility level.

c. Detailed workload reports provide trend information on year-over-year specialty workload growth in key practice management metrics like total workload (RVU sum), unique encounters per unique Veteran, RVU sum per unique Veteran and RVU sum per

encounter. The dashboard also provides time-level detail to identify when during the day workload is happening for the given specialty.

d. Detailed workforce reports provide trend information on key practice management metrics like year-over-year changes in physician workforce labor mapping distribution, Full Time Equivalent (FTE) growth over time and FTE counts by aggregate specialty.

5. SPECIALTY PROVIDER PRODUCTIVITY BENCHMARKING REPORTS

a. The Physician Productivity Standards Reports provide a management tool for the systematic, longitudinal measurement and reporting of clinical productivity, efficiency and staffing in VHA. The productivity benchmarking tools show the average, range and variation in productivity across specialties at the national, VISN, complexity group and administrative parent level. This information can be used to identify areas of need or improvement within relevant comparison groups.

b. The benchmarking report specifically provides the descriptive statistics of productivity performance at the VA medical facility level with comparisons to existing productivity standards, current year moving statistics and private-sector benchmarks in the form of the Medical Group Management Association (MGMA) Academic and Private Practice Mean and Median specialty group practice productivity measures.

c. The benchmarking report additionally provides productivity data at the subspecialty level, VA medical facility rankings for specialty productivity, trends in specialty productivity over time summarized at the national, MCG group and VA medical facility level and comparisons between VHA's productivity performance and MGMA's benchmarks over time.

ANNUAL PRODUCTIVITY REVIEW AND IMPROVEMENT PROCESS

1. MINIMUM REQUIREMENTS FOR IMPROVEMENT PLANS

Department of Veterans Affairs (VA) medical facilities are required to review specialty group practice productivity upon the close of the prior fiscal year's workload and workforce databases. As a part of this review process, VA medical facilities must develop improvement plans for specialties with provider productivity outside of the acceptable range of productivity for the specialty for all specialties that are included in Veterans Health Administration (VHA) Office of Productivity Efficiency and Staffing (OPES) reporting. Improvement plans for specialties that fail to meet the minimum productivity threshold for the VA medical facility must be forwarded to the Veterans Integrated Service Network (VISN) for review. At a minimum, improvement plans for VA medical facilities failing to meet the minimum productivity threshold should address the following:

a. A review of prior year data to determine if the failure to meet the minimum productivity threshold for the specialty is new to the current annual review or if the specialty has failed to meet the minimum standard in prior years. For specialties where the minimum threshold has not been met in multiple years, a summary of prior year efforts or issues should be addressed.

b. A review and re-validation of the validity of the data inputs for the productivity analysis.

c. A review and discussion of any potential issues relating to lack of supporting staffing required for productivity improvement.

d. A review and discussion of any potential issues relating to lack of supporting infrastructure or equipment required for productivity improvement.

2. ANNUAL PRODUCTIVITY REVIEW

a. OPES develops the annual productivity review and improvement process memorandum on behalf of the Assistant Under Secretary for Health for Operations.

b. Prior to the operational release of the productivity review and improvement process memorandum, the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services approve the memorandum as an accurate reflection of VHA's provider productivity monitoring process.

c. Notice of the annual productivity review and improvement process will be distributed to VISN Directors from the Assistant Under Secretary for Health for Operations in the form of an official operational memorandum. The announcement

memorandum will specify the current monitoring tools available for specialty group practice and VA medical facility leadership's use in developing an improvement plan.

d. The improvement plans are local tools targeted at ensuring that VHA has a highly productive workforce that provides ready access to high-quality specialty care. The improvement plans must be locally maintained and implemented. Each VISN Director must sign an attestation memorandum that attests that each VA medical facility has complied with the directive's instructions on development of improvement plans at the specialty group practice level.

e. The VHA Office of Productivity, Efficiency and Staffing (OPES) must collect the VISN attestation memoranda in compliance with the directive. The final set of attestation memoranda will be submitted to the Assistant Under Secretary for Health for Operations in a final annual review package. This final review package is shared with the Assistant Under Secretary for Health for Clinical Services and the Assistant Under Secretary for Health for Patient Care Services informationally.

f. OPES will provide education and training annually to review the productivity measurement process and tools available for monitoring and improving productivity.

GUIDANCE ON PROVIDER PRODUCTIVITY IMPROVEMENT

Below constitutes general guidance that can be used at the Department of Veterans Affairs (VA) medical facility level for improving specialty group practice provider productivity. The improvement approaches have been grouped into data validation, monitoring requirements, improvement approaches through workload throughput increases and improvement approaches through workforce adjustments.

1. DATA VALIDATION

Accurate productivity measurement relies on accuracy of the Veterans Health Administration (VHA) corporate data systems. The following algorithm is provided to assist VA medical facilities and specialty provider (or discipline) group practices to improve the critical data elements to ensure reliable productivity and staffing data. Information on the data validation process for productivity data is hosted on the VHA Office of Productivity Efficiency and Staffing (OPES) website: http://opes.vssc.med.va.gov/Pages/Default.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

2. MONITORING GUIDANCE

a. **Appropriate Current Procedural Terminology Coding.** Appropriate current procedural terminology (CPT) coding is required in order to accurately capture the RVU-based workload counts as described in Appendix A. Specialty provider group practice practitioners must not expand the scope of a requested patient procedure or consultation, thereby increasing wRVU, without medical justification specific to that patient. Specialists must follow the precepts of the CMS National Correct Coding Initiative (NCCI).

b. **Appropriate Utilization.** The need to increase workload must not be used as a justification for specialists to recruit consultations, clinical studies or approve studies, or extend treatments that are unsafe, not indicated, or otherwise would not be performed. The precepts of shared decision making with the patient are to be considered in the rendering of clinical specialty care.

c. **Monitors of Specialty Provider Group Practice Physician Productivity.** Each year OPES must conduct a specialty provider group practice productivity study in collaboration with the Office of Patient Care Services, the National Surgery Office, and other program offices in charge of providing guidance on specialty group practice productivity. This annual study results in the publication of specialty care provider and staffing productivity guidelines in the fiscal year (FY) Physician Specialty Workforce Report (*see* report description in Appendix C) The annual productivity studies hosted on the OPES website within the related reporting: http://opes.vssc.med.va.gov/Pages/Default.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

d. **Workload for Contracted Care and Without Compensation.** Although the productivity performance standard applies to the specialty provider group practice as a whole, the VA medical facility Chief of Staff (COS), in collaboration with their specialty provider group practice Service Chiefs, must track productivity for each VA Personnel and Accounting Integrated Data (PAID) specialty provider group practice physician who has clinical privileges at the VA medical facility. Workload for contracted care and Without Compensation (WOC) specialty provider group practice practitioners are to be monitored in accordance with the service specifications. The specialty contracted care provider productivity record is to be produced and reviewed.

3. IMPROVEMENT APPROACHES THROUGH WORKLOAD INCREASE

a. **Telemedicine and Adjunct Workload Approaches.**

(1) For practices with available workload capacity in a specialty, specialties can engage in virtual health care modalities to both improve provider productivity and to ensure timely care to Veterans.

(2) Virtual care approaches can occur in a synchronous or asynchronous format. Synchronous care is rendered through clinical activity associated with an appointment that involves a practitioners' delivery of a professional service and can include face to face encounters, telehealth encounters, telephone encounters or VA Video Connect encounters.

(3) Asynchronous care is rendered through clinical activity that's not associated with an appointment (e.g., e-consult, secure message, store & forward telehealth) or through an encounter indirectly associated with professional services delivered while the patient is not physically present through an occasion of service such as radiology and pathology and EKG/ECG interpretation.

b. **Re-evaluate Appointment Availability.** Variation in available appointment slots and in the time allotted for appointments across VHA leads to variation in total workload completed by specialty provider practices. VA medical facilities may re-evaluate the default appointment length for the specialty clinic to increase scheduled specialty workload. The VHA Office of Veterans Access to Care (OVAC) additionally provides guidance on bookable hours (i.e., clinical hours available to be booked by an appointment).

c. **Improving Practice Management.** Several workload monitors are available for review at the specialty group practice level that have a direct impact on the total workload of a given practice. These monitors include routine consult delays, ratio of established to new evaluation and management (E&M) encounters, cancelled by clinic prior to appointment rates and missed opportunity rates.

d. **Monitoring and Improving Specialty Workload Trends.** Practices with low productivity can monitor workload measures to ensure that the practice is completing a comparable amount of workload to peer VA medical facilities. These workload

measures include count of encounters per day per full-time equivalent (FTE), relative value unit (RVU) sum per encounter, percent of encounters with an advanced practice provider (APP), percent of RVUs completed by VA PAID/Non-VA PAID/Resident Only/APP workforce. These measures provide approaches to understanding alternative approaches to improving provider throughput via increasing provider workload to levels comparable to specialty group practice peers.

4. IMPROVEMENT APPROACHES THROUGH WORKFORCE ADJUSTMENTS

a. **Evaluate Provider Time Allocation.** Specialty group practices with productivity or access issues may be able to address variation in staffing requirements through re-allocating the administrative, education and research time associated with the providers.

b. **Re-evaluation of Physician Contracts.** Physician contracts provide additional workforce hours to a specialty outside of the constraints of a VA PAID employment arrangement. For specialty practices with limited productivity, these contractual arrangements can be re-evaluated to ensure sufficient workload for VA PAID staff.

c. **Evaluation of Support Staffing Needs.**

(1) Adequate support staff for the specialty/discipline provider group practice is necessary to promote efficiencies in the specialty practice. Where possible and practical, in accordance with licensure and scope of practice, support staff are assigned duties to assist the specialty provider.

(2) The composition of the care team including Advanced Practice Providers (APPs), support staffing, clinical team staff (e.g., nurses and clinical health technicians) and administrative support staff (e.g., medical support assistants (MSAs) and clerical support) are known to have a positive impact on specialty group practice productivity. For VA medical facilities with limited support staff, increasing support staffing in the form of hiring or reallocating personnel may be an appropriate approach to ensuring productivity of the provider workforce.

(3) Emerging technologies and practice enhancements such as the use of scribes can also be used as an approach to using support staff to maximize productivity of the provider workforce.

d. **Equitable Assignments.** It is recommended that the facility Chief of Staff (COS), Associate Director of Patient Care Services (ADPCS), and other relevant facility leadership work with the specialty provider group practice service chief to ensure equitable assignments for each individual specialty provider group practice physician as is appropriate. Unequal assignments of workload can result in asymmetric utilization of provider time and result in reduced productivity.

e. **Advanced Workforce Planning.** Where current specialty workload demand does not justify existing staffing levels, VA medical facilities can engage in advanced

workforce planning to ensure that future staffing levels appropriately meet the demand for specialty services.