Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1231
Transmittal Sheet
November 15, 2016

OUTPATIENT CLINIC PRACTICE MANAGEMENT

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy for outpatient clinic practice management.

2. SUMMARY OF CONTENT: This new VHA directive establishes the requirements for clinic practice management capability, responsibilities, definitions, and processes for outpatient clinic practice management.

3. RELATED ISSUES: Public Law 113-146 Veterans Access, Choice and Accountability Act of 2014, VHA Directive 1230, Outpatient Scheduling Processes and Procedures; VHA Directive 1232, Consult Processes and Procedures; VHA Directive 1090, Telephone Access to Outpatient Clinical Care.

4. RESPONSIBLE OFFICE: The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this directive. Questions relating to this directive may be referred to Executive Director of Access and Clinic Administration Program Office via Email at vha10NC10Action@va.gov.

5. RESCISSION: None.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of November 2021. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

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OUTPATIENT CLINIC PRACTICE MANAGEMENT

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for the management of outpatient care. This policy identifies and defines key clinical access and administrative standards to optimize Veterans' access to health care and provides instruction for how to implement the standards. This directive represents VHA's policy on this issue; all national or local policies are superseded to the extent that they conflict with this directive, and will not be followed. **AUTHORITY:** 38 U.S.C. 7301(b).

2. BACKGROUND

a. VHA's mission is to, "Honor America's Veterans by providing exceptional health care that improves their health and well-being." In order to achieve this mission, VHA must provide timely, predictable, high quality, standardized outpatient care that is responsive to the changing needs of Veterans, their families, and the VA health care system as a whole.

b. MyVA Access ensures that VHA is engaged in the transformation to a Veteran-centered service organization. To demonstrate our commitment, VHA developed the MyVA Access Declaration, a set of principles that defines and communicates our actions to improve and ensure access to care. This directive provides the framework for a sustainable infrastructure within VHA to ensure the MyVA Access principles are embedded across the organization.

c. This directive establishes a national Clinic Practice Management (CPM) program to provide Veterans with exceptional customer service and timely access to outpatient care services. CPM is intended to support efficient and productive operations.

d. This directive establishes a partnership between the clinical and administrative components of outpatient care. It identifies standards, roles, and key clinical processes that must occur in a timely and reliable fashion in order to achieve VA's mission, as guided by the VHA Strategic Plan, the Blueprint for Excellence, and ICARE values.

3. DEFINITIONS

a. **Advanced Clinic Access Principles.** Advanced clinic access principles provide basic guidelines for maintaining timely access "for" appointments, "at" appointments and "between" appointments. These principles provide high leverage changes which facilitate the ability to balance clinic supply and demand, streamline clinic flow, and allow for a more patient-centered, seamless flow for the Veteran across outpatient clinic services.

b. **Bookable Clinic Hours.** Bookable clinic hours are the number of hours allotted in each provider's clinic schedule for direct patient care. Bookable clinic hours include face-to-face and virtual patient care time (e.g., telephone visits, tele-health, e-consults,

and face to face visits). The time counted in the calculation must be unrestricted (i.e., no special permission scheduling or blocking of time).

c. **Clinic Cancellation.** Clinic cancellation means an appointment is cancelled by the clinic not the patient. This is also called cancelled by clinic in the Veterans Health Information Systems and Architecture (VistA) scheduling package. Reasons for cancelled by clinic listed in the VistA scheduling package include: Appointment is no longer required; clinic is cancelled; clinic staffing; inpatient status; other; patient death; patient ineligible; scheduling conflict/error; transfer outpatient (OPT) care to other VA; or weather.

d. **Clinical Lead and Administrative Lead.** The Clinical Lead (CL) and Administrative Lead (AL) roles will work in tandem on a daily basis and be responsible for the core processes as listed in the responsibilities section of this VHA directive. Clinical leads are responsible for addressing the staff and processes that occur in the clinical care setting. Administrative leads are responsible for addressing staff and processes that are administrative in support of clinical care.

e. **Clinic Practice Management Team.** Clinic Practice Management Team describes the combination of facility leadership, the Group Practice Managers (GPM) and the collective CLs and ALs.

f. **Contingency Planning.** Contingency planning provides for the ability to maintain normal clinic operations in the absence of providers and/or support staff. The intention of the contingency plan is to minimize appointment cancellations and thus prevent backlog and delayed patient care. Resource to help create local contingency plan policy can be found in appendix A.

g. **Continuity.** Continuity is defined in VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook**,** paragraph 6.i, or subsequent policy issue, http://www.va.gov/vhapublications/index.cfm.

h. **Direct Patient Care Time.** Direct patient care time is defined in VHA Directive 2011-009, Physician and Dentist Labor Mapping, or subsequent policy issue, http://www.va.gov/vhapublications/index.cfm.

i. **Emergent Care.** Emergent care is care for a condition for which immediate treatment is required to prevent the loss of life or limb or is required to prevent the progression of a disease process that could lead to the loss of life.

j. **Established Patient.** An established patient is a patient that has had an encounter within the same Decision Support System (DSS) stop code grouping when looking back 24 months, where the previous encounter occurred at one of the facilities (Community-based Outpatient Clinic [CBOC], Division, etc.) under the same parent facility.

k. **Group Practice Manager.** A GPM is a facility-level position meant to oversee access and quality care in the outpatient clinic services. This position should align to

facility Executive Leadership and help coordinate the efforts of the Clinical and Administrative Leads at the service level.

l. **Key Processes.** Key processes are standardized, common processes that the CL and AL have accountability to maintain for their related service within the outpatient clinic. The distinction between clinical and administrative processes is delineated in the Responsibilities section of this directive (see paragraph 5.). Those key processes are:

(1) Advanced Clinic Access (ACA) principles for appointments (balance supply/demand, decrease backlog, decrease appointment types, contingency planning, decrease/shape demand, increase supply),

(2) Scheduling,

(3) Telephone management,

(4) Decreasing no shows and clinic cancellations,

(5) Clinic support,

(6) Consult referrals, and

(7) Training.

m. **Key Systems.** Key systems are standardized, common systems that both the CL and AL have accountability to maintain for their related service within the outpatient clinic setting. Those key systems are:

(1) Training,

(2) Measurement/data analysis,

(3) Customer service,

(4) Auditing,

(5) Leadership/Culture,

(6) Communication and Marketing,

(7) Process Improvement, and

(8) Contingencies/Strategic.

n. **Lower Performing Practices.** Lower performing practices are practices that are contributing to the longest waits for care and/or the lowest level of patient satisfaction as well as the highest degree of inefficiency based on cancelled clinics, no shows, late appointment starts, etc. These lowest performing practices may be targeted as the

highest priority for improvement projects by the facility clinic practice management team.

o. **Make/Buy.** Make/buy is the act of choosing between creating a product/service in-house or purchasing it from an external supplier.

p. **New Patient.** A Veteran is a "new patient" when either (1) the Veteran has not had an encounter within the same stop code grouping when looking back 24 months; or (2) the Veteran had encounter with the same stop grouping when looking back 24 months but the previous encounter did not occur at one of the facilities (CBOC, Division, etc.) under the same parent facility.

q. **Non-Emergent Care Need.** Non-emergent care needs are requests for care which can be seen either in (1) Primary Care or (2) Specialty Care, where the care does not need to be made a high priority for access.

r. **Primary Care Direct Patient Care Time.** Primary Care Direct Patient Care (PCDPC) time is defined in VHA Handbook 1101.02, Primary Care Management Module (PCMM), http://www.va.gov/vhapublications/index.cfm.

s. **Urgent Care Need.** Urgent care need is care for either (1) an acute medical or mental health illness or (2) minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a condition where delay might impair recovery.

4. POLICY

It is VHA policy that Veterans receive the right care, at the right time, in a manner consistent with evidence-based health care practice and the legal authorities vested by Congress. It is VHA policy for every facility to have a clinic practice management program that consists of a partnership between the clinical and administrative outpatient clinical functions in order to achieve optimal access, satisfying, and high quality care strengthening VA's mission. See patient centered care resources: http://vaww.infoshare.va.gov/sites/OPCC/Shared%20Documents/Guidebook%20for%20Patient%20Centered%20Care/OPCCCT%20Guidebook%20for%20Patient%20Centered%20Care.pdf and http://vaww.va.gov/patientcenteredcare/PCC_Guidebook_Self-Assessment/#/home. ***NOTE:*** *These are an internal VA Web sites that are not available to the public.*

5. RESPONSIBILITIES

a. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for access and clinic management including overall review and oversight of corrective measures relating to access to care indicators including but not limited to, Veteran satisfaction, wait time measures, clinic utilization, clinic cancellations, and no-shows at the National, Veteran Integrated Service Network (VISN), and facility levels.

b. **Assistant Deputy Under Secretary for Health for Clinical Operations.** The Assistant Deputy Under Secretary for Health for Clinical Operations or designee is responsible for establishing administrative support and development of clinical access policies and procedures and corresponding oversight of their implementation across VHA. In addition, the Assistant Deputy Under Secretary for Health for Clinical Operations or designee will assist the Deputy Under Secretary for Health for Operations and Management in regularly reviewing and applying corrective measures to address national, VISN, and facility access to care indicators and be responsible for metrics and internal support/compliance for the program.

c. **VISN Director.** The VISN Director is responsible for:

(1) Ensuring Veteran access is optimized within available resources across the VISN. Responding to facility clinical access timeliness needs as informed by the VA medical facility Director pertaining to resources/make/buy in maintaining timely access and quality care for all facility outpatient care services. In responding to timeliness needs, there should be assurance that facilities within their jurisdiction have the resources needed to maintain timely access.

(2) Establishing local policy aligned with National policy.

(3) Ensuring the VISN Chief Medical Officer (CMO) and VISN Access Management designee are accountable to prioritize all VISN facilities to implement the standards of this directive.

d. **VISN Chief Medical Officer.** The VISN CMO is responsible for:

(1) Ensuring, in collaboration with the VISN Director, oversight of all access activities within the VISN.

(2) Oversight of compliance by VISN facilities with the standards of this Directive.

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

(1) Implementing the best structure within their facility to create the following:

(a) At least one full-time Group Practice Manager (GPM).

(b) CL and AL at the service level.

(2) Establishing clinics which are appropriately resourced and functioning to provide both optimal Veteran access and efficiency.

(3) Informing the VISN Director of clinic access needs that exceed the facility resources.

(4) Incorporating Veteran and staff feedback in clinic improvement actions.

(5) Ensuring all provider annual leave is approved at least 45 calendar days in advance of the planned absence or by exception by the Chief of Staff (COS) and communicated to the AL and CL in order to appropriately manage clinic scheduling.

(6) Ensuring the following for scheduling at the facility:

(a) Appropriate levels of scheduling staff resources are available to meet patient needs.

(b) Excellent scheduling customer service levels and scheduling processes occurring reliably and without error as established through the scheduling audit process.

(c) Maintaining an updated master list to manage scheduling application access, training, and oversight.

(d) Standardizing and reliably implementing processes to remind patients of their appointments. These standards are established in the Scheduling and Consult Directives (links provide on page #13 in reference section of this policy).

(e) Developing a standard operating procedure (SOP) for contingency planning to ensure Veterans have access to outpatient care when a full complement of staff is not available.

f. **Additional Facility Leadership**. Facility Leadership to include the Assistant Director, Chief of Staff, Deputy Chief of Staff, Associate Directors, Service Chiefs and any of these listed positions which may also be identified as a clinical and/or administrative lead are responsible for:

(1) Ensuring provider VistA Clinic profiles are effectively managed so that individual workers developing profiles for all clinics will be identified to the provider, GPM, and clinic leadership.

(2) Ensuring that the provider's time is used effectively, where the appointment schedule is derived from a clinic profile that is well planned and coordinated with the provider.

(3) Working with the Clinic Practice Management team to establish written contingency plans to provide guidance during the event of unplanned and planned provider and support staff absences, decrease of facility supply of appointments and/or unanticipated increases in patient demand. This plan should allow for who will cover for both appointment and non-appointment work. A template is provided in the Access Principles and Strategy Guidebook as a guide to establish local contingency plan policy.

(4) Will identify low performing practices and facilitate implementation of LEAN in concordance with access principles, strategies and continuous improvement using the appropriate Systems Redesign, improvement methodologies.

g. **COS/Associate Director (AD).** The COS/Associate Director (AD) has overall responsibility for clinic operations as outlined in this directive. The COS or designee will approve the deployment of provider's time as outlined by VHA Directive 2011-009 and this directive.

h. **Service Chief.** Service Chiefs are responsible for:

(1) Oversight of the Administrative and Clinical practice management within their service. Therefore, the Service Chief must support the work initiated by the CL/AL dyad as is directed under oversight from the facility GPM(s).

(2) In collaboration with the CL/AL dyad, establishment and oversight of the appropriate amount of time available for clinic scheduling and the mix of appointment types, length, and quantity created in provider clinic profiles.

i. **Group Practice Manager.** The GPM is responsible for:

(1) Developing processes to ensure that the provider and service chief have reviewed and acknowledged the most current provider clinic profile and that this review/acknowledgement has been documented. A naming process must be developed to ensure that all profiles can be shared among all facility clinics and teams.

(2) Ensuring execution of the following tasks related to access education and training:

(a) Orientation, mentoring, and planning for succession of staff.

(b) Assure or provide high quality clinic management training including Access principles and strategies.

(c) Assure clinical staff is provided training surrounding the required mix of appointment types, slot length, and quantity created in provider clinic profiles, as defined by the clinical program offices.

(d) Assess clinic practice management dashboard metrics and based on the data analysis, apply appropriate strategies through performance improvement teams.

j. **Group Practice Manager (GPM), Clinical Lead (CL), Administrative Lead (AL).** The GPM, CL, AL are responsible for leadership and the day-to-day clinic management of their assigned clinics but are not meant to have a supervisory role over the Service Chief or the clinic providers. In addition they have specific defined responsibility for the overall function of the key processes and systems defined in the definitions section of this policy, (page 3). GPM at the health systems level, and CL and AL at the service level collectively called Clinic Practice Management (CPM) have specific defined responsibility for the function, patient service levels and performance of outpatient clinic operations. CPM staff may operate by direct responsibility and authority for outpatient function(s), and/or facilitative/consultative support through others. GPMs will assist in establishing needed resources, standardize key clinic and

administrative processes, oversee and evaluate performance, and continually raise the level of service to Veterans. The GPM/CL/AL have responsibility for the following items and can delegate to the appropriate member of the CPM team as needed:

(1) **Maintaining Clinic Practice Management Structure.** A skeleton structure that can be adapted for each facility can be found at https://www.vapulse.net/docs/DOC-30439.

(2) **Performing Data Analysis on Clinical Performance.** This analysis will include but is not limited to the following:

(a) Data analysis based on the following:

1. Assessing and identifying next steps for performance.

2. Key metrics and reports (Access Glide Path, no show call list, Clinic Practice Management Dashboard, Specialty Productivity Access Report and Quadrant (SPARQ) tool, Strategic Analysis for Improvement and Learning (SAIL), and Consumer Assessment of Health Providers and Systems (CAHPS) surveys etc.)

(b) Applying access principles and strategies across the outpatient care services to include Primary Care, Surgical Care, Women's Health, Specialty Medicine and Mental Health (Primary Care, Surgical and Specialty Care Clinic and Mental Health refer to all related Stop codes). ***NOTE:*** *Please refer to the Access Principles and Strategies Guidebook on how to execute Access principles using strategies "For", "At" and "Between" appointments; provided in the appendix section of this directive on page A-1 .*

(3) **Schedule Management Oversight Responsibilities.** The CL/AL will work with the corresponding outpatient Service Chiefs to develop processes that ensure provider clinic profiles are coordinated for provider review before scheduling into the clinic, resulting in clinic profiles that have adequate numbers of appointments for scheduling Veterans in accordance with VHA Directive 1230, Appendix L, Clinic Profile Management Business Rules.

(4) **Adhere to Consult Management Business Rules and Practices.** The GPM will work with CL and AL to adhere to Consult Management Business Rules and Practices, as indicated in VHA Directive 1232, Consult Processes and Procedures. Refer to VHA Directive 1232 for the information needed to utilize consults optimally and maintain proper consult business rules.

(5) **Clinic Cancellations Procedures.** In the case of a clinic cancellation, the following procedures will be followed:

(a) Notify the scheduler of cancelled clinics as soon as possible.

(b) Review appointments with the responsible provider to determine which patients need to be seen by an alternative provider and which appointments can be rescheduled.

(c) Contact the patients that need to be rescheduled as soon as possible prior to their scheduled appointment in order to avoid them arriving at the facility without the ability to be seen.

(d) Must follow the details of the National Clinic Cancellation Policy https://www.vapulse.net/docs/DOC-44814

(6) **No-Shows and Clinic Cancellation.** The CL/AL will strive to minimize the clinic no-show rates. The goal is to keep overall no show rates as low as possible for all booked appointments and actively make efforts to improve clinics with no-show rates above 10 percent. To achieve this standard, clinics will implement strategies and systems to decrease no-shows and clinic cancellations. In order to implement these systems and strategies, CLs/ALs will work with the clinical and administrative staff to implement the No Show Implementation Tool, https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/ClinicAccess/Lists/NSCC Questionnaire/AllItems.aspx (***NOTE:*** *This is an internal VA Web site that is not available to the public)* in conjunction with the No show Trigger tool, http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fSysRD%2fWaitTimes%2fNo+Show+Trigger+Tool&rs:Command=Render%20%3chttp://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/SysRD/WaitTimes/No+Show+Trigger+Tool&rs:Command=Render%3e (***NOTE:*** *This is an internal VA Web site that is not available to the public)* to reduce no-shows and clinic cancellations.

(7) **Appointment Profile and Scheduling Grid Planning and Administration.**

(a) To ensure clinic profiles are mapped to DSS assignment, the CL/AL dyad will determine the appropriate mix of appointment types and quantity of appointment slots for any given day of the week and time of year as based on DSS/Managerial Cost Accounting (MCA) mapping and clinic profiles.

(b) Consider Factors When Developing Profiles/Grids. The CL/AL dyad and clinical staff will consider a number of factors when developing the clinic profiles to include:

1. Acuity and number of enrollees for which the clinic is responsible as related to the appropriate DSS mapping/Full-time Equivalent (FTE) for each provider,

2. Available space and equipment,

3. Special procedures the clinic performs,

4. Availability of support staff, and

5. Level of expertise of the clinic provider/support staff.

6. Assure the procedures listed in Directive 1230, Appendix L, Clinic Profile Management Business Rules, are followed.

(8) **Utilize Virtual Technologies.** Telephone appointments, e-consults, https://vaww.rtp.portal.va.gov/OQSV/10A4C/SRD/Guidebook%20and%20assoc%20Docs/SAIM%20Guidebook%20FINAL%20January%2027%202016.pdf (***NOTE:*** *This is an internal VA Web site that is not available to the public)*, Secure messaging https://www.vapulse.net/docs/DOC-32083 ,My HealtheVet (National Site; access local sites as needed, http://vaww.oia.va.gov/MHV/SitePages/Home.aspx (***NOTE:*** *This is an internal VA Web site that is not available to the public)*, Telehealthhttp://vaww.telehealth.va.gov/index.asp, SCAN-echo https://www.vapulse.net/docs/DOC-31988,Text Reminders https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/ClinicAccess/NSCC%20Questionnaire%20Documents/Outpatient%20Appointment%20Text%20RemindersSpecifications%20for%20set-up%20FINAL_mjf.docx (***NOTE:*** *This is an internal VA Web site that is not available to the public)*, etc.

(9) **Space, Staffing, and Equipment Considerations.** The Clinic Practice Management Team will work to assess on an on-going basis, the use of staff and space inside the clinic. Space, staff, and equipment will be optimized to best accommodate Veterans' needs at appointments.

(10) **Telephone Access and Contact Management.**

(a) The CL/AL will maintain regular and consistent, communication with call center staff. The purpose of this is to ensure there is optimum flow of information between the call center and the outpatient clinics so that patients are receiving timely quality phone service for any telephonic needs. Refer to the Telephone Access Improvement Guidebook, https://www.vapulse.net/docs/DOC-19903 , Directive 2007-033: Telephone Service for Clinical Care and VHA Directive 1090: Telephone Access to Outpatient Clinical Care for procedures in using phones and call centers.

(b) Optimize Veteran telephone access, including exceptional customer service, call answering timeliness, and resolving requests on the first call.

(c) Implementing best practices contained in VHA's Telephone Improvement Guidebook. (Reference section page number 12)

(11) **Education and Training.** GPMs/CLs/ALs will utilize national and local training modules and programs to train for onboarding and sustainment purposes. Please refer to the training section of the national SIM-simulation learn, https://vaww.portal2.va.gov/sites/SimLearn/SitePages/Home.aspx ***NOTE:*** *This is an internal VA Web site that is not available to the public)* for these training materials.

(12) **Assess Need for Improvement Efforts.** Both CLs and ALs will regularly review performance of the applicable access improvement initiatives and scheduling operations in order to make timely adjustments to meet clinic business planning objectives. Receive regular feedback on access performance and disseminate this feedback to their staff. Provide senior clinical leaders with regular feedback on clinic operations. Please refer to the Performance Improvement Guidebook at

https://vaww.rtp.portal.va.gov/OQSV/10A4C/SRD/Guidebook%20and%20assoc%20Docs/SAIM%20Guidebook%20FINAL%20January%2027%202016.pdf (***NOTE:*** *This is an internal VA Web site that is not available to the public)* for details on national VHA guidance to conduct performance improvement projects and teams.

(a) Analyze, provide and/or recommend optimal facility clinic resources including provider numbers and types, support staff, space and infrastructure in order to provide access to care.

(b) Monitor and analyze and continually improve patient access FOR all types of face-to-face and non-face-to-face care. This includes patient wait times, no-shows, cancellations, referrals, levels of patient demand compared to clinic supply and productivity.

(c) Monitor, analyze and continually improve patient access AT appointments. This includes starting appointments on time, efficient patient journeys at and between each step through the clinic and facility (check-in, rooming, check-out, etc.), staff working at their maximum potential and optimal use of resources including rooms and equipment.

(d) Monitor and analyze and continually improve patient access BETWEEN appointments and services for primary and specialty care. This includes practice referral patterns (volume and reason for referral) to both VA and community resources, the use of care coordination agreements, and changes to improve patient timeliness and experience.

(13) Applying basic access principles, including: supply matched to projected demand, immediate engagement, patient preference, surge contingencies, and continuous assessment.

(14) Assuring a sound process/policy for walk-in or urgent appointments.

(15) Medically urgent needs will be met by the VHA Healthcare System directly or through care in the community.

(16) Veterans will be offered specialty Mental Health, Audiology, and Optometry services with or without a referral from a provider.

(17) Information on patient care outside of regular business hours is outlined in VHA Directive 2013-001, Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, or subsequent policy issue.

(18) Veterans whose appointments are affected by a clinic cancellation will be offered an option to see another provider as soon as possible.

(19) In accordance with VHA Handbook 1601, Non-VA Medical Care Program, http://www.va.gov/vhapublications/index.cfm, Veterans with emergent conditions should call 911 or go to the nearest emergency room.

(20) Ensure follow-up appointments for clinical services will be offered (face-to-face or virtual) per Veteran preference, before the Veteran leaves the clinic.

(21) Establish and maintain written contingency plans for variations in both patient demand and facility supply in order to deliver care without delay.

(22) Suggested use of kiosks as a strategy in standardizing clinic practice management in the outpatient clinics. See Kiosk and Vet Link website in the reference section.

k. **Providers.** The provider is responsible for working with CL/AL and clinic leadership to develop provider clinic profile. Providers, to include primary, Women's health, specialty, mental health, and ancillary care, will work closely with CL/AL and clinic leadership to develop profiles which optimize access and patient continuity and which enhance the provider's practice of medicine. Providers will review their profiles with their CL/ALs at least semi-annually.

6. REFERENCES

a. Department of Veteran Affairs Blueprint for Excellence, Veterans Health Administration http://www.va.gov/HEALTH/docs/VHA_Blueprint_for_Excellence.pdf

b. Direct Access to Mental Health Clinics Memo https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/ClinicAccess/Policy/2014-11-28 Memo - Direct Access to Mental Health Clinics.pdf. ***NOTE:*** *This Web site is accessible only to authorized VA users.*

c. ICARE Quick Reference Core Values http://www.va.gov/ICARE/docs/core_values_quick_reference.pdf

d. Kiosk and Vet Link Resources:

(1) VA Pulse Page: https://www.vapulse.net/groups/vetlink

(2) VetLink Site POC List: https://www.vapulse.net/docs/DOC-17370

(3) Capability listing: https://www.vapulse.net/groups/vetlink/blog/2016/04/21/vetlink-capability-listing

(4) https://www.vapulse.net/groups/vetlink/blog/2015/09/02/initial-sharing-of-information

e. Patient centered care resources http://vaww.infoshare.va.gov/sites/OPCC/Shared%20Documents/Guidebook%20for%20

Patient%20Centered%20Care/OPCCCT%20Guidebook%20for%20Patient%20Centered%20Care.pdf, http://vaww.va.gov/patientcenteredcare/PCC_Guidebook_Self-Assessment/#/home (***NOTE:*** *This is an internal VA Web site that is not available to the public)*

f. Telephone Access Improvement Guidebook https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/TACM/ImprovingVeterans%20Access%20via%20the%20Telephone%20IVAT/Forms/AllItems.aspx?RootFolder=%2Fsites%2FDUSHOM%2F10NA%2FACAO%2FTACM%2FImprovingVeterans%20Access%20via%20the%20Telephone%20IVAT%2FTACM%20Improvement%20Guide%2FOutlines (***NOTE:*** *This is an internal VA Web site that is not available to the public)*

g. Veterans Health Administration (VHA) Strategic Plan FY 2013 – 2018 http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf

h. VHA Directive 1090, Telephone Access to Outpatient Clinical Care http://www.va.gov/vhapublications/index.cfm

i. VHA Directive 1230, Outpatient Scheduling Processes and Procedures http://www.va.gov/vhapublications/index.cfm

j. VHA Directive 1232, Consult Processes and Procedures http://www.va.gov/vhapublications/index.cfm

k. VHA Directive 2011-009, Physician and Dentist Labor Mapping, or subsequent policy issue, http://www.va.gov/vhapublications/index.cfm

l. VHA Directive 2013-001, Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, or subsequent policy issue, http://www.va.gov/vhapublications/index.cfm

m. VHA Handbook 1601, Non-VA Medical Care Program http://www.va.gov/vhapublications/index.cfm VHA Handbook 1101.02, Primary Care Management Module (PCMM), http://www.va.gov/vhapublications/index.cfm

ACCESS TEAM TRAINING, MANAGEMENT, AND TRAINING RESOURCES

a. ACAP General Education: https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/SitePages/ACAP%20Education.aspx?WikiPageMode=Edit&InitialTabId=Ribbon.EditingTools.CPEditTab&VisibilityContext=WSSWikiPage (***NOTE:*** *This is an internal VA Web site that is not available to the public)*

b. ACAP KMS: https://www.vapulse.net/groups/acap-kms/overview

c. Access Principles and Strategies Guidebook: https://www.vapulse.net/docs/DOC-44812

d. Aim, Change and Desired Outcomes: https://www.vapulse.net/docs/DOC-32048

e. Appointment Types in PC and SC: https://www.vapulse.net/docs/DOC-29966

f. Appointment Types in Primary Care: https://www.vapulse.net/docs/DOC-29967

g. Clinic Management Training: https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/CMT/default.aspx (***NOTE:*** *This is an internal VA Web site that is not available to the public)*

h. Conducting Effective Meetings Workbook: A Basic Business Victory Guide: https://www.vapulse.net/docs/DOC-32050

i. Contingency Plan Policy Template Guidebook: https://www.vapulse.net/docs/DOC-59013?sr=stream

j. CPM Implementation Guidebook: https://www.vapulse.net/docs/DOC-44799

k. Equation for Determining Number of Rooms Required: https://www.vapulse.net/docs/DOC-32051

l. Five Levels of Mapping: https://www.vapulse.net/docs/DOC-32041

m. Group Primary Care Visits Improve Outcomes for Patients with Chronic Conditions: https://www.vapulse.net/docs/DOC-32042

n. Home Telehealth Improves Clinical Outcomes at Lower Cost for Home Healthcare: https://www.vapulse.net/docs/DOC-32039

o. Integrated Operations Platform: http://vhaindwebsim.v11.med.va.gov/hub2/atc/projects.html (***NOTE:*** *This is an internal VA Web site that is not available to the public)*

p. Lean Thinking: Questions and Answers: https://www.vapulse.net/docs/DOC-32043

q. Link To Additional Mark Murray Articles: https://www.vapulse.net/docs/DOC-32044

r. Measuring Delay for Group Visits and "Classes": https://www.vapulse.net/docs/DOC-32045

s. Myth of Full Utilization: https://www.vapulse.net/docs/DOC-32046

t. National Clinic Cancellation Policy: https://www.vapulse.net/docs/DOC-44814

u. Office Efficiency Simplified: https://www.vapulse.net/docs/DOC-32047

v. Process Improvement and Supply and Demand: The Elements That Underlie Integration: https://www.vapulse.net/docs/DOC-29970

w. Solo Physicians Use of Virtual and Phone Visits, Same-Day Appointments, and Extended In-Person Visits Leads to High Patient Satisfaction and Improved Chronic Disease Outcomes: https://www.vapulse.net/docs/DOC-32049

x. Synchronization with Room as the Constraint: https://www.vapulse.net/docs/DOC-32037?sr=stream

y. System Design Choices in Specialty Care: https://www.vapulse.net/docs/DOC-29969

z. System Performance Goals: https://www.vapulse.net/docs/DOC-32038

aa. The Hot Spotters: https://www.vapulse.net/docs/DOC-32040

bb. Transitions Across Access Systems: https://www.vapulse.net/docs/DOC-29991

OUTPATIENT SERVICES DEFAULT APPOINTMENT LENGTHS

National program offices have submitted the following "default" appointment lengths. These are not mandates but suggested appointment times from the national outpatient program offices.

a. **Primary Care Clinic.**

(1) Related to panel size.

(2) Number of slots for face-to-face visits per day.

(a) Formula for slots equals (number of patients times average number of visits) divided by (number of workdays)

(b) The remainder of time is devoted to non-face-to-face care and clinical responsibilities.

(3) Appointment times:

(a) Established patient equals 30 minutes.

(b) New patient equals 60 minutes (visit lengths may vary based on patient complexity).

(c) Women's Health annual exams requiring a pelvic exam or Pap smear may require 60 minutes.

b. **Surgery.**

(1) Primary Decision Support Stop (DSS) stop codes (defined in VHA Directive 2011-009, Decision Support System Outpatient Identifiers, or subsequent policy issue, http://www.va.gov/vhapublications/index.cfm.) need to be modernized.

(2) Slot times based on standard primary DSS/Managerial Cost Accounting (MCA) mapping and stop codes. Any number of secondary stop codes can exist, but they must not modify the slot time recommendations under the primary stop codes.

(3) Appointment times:

(a) Established patient equals 1 basic slot or 30 minutes.

(b) New patient equals 2 basic slots or 60 minutes.

(c) Procedure equals 2 basic slots or 60 minutes.

c. **Mental Health.**

(1) The same provider conducts a variety of services that require a range of appointment slots.

(2) Depending on the service, some appointment could be 15 minutes while others could be as long as 85 minutes.

(3) Need to develop individually tailored standards.

(4) Overall bookable hours

d. **Medical Specialty Care.**

(1) Consists of anything other than Mental Health, PC, and Surgery.

(2) Consists of multiple specialties.

(3) Many providers are part-time employees.

(4) For maximal flexibility, Medical Specialty Care proposes 15-minute slots.

(a) Most follow-up appointments equal two 15-minute slots or 30 minutes.

(b) New patient equals three to four 15-minute slots or 45-60 minutes; depends on the specialty.

(c) Some exceptions are one 15-minute slot (e.g., follow-up for a minor procedure).

(5) It is expected that providers will work to the top of their license and optimize productivity via both face to face and non-face to face care (i.e., maximize the patient contact time with the available).

e. **Clinical Pharmacy Care**

(1) The same provider conducts a variety of services that require a range of appointment slots.

(2) It is expected providers will work to the top of their license and optimize productivity via both face to face and non-face to face care (i.e. maximize the patient contact time with the available staff)

(3) Depending on the modality of care, some appointments could be 15 minutes while others could be as long as 90 minutes.

1. Face to face clinic schedules should generally be built on 30 minute appointment slots but may vary based on patient complexity and practice setting

2. Telephone clinic schedules should generally be built on 15 minute appointment slots

(4) The remainder of time is devoted to non-face to face care and clinical responsibilities

(5) Clinical pharmacy clinic set-up should be in accordance with PBM guidance and workload capture information found on the Clinical Pharmacy SharePoint at: http://vaww.infoshare.va.gov/sites/ClinicalPharmacy/Clinical%20Specialty%20Pages/Workload%20Capture.aspx