PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook defines the policy for monitoring and assessing specialty provider group practice productivity and associated staffing. For the purpose of this VHA Handbook and associated VHA Directive 1065 this policy excludes Mental Health and Emergency Medicine which have individual policies regarding productivity and staffing.

2. SUMMARY OF CONTENT: This VHA Handbook sets forth policy for productivity and staffing guidance for Specialty Provider Group Practice providers. This is a new VHA Handbook.

3. RELATED ISSUES: VHA Directive 1065.

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: None.

6. RECERTIFICATION: This VHA Handbook is due to be recertified on or before the last working day of May 2020.

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Interim Under Secretary for Health

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PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE HANDBOOK

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PRODUCTIVITY AND STAFFING GUIDANCE FOR SPECIALTY PROVIDER GROUP PRACTICE HANDBOOK

1. PURPOSE: This Veterans Health Administration (VHA) Handbook defines the policy for monitoring and assessing specialty provider group practice productivity and associated 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. BACKGROUND:

a. This VHA Handbook defines a nationwide guidance on the staffing of VA medical facilities in order to ensure that such facilities have adequate staff for the provision to Veterans of appropriate, high-quality care and services.

b. In June 2012, the Under Secretary for Health charged a VHA Task Force on Specialty Physician Productivity and Staffing Plan with developing productivity models for specialty provider group practice in VHA. This Task Force was asked to establish a staffing model that includes productivity standards and other criteria for a full robust model to address overall staffing needs.

c. To address the Under Secretary for Health charge, the Office of Productivity Efficiency and Staffing (OPES) developed Physician Productivity, Benchmarks & Study Data as a data source, by considering the management of:

(1) Specialty provider group practice practitioners; and

(2) Ancillary health care personnel.

d. The Physician Productivity, Benchmarks & Study Data, Specialty Physician Productivity Report and Specialty Productivity Access Report and Quadrant Tool (SPARQ) provides for a Relative Value Unit (RVU)-based modeling to measure specialty provider group practice level-based productivity and staffing. The tool defines productivity as the ratio of total Relative Value Unit (RVU) for the entire specialty provider group practice Full Time Equivalent Employees, and more specifically, work RVU (wRVU)/Physician worked Clinical Full-Time Equivalent [FTE (c)]. For purposes of physician productivity measurement, only the specialty group practice physician clinical work component of the RVU (wRVU) value was utilized.

e. Pilot sites were spread across four Veterans Integrated Service Networks (VISN), and were asked to validate and refine:

(1) **Workload.** RVUs are assigned to VHA workload by extracting Current Procedural Terminology (CPT)–coded clinical encounters from the Veterans Health Information System Technology Architecture (VistA). Each CPT code is converted to an RVU using the National Physician Fee Schedule Relative Value File supplemented with Ingenix Gap codes and an imputed Compensation and Pension (C&P) Exam RVU. Current capture of specialty group practice workload incorporates all Patient Care Encounter (PCE) reported workload. Specialty classification of this workload is derived from the specialty group practice provider active person class code assignment. At the current time, there is no business requirement to capture inpatient

(daily evaluation and management) services in the form of PCE reported workload. Outpatient clinic and procedure professional workload is derived from specialty clinic stop codes (also known as Managerial Cost Account Office (MCAO) identifiers). Specialty provider group practice time devoted to patient care 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.

(2) **Workforce.** The number of FTEE specialty provider group practice practitioners was extracted from the Personnel and Accounting Integrated Data (PAID) file and only the clinical portion of FTEE (clinical) [FTE(c)] was considered.

NOTE: *The fraction of time the employee devoted to administration, teaching, and research, as specified in the current MCAO labor mapping and Physician and Dentist Labor Mapping (VHA Directive 2011-009), was excluded from the FTE(c) calculation. Furthermore, the time spent in inpatient bed day of care time was isolated for the specialty group practices. The support staffing ratios (nursing, clerical) for specialty provider group practice practitioners, i.e. on a 'per provider' basis, at the various VA medical facilities are also reported in Physician Productivity Cube for use by the facility Resource Management Boards (RMB) as described in assessing group practice productivity.*

(3) **Validation of Specialty and FTE(c).** VISN pilots validated specialty group practice FTE(c) by ascertaining the correct specialty designation [person class code –Person Class File Taxonomy (VHA Directive 2012-003) and Patient Care Data Capture Directive (VHA Directive 2009-002) and the proportion of clinical care time derived from MCAO labor mapped time. This validation resulted in refined business rules, for the consistent labor mapping for research, education and administrative activities and then applied in the VISN pilots.

(4) **Productivity Modifiers.** Factors associated with productivity have been found to be: Practice Setting (Facility Complexity Level), Teaching Mission (Residents), Support Staff Ratios, Associate Providers (Advance Practice Registered Nurses (APRN) and Physician Assistants) and access to certain capital infrastructure (such as Operating Rooms (OR), procedure areas and examination rooms).

f. The four VISN pilot sites found in this validation:

(1) The observed productivity [wRVU per FTE(c)] for each specialty provider group practice service was utilized to calculate the descriptive statistics. As a baseline the interquartile range was used as an acceptable productivity range and specialty practices above or below this threshold were requested to review the data for accuracy and data integrity.

(2) Factors associated with productivity were found to be the aforementioned productivity modifiers (see paragraph 2. e. (4)) and are contained in Physician Productivity, Benchmarks & Study Data and SPARQ.

3. DEFINITIONS:

a. **Acceptable Group Practice Range of Productivity.** The productivity within the mean +/- 1 StDev level is considered an acceptable range of productivity, taking care not to compromise quality and patient access standards. Productivity above the mean + 1StDev is considered a best practice, after review of mapping and other data inputs confirm accuracy. Productivity below the mean minus 1 StDev, 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 more than 1- StDev below the mean for its specialty and medical center complexity group, 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 http://opes.vssc.med.va.gov/PhysicianProductivityStudyData/Pages/default.aspx)

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 Handbook, 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 Handbook and associated Directive (VHA Directive 1065) 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.

4. SCOPE: This VHA Handbook applies to each VA medical facility as defined by VHA Directive 1065.

5. STAFFING AND PRODUCTIVITY GUIDELINES: The goal of specialty provider group practices is to achieve a yearly clinical productivity value above the level of the mean minus 1 StDev of observed wRVU per FTE(c) averaged over all physicians in the various individual specialty services and listed by facility complexity rank. These values are calculated utilizing certain elements and methodology (See VHA Directive 1065 paragraph 3.g.(3).

a. **Productivity Specialty Provider Group Practice Algorithms (Productivity Algorithms).** The purpose of these productivity algorithms is to assist VA medical facility leaders in the management of specialty provider group practice services with resources and ensure appropriate staffing for specialty provider group practice services across all VA medical facilities.

(1) **Minimum.** There are no national minimum productivity standards for individual specialty provider group practice practitioner. There are thresholds, both low and high for specialty provider group practice physician (recognizing the heterogeneity of individual's contributions and associated wRVU levels) which trigger mandatory review of the specialty provider group practice service needs by the Chief of Staff (COS) in conjunction with specialty provider group practice Service Chiefs and when appropriate remediation plans.

(2) **Maximum.** There is no maximum productivity standard for individual practitioners or specialty physician group practice, so long as healthcare quality and access is not compromised. Indicators of excessive workload might be loss of quality, diagnostic accuracy or lack of availability of the physician for consultations and Associate Physician Providers (APP), resident or technologist supervision.

NOTE: *Current specialty group practice productivity levels are based on fiscal year (FY) 2013, which has been used to establish a baseline during the initial implementation period for FY 2014-2015, and then will be reevaluated by Deputy Under Secretary for Health for Policy and Management and Deputy Under Secretary for Health for Clinical Operations and then every two years at minimum. 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 an Integrated Delivery System [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®, etc.) may be better served by a focus on efficiencies.*

b. **Ideal Productivity.** The ideal specialty service staffing model considers the productivity of the specialty provider group practice, access and quality standards, the complexity of the work, and the needs of the population served.

(1) **Specialty Provider Group Practice Staffing.** Specialty provider group practice staffing is defined as adequate when the specialty provider group practice service productivity falls within the acceptable range, performance standards are being met, and the needs of the population are served. Activities that are appropriate for a specialty provider group practice practitioners include, but are not limited to, the following:

(a) Screening of consults notes/orders of APP or resident, to ensure the notes/orders are appropriate, along with documentation when appropriate for APP and resident interactions;

(b) Setting clinical specialty protocols, templates, and service agreements;

(c) Obtaining informed consent;

(d) Supervising staff of the specialty team;

(e) Performing clinical procedures;

(f) Interpreting and reporting specialty studies (e.g., Cardiac Catheterization, pulmonary function test, etc.);

(g) Conferring with other members of the medical provider group involved in the patient's care, and;

(h) Follow up of test results ordered by the specialty provider group practice physician and follow up of same with patient or directed to the referring physician and/or team.

(2) **Support Staffing.** Sufficient support staff for the specialty provider group practice service needs to be assigned such that Veterans receive service in conformity with ACAP goals, and specialty provider group practice practitioners are not drawn away from the performance of direct or non-face-to-face (telemedicine) patient interaction, procedures, and the interpretation of laboratory or radiologic results. Duties that are performed by appropriate specialty provider group practice support staff, and that are not appropriate for specialty provider group practice practitioners, include, but are not limited to, the following:

(a) Scheduling of patients;

(b) Routine intake screening of patients;

(c) Monitoring of vital signs;

(d) Chaperoning of providers as appropriate;

(e) Tracking abnormal test results; and

(f) Administrative filing of specialty study reports (other than direct electronic or Computerized Patient Record System (CPRS) reportage).

NOTE: *COS in conjunction with Service Chiefs and other facility leaders should assess their specialty provider group practice support staff levels relative to VHA averages as documented on the OPES Website.*

c. **Labor Mapping.** COS, in conjunction with the Service Chief, will appropriately labor map all specialty provider group practice practitioners, by assigning the fraction of time devoted to clinical care time, administration, teaching, and research Labor assignments, as entered in MCAO, are the basis for computing Physician [Medical Doctor (MD) and Doctor of Osteopathic Medicine (DO)] FTE(c).

d. **Clinical Care Time Specialty Provider Group Practice Practitioners.** Clinical care time is the time left when justifiable administrative, teaching, and research hours have been subtracted. Examples of clinical duties include:

(1) Reviewing medical records;

(2) Researching diseases of active patients;

(3) Setting protocols;

(4) Interviewing patients; monitoring APP, residents, technologists, and patients clinical and operative procedures;

NOTE: *Telehealth modalities are included.*

(5) Interpreting diagnostic studies;

(6) Writing and approving reports and notes;

(7) Consulting or reviewing clinical information with the treating team on an as needed basis;

(8) Preparing for and attending scheduled multidisciplinary conferences;

(9) Attending medical courses for Continuing Medical Education (CME) credit; and

(10) Reading out current specialty studies with residents.

NOTE: *It is strongly recommended that clinical duties be recorded daily, for example on a duty roster, so that calculation of FTE(c) can be verified.*

e. **Research Administrative and Education Time for Specialty Provider Group Practice Practitioners.** Guidelines detailing activities of research, administrative and education time (See APPENDIX A).

f. **Mapping of Authorized Absence.** For the purpose of this Handbook, authorized absence (AA) to give lectures, research presentations, or for administrative VA business is to be reflected as teaching, research, or administrative time, as appropriate.

SPECIALTY PROVIDER GROUP PRACTICE EXAMPLES

a. The following scenarios illustrate how to labor map practitioners with a range of different responsibilities:

NOTE: *The productivity monitor does not account for the frequency or difficulty of on-call responsibilities, attendance at clinical conferences, or the presence or lack of productivity modifiers such as number of specialty provider group practice support staff. Guidelines for mapping of Research and Educational activities are noted in Appendix B. 80 PAID hours consists of a biweekly 40 hour per two week pay period.*

b. **Clinical Care.** Dr. James Scott is a full-time VA specialty provider group practice cardiologist whose clinical responsibilities consist entirely of supervising cardiac catheter laboratory technologists, interpreting cardiologic imaging studies, and consulting in response to referring clinicians. He may also attend on the Cardiac Care Unit, and attend cardiology clinic. He is not responsible for managing any programs and does not serve on any VA medical facility or Veterans Integrated Service Network (VISN) committees. He teaches residents on certain days in concert with certain of the clinical duties described above, but does not give lectures. He is not involved in any educational didactic courses or research. In this scenario, all 80 of Dr. Scott's PAID hours need to be mapped to Clinical Care Account Level Budgeter Cost Centers (ALBCCs).

c. Dr. Leo Alvarez is a half-time VA specialty provider group practice rheumatologist who spends 50 percent of his time attending on the rheumatology consultative service, and 50 percent of his time attending in the rheumatology clinic. He is not involved in any educational programs or research. In this scenario, all 40 of Dr. Alvarez's PAID hours need to be mapped to Clinical Care ALBCCs.

d. **Administration.** Dr. Shelia Hollingsworth is the Chief of Surgery at a large VA medical facility. She spends one-half of her time handling administrative responsibilities as a specialty provider group practice Service Chief. Her administrative duties include attending VISN Surgery Committee meetings. She spends the other half of her time as a general surgeon. She is not involved in any educational programs or research. In this scenario, 40 of Dr. Hollingworth's PAID hours need to be mapped to ALBCCs in Administration and 40 of those hours need to be mapped to Clinical Care ALBCCs:

e. **Education.** Dr. Anthony Chin is full-time academic infectious disease specialist working at a VA medical facility affiliated with a medical school. He is the Residency Director for the medicine residency program. He spends 1 hour per day giving a didactic lecture and showing teaching files to residents and medical students. In addition, he spends approximately 3 hours per week in various administrative tasks arising from this position, such as developing curriculum, planning schedules, and attending meetings at the medical school. He also spends approximately 4 hours per week related to the administrative management of the medical center's Infection Disease Control program, reviewing data on trends in concert with the infectious disease Coordinator. He spends the remaining 70 percent of his time in the clinic and

consultative service. He is not involved in research. In this scenario, 30 percent of Dr. Chin's PAID hours (24 hours) need to be mapped to ALBCCs in Education and 70 percent of those hours (56 hours) need to be mapped to Clinical Care ALBCCs.

f. **Research.** Dr. Charles Singh is a full-time VA specialty provider group practice endocrine physician who recently received a full-time Career Development Award in health services research. He continues to attend on the endocrine specialty provider group practice service two half days (eight hours total) a week. The other 4 days per week he spends involved in his research activities. He is not involved in any educational activities. In this scenario, 80 percent of Dr. Singh's PAID hours (64 hours) need to be mapped to ALBCCs in Research and 20 percent of those hours (16 hours) need to be mapped to Clinical Care ALBCCs.

g. **Appropriate CPT Coding.** Specialty provider group practice practitioners are not to 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 Correct Coding Initiative.

h. **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.

i. **Monitors of Specialty Provider Group Practice Physician Productivity.** Each year OPES will conduct a specialty provider group practice productivity study in collaboration with the Office of Patient Care Services and the National Surgery Office. This annual study will result in the publishing of specialty care provider and staffing productivity guidelines in the fiscal year (FY) Physician Specialty Workforce Report.

j. **Considerations for Remediation.** Plans for improving specialty provider group practice physician productivity must be developed if a specialty provider group practice productivity is low. Elements of such remediation plans could include implementing:

(1) Telemedicine (or other adjuncts) to bring more work to underutilized personnel,

(2) Re-evaluating the need for or cost of physician contracts,

(3) Evaluating current FTEE staffing resulting in:

(4) Proposed hiring of:

(a) Nurses;

(b) Clerks; or

(c) Other related support personnel; or

(5) Reallocation of personnel may be used as a tool to increase productivity, but should be weighed against:

(a) The need to staff other specialty provider group services;

1. Maintaining access, quality, and diagnostic accuracy of procedures provided;

2. Supervising APP, residents, and technologists;

3. Staffing clinical conferences;

(b) Providing consultations;

(c) Meeting national performance measures for timeliness of care;

(d) Evaluating clinic space/exam rooms/procedure-treatment rooms; and

(e) Evaluating equipment needs for the delivery of specialty care group practice services.

NOTE: *Remediation plans should be forwarded to the VA medical facility Director (via the local Resource Management Boards (RMB), if desired by the VA medical facility Director) and then to the VISN for review and concurrence.*

k. **Equitable Assignments.** It is recommended that the COS work with specialty provider group practice Service Chief to ensure that are equitable assignments for each individual specialty provider group practice physician is appropriate.

NOTE: *The COS in conjunction with the specialty provider group practice Service Chief may use these additional factors in an informal way when comparing physician productivities and setting duty assignments. In addition, they may use indicators of specialty provider group practice productivity when assigning duties, such as teaching and research, as relevant to the mission of the specialty provider group practice service.*

l. **Workload for Contracted Care and Without Compensation.** Although the productivity performance standard applies to the specialty provider group practice as a whole, COS, in conjunction with their specialty provider group practice Service Chiefs, should track productivity for each VA 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.

NOTE: *Physician Productivity, Benchmarks & Study Data should be used to calculate MD or DO wRVU, which can be found in the VHA Physician Productivity Web Portal.*

m. **Calculating Physician Productivity.**

(1) **VA Employee Specialty Provider Group Practice.** Instructions for calculating physician productivity are as follows: *FTE(*c) for individual employees is calculated as= = (Total PAID hours per biweekly pay period) – (research, education and administration)

NOTE: *Cautionary steps should be taken to ensure workload is not duplicated at multiple facilities. If a specialty provider group practice physician conducts telemedicine related clinical work for another VA medical facility, but is not assigned a fraction of their appointment to that facility, then the workload that the specialist performs at the secondary facility needs to be included at their primary location. The exchange wRVU reports as needed to obtain a complete accounting.*

(2) **Contracted Care Physician FTE(c).** The FTEE of contractors may be corrected for percent time not assigned to clinical duties, if the contract states that the contractor is paid to provide teaching, research or administrative services, using official MCAO definitions defined in current VHA Directive 2011-009, Physician and Dentist Labor Mapping. The fraction of time devoted to teaching, research, and clinical duties must be specified by the contract. If the VA medical facility contracts with a specialty provider group practice who staff a position from a pool of practitioners in rotation, then the productivity of the contract can be monitored as a group. In that case, the wRVU is the sum of the wRVU for the contract, and the FTE(c) for the contract: w(RVU) for contracted care provider Physician FTE(c)= ∑ {(wRVU for the contract) + [FTE (c)]}

(3) **Correction for Contractor Salary.** The FTEE of contract practitioners does not need to be adjusted by salary for the purposes of local productivity monitoring, but it will be so corrected in the national yearly report. Contractor FTE(c) = (fraction of time clinical) x (FTEE).

(4) Per Diem or Locum Tenens Contractor. The FTEE of contractors paid on the basis of time worked, such as per diem or locum tenens contractors, may be computed by: Per diem contractor FTE(c) = [(fraction of time clinical) x (hours on service.)] 520

NOTE: *This formula only applies to a quarter of year period of time, where the number of hours on service are usually the number of days on service times eight. The fraction of time clinical is usually one. Health Care Resources Contracting: Education Costs of Physician and Dentist Resident Training Pursuant to Title 38 United states Code 8153 (VHA Handbook 1400.10), outlines the procedures for contracting with practitioners either on the basis of time or per procedure (paid by the study).*

(n) **Exempt Physician.** The following specialty provider group practice practitioners do not need to be tracked in the quarterly report:

(1) Specialty provider group practice practitioners who have no clinical assignment;

(2) Specialty provider group practice practitioners who work without compensation;

(3) Specialty provider group practice contract practitioners who are paid per procedure, rather than by the hour or FTE;

(4) Specialty provider group practice contractors that cover on-call emergency duties only; and

(5) A contract that is staffed for fewer than 5 days of service per quarter. When deciding whether contracted position(s) are staffed fewer than 5 days per quarter, add the days of attendance of all practitioners in the contract

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GUIDANCE FOR LABOR MAPPING SPECIALTY PROVIDER GROUP PRACTICE

NOTE: *Labor mapping for all Specialty Providers Group Practice as defined by this Handbook Section 4. a.*

Section 1: Research - Mapping Allocations		
Research Activity	**Maximum Suggested FTEE Allocation**	**Maximum Suggested Hours per week**
Principal Investigator (PI) Merit review	0.380	15.2
Chair on VA Cooperative Studies Program (CSP)	0.500	20.0
Site PI on Merit/VA CSP	0.250	10.0
PI NIH ROI*	0.380	15.2
VA Career Development Award (CDA)	0.750	30.0
Major Foundation Awards	0.250	10.0
PI of VA Center of Excellence	0.500	20.0
Mentor of VA CDA	0.060	2.4
New Investigator	0.500	20.0
Chair, Institutional Review Board (IRB) or Institutional Animal Care and Use Committee (IACUC)	0.500	20.0
Chair, Institutional Bio-safety Committee (IBC) / Subcommittee on Research Safety (SRS) or Research and Development Committee	0.130	5.2
Member, IRB, IACUC	0.130	5.2
Member, IBC/SRS, R&D Committee	0.060	2.4
Other Research duties not covered above approved by COS, i.e., (peer reviewer of manuscripts referred for abstracts, editor of book, monograph, or other publications)	0.025	1.0

NOTE**:** *NIH grants are managed through the affiliate or the nonprofit corporation. VA time allocation varies depending on the particular research project.*

Section 2: Administrative – Mapping Allocations		
Administrative Activity	**Maximum Suggested FTEE Allocation**	**Maximum Suggested Hours per week**
Complexity 1a		
Chief of Staff	1.000	40.0
ACOS or Deputy COS	1.000	40.0
Service Chief of Large Service (i.e., Medicine, Surgery; > 25 direct report FTEE [including contracted care providers]).	0.700	28.0
Service Chief of Small Service (i.e., Dental, Neurology; < 25 direct report FTEE [contracted care providers]).	0.400	16.0
Assistant Chief of Large Service (i.e., Medicine, Surgery; > 25 direct report FTEE [including contracted care providers]).	0.550	22.0
Assistant Chief of Small Service (i.e., Dental, Neurology; < 25 direct report FTEE [including contracted care providers]).	0.350	14.0
Section Chief of Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 5 direct report FTEE [including contracted care providers]).	0.400	16.0
Section Chief of Small Section (i.e., Allergy / Immunology, Urology; < 5 direct report FTEE [including contracted care providers]).	0.300	12.0
Program Lead within Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 5 direct report FTEE [including contracted care providers]).	0.200	8.0
Program Lead within Small Section (i.e., Allergy / Immunology, Urology; < 5 direct report FTEE [including contracted care providers]).	0.150	6.0
Chair, Hospital Committee	0.125	5.0
Supervision, for every 15 direct reports (if not in a formal position listed above)	0.100	4.0
Committee Membership or Performance Improvement Activities	0.025	1.0
Other Administrative duties not covered above approved by COS	0.025	1.0

Administrative Activity	Maximum Suggested FTEE Allocation	Maximum Suggested Hours per week
Complexity 1b		
Chief of Staff	1.000	40.0
ACOS or Deputy COS	0.750	30.0
Service Chief of Large Service (i.e., Medicine, Surgery; > 15 direct report FTEE [contracted care providers]).	0.600	24.0
Service Chief of Small Service (i.e., Dental, Neurology; < 15 direct report FTEE [contracted care providers]).	0.300	12.0
Assistant Chief of Large Service (i.e., Medicine, Surgery; > 15 direct report FTEE [including contracted care providers]).	0.450	18.0
Assistant Chief of Small Service (i.e., Dental, Neurology; < 15 direct report FTEE [including contracted care providers]).	0.250	10.0
Section Chief of Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 4 direct report FTEE [including contracted care providers]).	0.300	12.0
Section Chief of Small Section (i.e., Allergy / Immunology, Urology; < 4 direct report FTEE [including contracted care providers]).	0.200	8.0
Program Lead within Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 4 direct report FTEE [including contracted care providers]).	0.150	6.0
Program Lead within Small Section (i.e., Allergy / Immunology, Urology; < 4 direct report FTEE [including contracted care providers]).	0.100	4.0
Chair, Hospital Committee	0.125	5.0
Supervision, for every 15 direct reports (if not in a formal position listed above)	0.100	4.0
Committee Membership or Performance Improvement Activities	0.025	1.0
Other Administrative duties not covered above approved by COS	0.025	1.0

Administrative Activity	Maximum Suggested FTEE Allocation	Maximum Suggested Hours per week
Complexity 1c		
Chief of Staff	1.000	40.0
ACOS or Deputy COS	0.500	20.0
Service Chief of Large Service (i.e., Medicine, Surgery; > 10 direct report FTEE [including contracted care providers]).	0.500	20.0
Service Chief of Small Service (i.e., Dental, Neurology; < 10 direct report FTEE [including contracted care providers]).	0.300	12.0
Assistant Chief of Large Service (i.e., Medicine, Surgery; > 10 direct report FTEE [contracted care providers]).	0.350	14.0
Assistant Chief of Small Service (i.e., Dental, Neurology; < 10 direct report FTEE [including contracted care providers]).	0.250	10.0
Section Chief of Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 3 direct report FTEE [including contracted care providers]).	0.200	8.0
Section Chief of Small Section (i.e., Allergy / Immunology, Urology; < 3 direct report FTEE [including contracted care providers]).	0.200	8.0
Program Lead within Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 3 direct report FTEE [including contracted care providers]).	0.100	4.0
Program Lead within Small Section (i.e., Allergy / Immunology, Urology; < 3 direct report FTEE [including contracted care providers]).	0.100	4.0
Chair, Hospital Committee	0.125	5.0
Supervision, for every 15 direct reports (if not in a formal position listed above)	0.100	4.0
Committee Membership or Performance Improvement Activities	0.025	1.0
Other Administrative duties not covered above approved by COS	0.025	1.0

Administrative Activity	Maximum Suggested FTEE Allocation	Maximum Suggested Hours per week
Complexity 2		
Chief of Staff	1.000	40.0
ACOS or Deputy COS	0.400	16.0
Service Chief of Large Service (i.e., Medicine, Surgery; > 5 direct report FTEE [including contracted care providers]).	0.500	20.0
Service Chief of Small Service (i.e., Dental, Neurology; < 5 direct report FTEE [including contracted care providers]).	0.300	12.0
Assistant Chief of Large Service (i.e., Medicine, Surgery; > 5 direct report FTEE [including contracted care providers]).	0.350	14.0
Assistant Chief of Small Service (i.e., Dental, Neurology; < 5 direct report FTEE [including contracted care providers]).	0.250	10.0
Section Chief of Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 2 direct report FTEE [including contracted care providers]).	0.200	8.0
Section Chief of Small Section (i.e., Allergy / Immunology, Urology; < 2 direct report FTEE [including contracted care providers]).	0.200	8.0
Program Lead within Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 2 direct report FTEE [including contracted care providers]).	0.100	4.0
Program Lead within Small Section (i.e., Allergy / Immunology, Urology; < 2 direct report FTEE [including contracted care providers]).	0.100	4.0
Chair, Hospital Committee	0.125	5.0
Supervision, for every 15 direct reports (if not in a formal position listed above)	0.100	4.0
Committee Membership or Performance Improvement Activities	0.025	1.0
Other Administrative duties not covered above approved by COS	0.025	1.0

Administrative Activity	Maximum Suggested FTEE Allocation	Maximum Suggested Hours per week
Complexity 3		
Chief of Staff	1.000	40.0
ACOS or Deputy COS	0.300	12.0
Service Chief of Large Service (i.e., Medicine, Surgery; > 5 direct report FTEE [including contracted care providers]).	0.300	12.0
Service Chief of Small Service (i.e., Dental, Neurology; < 5 direct report FTEE [including contracted care providers]).	0.100	4.0
Assistant Chief of Large Service (i.e., Medicine, Surgery; > 5 direct report FTEE [including contracted care providers]).	0.200	8.0
Assistant Chief of Small Service (i.e., Dental, Neurology; < 5 direct report FTEE [including contracted care providers]).	0.200	8.0
Section Chief of Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 2 direct report FTEE [including contracted care providers]).	0.100	4.0
Section Chief of Small Section (i.e., Allergy / Immunology, Urology; < 2 direct report FTEE [including contracted care providers]).	0.100	4.0
Program Lead within Large Section (i.e., Cardiology, Pulmonary / Critical Care; > 2 direct report FTEE [including contracted care providers]).	0.050	2.0
Program Lead within Small Section (i.e., Allergy / Immunology, Urology; < 2 direct report FTEE [including contracted care providers]).	0.050	2.0
Chair, Hospital Committee	0.125	5.0
Supervision, for every 15 direct reports (if not in a formal position listed above)	0.100	4.0
Committee Membership or Performance Improvement Activities	0.025	1.0
Other Administrative duties not covered above approved by COS	0.025	1.0

Section 3 Education – Mapping Allocations:		
Education Activity	**Maximum Suggested FTEE Allocation**	**Maximum Suggested Hours per week**
Associate Chief of Staff for Education or similar title (includes others who serve in the functional role of the Designated Education Officer or DEO)		
Number in facilities with 100 or > GME positions	1.000	40.0
Number in facilities with 50 - 99 GME positions	0.500	20.0
Number in facilities with 20 - 49 GME positions	0.400	16.0
Number in facilities with 1 - 19 GME or AH positions	0.300	12.0
Program Director for VA-based Physician/Associated Health Program		
Number in program > 10	0.500	20.0
Number in program = 5 - 10	0.400	16.0
Number in program = 1 - 4	0.400	16.0
VA-based Program Director for an Affiliate-sponsored Physician or Associated Health (AH) Program	0.500	20.0
Associate Program Director for VA or Affiliate-based Physician/Associated Health Program	0.500	20.0
Internal Medicine	0.500	20.0
Number in program > 10	0.300	12.0
Number in program = 5 - 10	0.200	8.0
Number in program = 1 - 4	0.200	8.0
Core Clinical Faculty	0.375	15.0
Other Clinical Faculty	0.250	10.0
VA Site Director	0.500	20.0
Number in program > 10	0.500	20.0
Number in program ≤ 10	0.300	12.0
Medical School Clerkship Director (or analogous Associated Health Position)	0.500	20.0

Education Activity	Maximum Suggested FTEE Allocation	Maximum Suggested Hours per week
Other Educational Duties approved by COS to include teaching didactic sessions, developing educational products, presentations at grand rounds, participation in interviews for prospective students, completion of trainee evaluations, education administration, service on university affiliate committees, scholarly activities (i.e., abstracts, workshops) entered as average hours per week over a year period of time.	0.025	1.0

NOTE: *Examples of such time spent in education or research are as follows:*

1. Teaching time is time spent showing teaching files to residents and students, as is time spent preparing and delivering lectures.

2. Research time is time spent:

a. *Conducting approved clinical research protocols*;

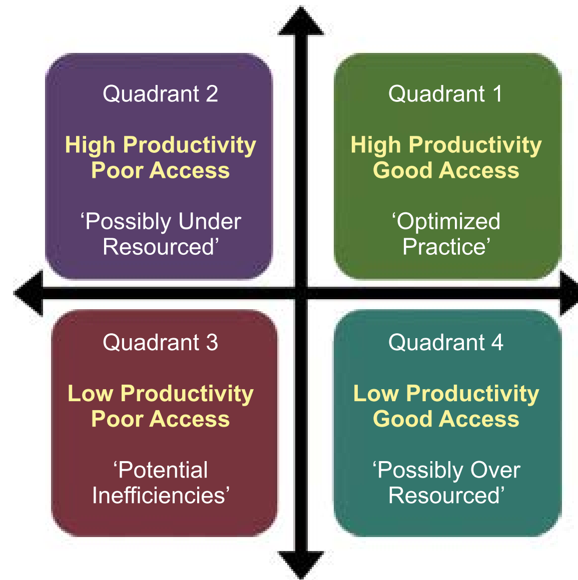
b. Attending research committee meetings;

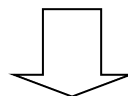
c. Conducting funded and/or approved laboratory research activities, and

d. Preparing or presenting scientific abstracts and publications.

APPENDIX C

SPECIALITY PROVIDER GROUP PRACTICE PRODUCTIVITY ACCESS REPORT AND QUADRANT TOOL (SPARQ)





Specialty is in high productivity, positive (good) access
No action

Specialty is in high productivity, negative (poor) access
Review for potential need of increased resources, contracted care provider relief

Specialty is in low productivity, positive (good) access
Review for potential expansion to other facilities with need via TeleHealth, or interfacility sharing of resources to fully utilize capacity

Specialty is in low productivity, negative (poor) access

⇩ **Begin examination Of Date Streams**

⇩ **Drill down to Provider Level for outliers**

⇩ **Examine Space for Adequacy**

⇩ **Examine Support Staff Ratios**

SPECIALTY PRACTICE DATA INPUT REVIEW

INPUT	PROCESS OWNER	POSSIBLE CAUSE OF INACCURACIES
NPI #	Variable	Inaccurate or 'corrupted' file reduces workload.
Taxonomy	Variable	Inaccurate or 'corrupted' file reduces workload.
Costing data	HR	Inaccurate organization codes, organization chart, PAID file
Labor Map	Clinical Svc (usual)	Inaccurate estimation of clinical, education, or research time may cause under or over estimates of workload.
Vesting	Clinical – Primary Care	Lack of vested status reduces VERA patient complexity and will diminish workload impacts.
Stop Code	MCAO	Improper stop code assignment may diminish workload.
Clinic Set Up	Business Offc/HAS	Naming convention affects whether proper note is selected for a clinic encounter, affecting workload, if the note is not linked to the open scheduled encounter.
Registration	Business Offc/HAS	Registration allows for proper note to be accessed the clinician, without which the clinician begins a 'new' note that does not then link with the clinic encounter.
Telehealth	Business Offc/HAS Clinical	Special case – specific codes and proper set up necessary for appropriate data capture. As a new endeavor, there are elements still being set up.
Open/Close	Clinical	Must open the clinic note in VISTA and document a notes at appropriate level of care given – note must link to the open encounter scheduled.

INPUT	PROCESS OWNER	POSSIBLE CAUSE OF INACCURACIES
Sign note	Clinical	Must occur within 7 days for workload capture.
Assign Provider	Resident Attending	If resident does not acknowledge attending, lower taxonomy used, major reduction in workload.
Code Encounter	Resident Attending	If improper encounter code used, inaccurate level will occur.
Code	Nursing, Pharmacists, IV care team	Open notes in Primary Care when utilized for Flu Shots, etc. may not be available for providers if Nurse/others assign themselves as primary Providers. IF nurse uses Primary Care provider assignment and the patient is seen in a specialty, the Primary Care Provider may receive credit erroneously.
Coding	HIMS	Upon review, must validate accurately the level of care that is documented.
Transmission	Business Offc/HAS	Responsible for transmission to Austin for VSSC use.
Consult Set Up	Business Offc/HAS	Lexicon 'button' – if **off**, any free text; if **on**, can only enter a coded indication from a list.