

OUTPATIENT CLINIC PRACTICE MANAGEMENT

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

2. SUMMARY OF MAJOR CHANGES: This revised VHA directive:

a. Combines separate directives on Outpatient Clinic Practice Management and Extended Hours access into one directive on Outpatient Clinic Practice Management and updates the requirements and processes for Extended Hour (EH) access and the clinic cancellation policy.

b. Extends the required minimum bookable Extended Hours offered by any VA medical centers and Community Based Outpatient Clinics (CBOCs) treating 10,000 or more Primary Care enrolled unique Veterans per fiscal year (FY), from 2 to 4 hours; and

c. Establishes the definition of Same Day Services.

d. Amendment dated March 10, 2020 updates training requirements associated with this directive.

3. RELATED ISSUES: VHA Directive 1230(1), Outpatient Scheduling Processes and Procedures, dated July 15, 2016 and VHA Directive 1232(2), Consult Processes and Procedures, dated August 23, 2016.

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 Office of Veterans Access to Care (10NG) via email at VHA10NGAction@va.gov.

5. RESCISSIONS: VHA Directive 1231, Outpatient Clinic Practice Management, dated November 15, 2016, and VHA Directive 2013-001, Extended Hours Access for Veterans Requiring Primary Care, dated January 9, 2013 are rescinded.

RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of October 31, 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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

/s/ Renee Oshinski
Deputy Under Secretary For
Operations and Management

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

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OUTPATIENT CLINIC PRACTICE MANAGEMENT

1. PURPOSE

This Veterans Health Administration (VHA) directive revises policy for the management of Veterans' access to outpatient care, establishes a national Clinic Practice Management (CPM) program and identifies and describes the required standards, roles, and key clinical process for both the clinical and administrative roles within a service line in an outpatient clinic, that must occur in a timely and reliable fashion in order to achieve VA's mission. **AUTHORITY:** 38 United States Code (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, high-quality outpatient care which responds to the changing needs of Veterans and their families. To this end, VHA developed an Access Declaration, a set of nine principles that defined and communicated our commitment to ensure access to care. **NOTE:** For more information, please refer to the *MyVA Access Implementation Guide*, located at <https://www.vapulse.net/docs/DOC-94429>, and the *Primary Care Open Access Roadmap*, located at <https://www.vapulse.net/docs/DOC-94724>. **NOTE:** These are internal VA Web sites that are not available to the public.

b. This is a recertification of the directive which establishes a national Clinic Practice Management (CPM) program as required by the 2014 Veterans Access, Choice and Accountability Act (VACAA). The CPM program provides the framework for standardizing outpatient clinical practices across the VA healthcare system. The directive describes standards and processes for both clinical and administrative roles within a service line in an outpatient clinic. Updates have been made to the guidance for clinic Extended Hour access, clinical cancellation policy, and the definition of Same Day Services.

3. DEFINITIONS

a. **Advanced Clinic Access Principles.** The Advanced Clinic Access (ACA) Principles describe universal 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. **NOTE:** For more information and the most up-to-date version of the ACA please visit <https://www.vapulse.net/docs/DOC-100229>. **NOTE:** This is an internal VA website that is not available to the public.

b. **Bookable Clinic Hours.** Bookable clinic hours are the number of hours allotted in each provider's clinic schedule for direct patient care including face-to-face and virtual patient care time (e.g., telephone visits, telehealth, and other virtual modalities). The time counted in the calculation must be unrestricted (i.e., no special permission

scheduling or blocking of time).

c. **Cancelled by Clinic.** Cancelled by Clinic means an appointment is cancelled by the clinic and not the patient. **NOTE:** *This definition of Cancelled by Clinic supersedes the definition listed in VHA Directive 1230(1), Outpatient Scheduling Processes and Procedures, dated July 15, 2016.*

d. **Cancelled by Patient.** Cancelled by Patient means the patient has requested cancellation of a currently scheduled appointment. The patient may or may not reschedule the appointment.

e. **Clinic Profile.** The clinic profile in VistA Scheduling (or subsequent VA electronic scheduling system) is a customized record that defines outpatient clinic parameters. These parameters include clinic name, start date/time, provider, location, frequency of the clinic, operating times, Stop Codes, overbooking allowance, count or non-count clinic, billable or non-billable for the first party copays, billable or non-billable for third party billing, appointment lengths, users, etc.

f. **Clinical Lead and Administrative Lead.** The Clinical Lead (CL) and Administrative Lead (AL) roles are collateral. They work in tandem daily and are responsible for the core processes as listed in Paragraph 6 of this directive. CLs are responsible for addressing the clinical staff and clinical care processes, while ALs are responsible for addressing administrative staff and key processes that support clinical care. All outpatient services – Primary Care, Mental Health, Specialty Care, and Other Service Lines (as defined in this directive) – must have CL and AL roles filled. The exact position titles that fill the clinical and administrative lead roles may differ based on the needs and makeup of individual VA medical facilities. **NOTE:** *More information about the required functions of the clinical and administrative leads can be found in Paragraph 6.*

g. **Clinic Practice Management Team.** A Clinic Practice Management (CPM) Team is the combination of the Group Practice Managers (GPM) and the collective CLs, ALs. The team may include data staff and scheduling leaders as locally determined to be appropriate.

h. **Contingency Plan.** A contingency plan is a written plan outlining the procedures to maintain normal clinic operations in the absence of providers or support staff. The intention of the contingency plan is to minimize the appointment cancellations and thus prevent backlog and delayed patient care. **NOTE:** *Resources to help create local contingency plan policy can be found in the References section in Paragraph 9.*

i. **Extended Hours.** Extended Hours (EH) comprise hours of operation beyond 8:00 a.m. to 4:30 p.m., Monday through Friday. For example, Extended Hours include evenings and weekends.

j. **Group Practice Manager.** A Group Practice Manager (GPM) is a facility-level position intended to oversee access to care in 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.

k. **No Show.** A no show occurs when a patient does not present for a scheduled appointment. **NOTE:** “No show” was formerly referred to as missed opportunity.

l. **Other Service Lines.** Other Service Lines, for the purposes of this directive, is broadly defined as clinical services providing outpatient care not specifically included in Primary Care, Mental Health, and Specialty Care. Examples include Rehabilitation Service and the Spinal Cord Injury Unit.

m. **Patient Self-Referral Direct Scheduling.** Patient Self-Referral Direct Scheduling (PSDS) is a process in which Veterans can make specialty care appointments themselves - without a consult from a referring provider.

n. **Regular Business Hours.** Regular Business Hours for VHA services are from 8:00 a.m. to 4:30 p.m., Monday through Friday.

o. **Same Day Services.** Same-day services are defined as a Veteran needing care right away during regular business hours, and having healthcare services the same day, or if after hours, by the next day. Options for care delivery include in person, via telephone, smart phone, through video care, secure messaging, or other options including ordering a prescription and scheduling a future appointment including referral to a specialist. Care may be delivered by the Veteran’s provider or another appropriate clinical staff member based on availability and their care needs. **NOTE: Same Day Services in Mental Health: If the Veteran is in crisis or has another need for care right away in Mental Health, they will receive immediate attention from a health care professional at a VA medical facility.**

p. **Scheduler.** A scheduler can be any staff member with access to VistA, or subsequent VA electronic scheduling system, Scheduling Menu Options, Make Appointment, EWL, and Recall Reminder. Schedulers make, reschedule, cancel, and no-show Veteran appointments and, when appropriate, enter patients on EWL.

4. POLICY

a. It is VHA policy for every VA medical facility to have a CPM program that uses partnerships between the clinical and administrative outpatient clinical functions to standardize processes and best practices across the VA medical facility to ensure Veterans’ access to care.

b. Further, it is VHA policy that VA medical facilities and Community Based Outpatient Clinics (CBOC) treating 10,000 or more Primary Care enrolled unique Veterans per fiscal year (FY), must provide access to a minimum of 4 Extended Hours (EH) per week in both a Primary Care clinic and Mental Health clinic. A minimum of 1 Extended Hours per month must be offered for the Women’s Health clinic.

NOTE: Intake clinics do not qualify in the minimum of EH as defined in this policy. The intent of offering a full range of services is to avoid walk-in clinics or situations

where Veterans are scheduled for appointments but do not have access to support services typically available during regular business hours (i.e., blood draws, x-rays, or pharmacy). If a Veteran walks in for care during EH, staff on site must assess the needs of the Veteran through locally established processes and procedures with the appropriate team member.

5. RESPONSIBILITIES

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

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for

(1) Maintaining review and oversight of clinic management, including but not limited to access, Veteran satisfaction, wait time measures, clinic utilization, clinic cancellations, and no-shows at the national, Veteran Integrated Service Network (VISN), and VA medical facility levels.

(2) Communicating the contents of this directive to each Veterans Integrated Service Network (VISN).

(3) Ensuring that each VISN Director has sufficient resources to fulfill the terms of this directive in all of the VA medical facilities within that VISN.

(4) Providing oversight of VISNs to assure compliance with this directive.

c. **Assistant Deputy Under Secretary for Health for Access for Care.** The Assistant Deputy Under Secretary for Health for Access for Care is responsible for:

(1) Developing and communicating clinical access policies and procedures, as needed, and overseeing their implementation across VHA.

(2) Regularly reviewing access to care indicators and other available data on clinic cancellations, wait times, and Veterans satisfaction as part of a continuous improvement process to assess the outcomes and performance of the VHA access program.

(3) Working with a VISN or VA medical facility to take appropriate action when a review of the access to care indicators and other data indicate an opportunity for improvement based on comparisons to national benchmarks or facility specific trends.

d. **VISN Director.** The VISN director is responsible for:

(1) Ensuring that VA medical facilities within the network are implementing the requirements of the Access program as outlined in this directive and reporting progress towards improving access to the Assistant Deputy Under Secretary for Health for Access for Care.

(2) Working with the VISN Access Point of Contact to respond to VA medical facility clinical access improvement needs as informed by the VA medical facility Director and VA medical facility Group Practice Manager (GPM). **NOTE:** *In responding to timeliness needs, the VISN director must work with both local facility and VHA Program Office leadership to ensure that VA medical facilities within their jurisdiction have the resources needed to maintain timely access.*

(3) Ensuring that VA medical facilities and Community Based Outpatient Clinics (CBOCs) within the VISN treating 10,000 or more Primary Care enrolled unique Veterans per FY provide access to a minimum of 4 Extended Hours per week in both a Primary Care clinic and Mental Health clinic. A minimum of one extended hours clinic per month must be offered for Women's Health. **NOTE:** *The use of Saturday hours is encouraged if supported by Veteran preference. NOTE: The number of extended hours is a minimum of four but may be more to meet the needs of the clinic population. The most common extended hours are Saturday, early morning or evening hours. Veteran preference must be assessed via both direct Veteran feedback and utilization of specific extended hours over time. Changes to extended hours may change in response to utilization and Veteran preference.*

(4) Reviewing and assessing Veteran preference and utilization for extended hours on a regular, at least annual basis based on available data (i.e. no shows and feedback from Veterans).

(5) Monitoring and evaluating EH utilization through internal VHA data generated reports, including but not limited to access, productivity data, the CPM dashboard, indicators of same day services and other appropriate metrics, as part of a continuous improvement process, and taking appropriate action when an opportunity for improvement is identified.

(6) Continuously improving Veteran's access to care as indicated by available access to care indicators noted in the above paragraph.

e. **VISN Access Point of Contact.** The VISN Access Point of Contact is responsible for:

(1) Ensuring that all VA medical facilities across the VISN implement this directive.

(2) Providing regular updates to VISN and National leadership regarding VISN progress towards access initiatives.

(3) Providing potential solutions for VA medical facilities that have challenges with meeting and/or sustaining access initiatives.

(4) Coordinating with VA medical centers and other VISN designated staff to achieve access initiatives as required.

f. **VISN Chief Medical Officer.** The VISN Chief Medical Officer (CMO) is responsible for:

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

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

(3) Reviewing available access indicators, including but not limited to access to care metrics, and other available reports as part of a continuous improvement process.

NOTE: For more information on the access indicators and performance data, please see the CPM Guidebook, located at <https://www.vapulse.net/docs/DOC-44799>. **NOTE:** This is an internal VA Web site that is not available to the public.

(4) Assessing and identifying next steps for performance improvement as appropriate and working with the VISN Director to implement performance improvement activities when an opportunity for improvement is identified.

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

(1) Establishing a functional CPM team consisting of at least one full-time GPM.
NOTE: Higher complexity facilities commonly have more than one GPM.

(2) Ensuring the clinical and administrative lead roles are assigned at the service level in the Mental Health, Primary Care, and Specialty Service lines, as well as other service lines as identified in this directive and function as part of the CPM team.

(3) Ensuring GPM(s) are included in strategic decisions related to access and have both the authority and leadership support to implement change.

(4) Establishing clinics, which are appropriately resourced and functioning, to provide access and efficiency.

(5) Ensuring that contracts with clinics in the community, where necessary, are compliant with this directive.

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

(7) Incorporating Veteran and staff feedback in clinic improvement actions including knowledge of EH availability.

(8) Ensuring appropriate staffing and resources are provided to enable those clinics to schedule and operate in the most efficient manner.

(9) If the VA medical center, and any related CBOCs meet the unique Veteran requirements outlined in Paragraph 4, ensuring that a minimum of 4 EH per week in both a Primary Care clinic and Mental Health clinic, as well as a minimum of 1 EH per month in the Women's Health Clinic is offered.

(10) Ensuring additional services, as determined by local need, provide outpatient care during EH including appropriate staffing and resources to enable those clinics to operate in the most efficient manner.

(11) Ensuring appropriate efforts are made to inform the Veteran population of services offered during EH and continuing to offer EH that have been well utilized and have shown to meet Veteran's needs. EH which have not been efficient or well utilized must be re-evaluated.

(12) Ensuring appropriate efforts are made to inform the Veteran population about their eligibility for services offered in the community through the new Veterans Community Care Program (VCCP).

(13) Ensuring designated staff responsible for Veterans Health Information Systems and Technology Architecture (VistA) or subsequent VA electronic scheduling system, clinic set up ensure clinic profile data integrity and that the clinic grids match the providers responsibilities. **NOTE:** *Clinic set up/ build functions/clinic deactivation should be completed in accordance with the Clinic Profile Management Guide, which can be access at <https://www.vapulse.net/docs/DOC-100670>. NOTE: This is an internal VA Web site that is not available to the public.*

(14) Ensuring Same Day Services are offered in both Primary Care and Mental Health.

(15) Ensuring that all VA medical facility clinic staff comply with the Training Requirements in Paragraph 7.

(16) Continuously improving Veteran's access to care within the VA medical facility as indicated by available Veteran's wait time and satisfaction data.

h. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff (COS) is responsible for:

(1) Approving leave requests submitted less than 45 days (for Title 38 and hybrid Title 38 employees and others) in advance that result in the cancelation of clinic appointments. **NOTE:** *"Others" in this context refers to any other employees or providers who are providing care via a clinic grid. Examples include speech therapists and dieticians.*

(2) Ensuring a contingency plan is in place to provide gap coverage for unexpected clinician absences to maintain timely Veteran access.

(3) Approving the deployment of provider's time as recorded in the Managerial Cost Accounting (MCA) system.

(4) Overseeing the use of providers' time as directly managed by Service Chiefs.

(5) Overseeing the implementation of Advanced Clinic Access (ACA) principles in

clinical practices including the optimization of panel size and productivity in Primary Care, Mental Health, and other specialties.

(6) Collaborating with Service Chiefs to review the scheduling system, including panel size and productivity, to ensure that the MCA mapping and clinic grids are correct, and that time has been allocated such that providers are being utilized effectively and to the top of their license.

i. **Associate Director for Nursing/Patient Care Services.** The VA medical facility Associate Director for Nursing/Patient Care Services (AD/PCS) may have responsibility for clinic operations as outlined in this directive based on the local organizational structure. The AD/PCS may have additional specific responsibility for:

(1) Ensuring a plan is in place to provide gap coverage for unexpected Nursing staff absences to maintain timely Veteran access.

(2) Overseeing the optimization of Nursing staff productivity in Primary Care, Mental Health, and other specialties.

(3) Overseeing and/or managing staff providing administrative support services such as scheduling, telephones, etc.

(4) Collaborating with Service Chiefs to ensure the MCA mapping and clinic grids are correct, and that time has been allocated such that staff are being utilized effectively and assigned to work at the top of their license.

j. **Service Chiefs.** Service Chiefs for the Mental Health, Primary Care, Specialty Care, and other service lines as identified in this directive are responsible for:

(1) Providing oversight of the administrative and clinical practice management team within their service and supporting the work initiated by the clinical and administrative lead roles in collaboration with the GPM(s).

(2) Ensuring provider Clinic profiles are effectively managed to maximize the number of bookable clinic slots and that all individuals creating and/or modifying profiles for all clinics will be identified to the provider, GPM(s), and clinic leadership.

(3) Working in collaboration with the GPM(s) and the clinical and administrative leads to establish and provide 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.

(4) Approving leave requests submitted at least 45 days in advance that result in the cancelation of patient care activities and communicating with the administrative and clinical leads in order to appropriately manage clinic scheduling (for Title 38 employees and others). **NOTE:** "Others" in this context refers to any other employees or providers who are providing care via a clinic grid. Examples include speech therapists and dieticians.

(5) Conducting an annual review of all clinic and stop code assignments to ensure they accurately reflect the type of services and treatment provided, in collaboration with the Facility Revenue Manager.

(6) Reviewing labor mapping of active and inactivated clinics and making appropriate changes in accordance with MCA guidelines in collaborations with the MCA Manager.

k. **Group Practice Manager.** The Group Practice Manager (GPM) is responsible for:

(1) Working with the VA medical facility director and the CPM team to continuously improve Veterans' access to care within the VA medical facility as indicated by available Veteran's wait time and satisfaction data.

(2) Developing processes on a facility level to ensure providers and service chiefs have reviewed and documented acknowledgement of the most current provider clinic profile and assisting the VA medical facility chief of staff with oversight over clinic scheduling.

(3) Continuously improving Veteran's access to care by identifying low performing practices and facilitating implementation of LEAN principles in concordance with the ACA principles, strategies and the appropriate Systems Redesign, and improvement methodologies.

(4) Facilitating execution of the following tasks related to access education and training:

(a) Providing orientation and mentoring materials to the service line clinical and administrative leads and other appropriate staff.

(b) Ensuring high quality training is provided on CPM, ACA principles and strategies, and balancing supply and demand. Training should be provided to the administrative leads, clinical leads, service line leaders and supervisors, and facility executive leadership.

(c) Reviewing and assessing CPM dashboard metrics and based on data analysis, applying appropriate strategies through performance improvement teams.

(d) Reviewing, assessing, and continuously improve the facility level of Same Day Services (SDS), including the SDS indicators. **NOTE:** *The same day service indicators can be accessed at <https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/ACAO/OVAC%20Communications/Forms/AllItems.aspx>. **NOTE:** This is an internal VA website that is not available to the public.*

l. **Clinical Lead.** The Clinical Lead has overall responsibility for clinical functions of the service. This includes responsible for adequate staffing in the applicable service

area and implementation and continuous improvement of ACA principles in each practice. Additional functions are included in Paragraph 6.

m. **Administrative Lead**. The Administrative Lead has overall responsibility for the administrative functions of the clinical service. This includes oversight of key processes such as management of patient appointment requests, telephone access, and clinic flow. Additional functions are included in Paragraph 6.

n. **Facility Revenue Manager**. The Facility Revenue Manager (FRM) or equivalent is responsible for ensuring:

(1) Reviewing whether a new or updated clinic is billable or non-billable based upon the assigned primary/secondary stop codes and workload conducted in the clinic.

(2) Conducting an annual review, at a minimum, of all clinic and stop code assignments to ensure they accurately reflect the type of services and treatment provided, as it pertains to billing, in collaboration with the respective Associate Chief of Staff/Service Line Chief/Manager (ACOS/SLC/M) and Managerial Cost Accounting (MCA) staff. **NOTE:** For more information on Facility Revenue Management, please see the Facility Revenue Guidebook, located at https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001029/content/554400000040549/Facility-Revenue-Guidebook-Table-of-Contents. **NOTE:** This is an internal VA website that is not available to the public.

o. **Managerial Cost Accounting (MCA) Manager**. The MCA Manager or equivalent is responsible for:

(1) Reviewing labor mapping of active and inactivated clinics and making appropriate changes in accordance with MCA guidelines and in collaboration with ACOS/Clinical Service staff and FRM.

(2) Working with clinical service staff to assess/determine appropriate Primary Stop Code, Secondary Stop Code, and CHAR4 Codes, where applicable.

(3) Conducting annual review of all active clinic profiles in collaboration with FRM ensuring accuracy of MCA codes, labor mapping, and making any needed adjustments to correct inaccuracies. **NOTE:** For more information on the MCA system, please see Directive 1750, VHA Managerial Cost Accounting System (Decision Support System (DSS)), dated March 24, 2015.

p. **Program Application Specialist/Clinic Profile Manager**. The Program Application Specialist or Clinic Profile Manager is responsible for:

(1) Establishing clinic profiles in the VA electronic health records system, in collaboration with provider and MCA staff, in accordance with the completed Clinic Profile Template, approved by Group Practice Manager or designee.

(2) Completing clinic cancellation requests approved by GPM, or designee, as outlined in VHA Directive 1230(1), Outpatient Scheduling Processes and Procedures, dated July 15, 2016, in a timely manner.

q. **Providers.** Providers are responsible for:

(1) Managing their appointment and non-appointment workload in a timely manner through effective use of support staff and decisions about the best venue to provide care (telephone, virtual, group, individual, face-to-face and other mechanisms as appropriate.

(2) Utilizing available clinic management data to continuously improve their practice.

NOTE: Providers in this section refer to providers in the Mental Health, Primary Care, Specialty Care, and other service lines as defined in this directive.

r. **Schedulers.** VA medical facility staff performing scheduling tasks are responsible for:

(1) Complying with the requirements of this directive and VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016.

(2) Managing the check-in and check-out process with Veterans to enable to timely start of appointments and smooth clinic flow.

(3) Managing and coordinating appointments in accordance with Clinical Team direction.

(4) Entering no-show appointments at the end of each day.

6. REQUIRED FUNCTIONS OF THE CLINIC PRACTICE MANAGEMENT TEAM

The Clinic Practice Management (CPM) team is responsible for the overall day to day management of access for the VA medical facility. Their goal is to maximize and optimize patient experience and patient access to services while also assuring that resources are used effectively.

a. The CPM team consists of the Group Practice Manager (GPM) and individuals in the service lines filling the clinical and administrative lead roles (CL and AL). The CPM team is responsible for leadership and the day-to-day clinic management of their assigned clinics. The CPM team has specific responsibilities for the function 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;

b. The GPM at each facility provides health systems level support and will assist in establishing needed resources, standardize and continuously improve key clinic and administrative processes, oversee and evaluate performance, and continually raise the level of service to Veterans.

c. At a service line level in the Mental Health, Primary Care, and Specialty Service Lines, and other Service lines as defined in this directive, clinical and administrative lead are a key part of the CPM team. The individuals who fill those roles may vary based on the makeup and needs of the specific VA medical facility. **NOTE:** *More information on the roles that need to be filled on the CPM team can be accessed at <https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/CAAO/CMT/default.aspx>.* **NOTE:** *This is an internal VA Web sites that are not available to the public.*

d. The following are required functions of the CPM team at the health systems level and service level. The CPM team should be empowered to delegate to appropriate staff as needed.

(1) Applying access principles and strategies to continuously improve clinic function and service to Veterans. **NOTE:** *Please refer to the Access Principles and Strategies Guidebook, located at <https://www.vapulse.net/docs/DOC-100229>, on how to execute Access principles using strategies “For”, “At” and “Between” appointments.* **NOTE:** *This is an internal VA Web site that is not available to the public.*

(2) Applying basic access principles, including: appointment and non-appointment supply matched to projected demand, appointment backlog reduction, appropriate demand reduction, increase appointment supply, starting appointments on time, and continuous assessment.

(3) Managing clinics so patients can access all types of face-to-face and non-face-to-face care.

(4) Establishing and maintaining written contingency plans for variations in both patient demand and facility supply in order to deliver care without delay.

(5) Managing patient access at appointments to assure patient arrival times are communicated, appointments start appointments on time, and the overall patient journey at and between each step through the clinic and facility (check-in, rooming, check-out, etc.), is timely and reliable.

(6) Managing patient access between appointments. This includes understanding 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.

(7) Incorporating kiosks where appropriate as a strategy in standardizing clinic practice management in the outpatient clinics.

(8) Performing data analysis including wait time and satisfaction data to continuously assess clinic performance. This analysis must include but is not limited to the following:

(a) Reviewing key metrics and reports a minimum of monthly. Please see CPM Guidebook located at <https://www.vapulse.net/docs/DOC-44799> for more information. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(b) Assessing and identifying next steps for performance improvement.

(c) Assessing all available facility clinic resources, including number and types of providers, support staff, space, and infrastructure to ensure adequate access to care, and advocating for more resources when necessary;

(9) Adhering to Consult Management Business Rules and Practices as indicated in VHA Directive 1232(2), Consult Processes and Procedures, dated August 23, 2016.

(10) Implementing clinic cancellations procedures. Cancellation of patient care activities must be avoided whenever possible and only after all alternatives have been exhausted; however, in the case of a clinic cancellation, the following procedures must be followed: **NOTE:** *Clinic cancellation procedures can be accessed in the CPM Guidebook, located at <https://www.vapulse.net/docs/DOC-44799>. **NOTE:** This is an internal VA website that is not available to the public.*

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

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

(c) Contacting 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.

(11) Minimizing no-shows by working with clinical and administrative staff to implement strategies and systems to decrease no-shows and clinic cancellations.

NOTE: *More information on resources related to minimizing No Shows can be accessed at*

*<https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/CAAO/ClinicAccess/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2fsites%2fDUSHOM%2f10NA%2fCAAO%2fClinicAccess%2fShared%20Documents%2fNo%20Show%20Toolkit&FolderCTID=0x01200042EC3228A4E5AB44AFDB35D016054BBD>. **NOTE:** This is an internal VA website that is not available to the public.*

(12) Planning and administering the Appointment Profile and Scheduling Grids.

(a) Ensuring clinic profiles are created using the Clinic Profile Management Guide, located at <https://www.vapulse.net/docs/DOC-110266>, (**NOTE:** *This is an internal VA Web site that is not available to the public*), and mapped to DSS assignment, and determining 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 Managerial Cost Accounting (MCA) mapping and clinic profiles.

(b) Considering factors when developing profiles/grids. The factors the CPM team must consider when developing clinic profiles include, but are not limited to:

1. 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.

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

6. Ensuring that Bookable Hours are accurately reflected in the clinic grid and are consistent with increasing provider productivity and efficiency.

(c) Annually reviewing respective service clinics for accuracy in collaboration with MCA staff and FRM with corrective updates made by the Clinic Profile Manager and/or MCA staff.

(d) Ensuring providers submit template request(s) for new clinic establishment or existing clinic changes, in accordance with Clinic Profile Management Business Rules.

(e) Ensuring compliance with clinic profile management business rules, as outlined in the Clinic Profile Management Business Rules.

(f) Continuously improving access by monitoring VA appointment availability timeframes and Community Care Referral volumes.

(g) Recommending next steps and flagging resources needed from the VA medical facility director to addresses issues within clinics with wait times of greater than 20 calendar days for Primary Care and Mental Health and 28 calendar days for Specialty Care.

(13) Utilizing virtual technologies such as telephone appointments, e-consults, secure messaging, text reminders, Clinical Video Telehealth (CVT), and VA Video Connect (VVC). See the MHV Secure Messaging Factsheet, located at <https://www.vapulse.net/docs/DOC-100624>, for more information. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(14) Optimizing space, staffing, and equipment considerations to best accommodate Veterans' needs at appointments.

(15) Maintaining telephone access and contact management by:

(a) Facilitating regular and consistent communication between front line providers and 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 patients are receiving timely quality phone service for any telephonic needs. Refer to the Telephone Access Improvement Guidebook, located at <https://www.vapulse.net/docs/DOC-19903> (**NOTE:**

This is an internal VA Web site that is not available to the public), and VHA Directive 2007-033, Telephone Service for Clinical Care, dated October 11, 2007.

(b) Collaborating with the call center to optimize Veteran telephone access, including exceptional customer service, call answering timeliness, and resolving requests on the first call.

(c) Monitoring the patient experience with the telephone including time to answer and call abandonment rates.

(16) Utilizing education and training resources. The CPM team will utilize national and local training modules and programs to train for onboarding and sustainment purposes. NOTE: Please refer to Paragraph 7 for more information regarding training.

7. TRAINING

a. Required trainings associated with this directive are:

(1) Same Day Services Scheduler training, TMS # 38178, as part of the onboarding curriculum, for all MSAs, Scheduling Managers and MSA Supervisors, and Scheduling Trainers hired after August 30, 2019:

(2) Same Day Services Training for Other Designated Staff, TMS # 38177, for:

(a) All clinicians in Primary Care and Mental Health (Including but not limited to, Physicians, Nurse Practitioners, Physicians Assistants, and Registered Nurses.) and all Licensed Practical Nurses, Psychologists, Pharmacists, and Social Workers, regardless of assignment.

(b) Administrative Staff: GPMs, Patient Advocates, and Public Affairs Officers (PAOs).

(c) New clinical and administrative staff in the Primary Care and Mental Health Service Lines

NOTE: *The scope of the Same Day Services training requirement is subject to change as same day offerings expand to include Specialty Care in later fiscal years.*

b. Recommended training associated with this directive can be accessed at <https://www.vapulse.va.gov/groups/group-practice-manager-pilot>. **NOTE:** *This is an internal VA website that is not available to the public.*

8. RECORDS MANAGEMENT

All records regardless of format (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. Any questions regarding any aspect of records management should be directed to the

facility records manager or records liaison

9. REFERENCES

- a. 38 U.S.C. 7301(b).
- b. VHA Directive 1230, Outpatient Scheduling Processes and Procedures, dated July 15, 2016.
- c. VHA Directive 1232, Consult Processes and Procedures, dated August 23, 2016.
- d. VHA Directive 1330.01(2), Health Care Services for Women Veterans, dated February 15, 2017.
- e. VHA Directive 1406, VHA Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017.
- f. VHA Directive 1750, VHA Managerial Cost Accounting System (Decision Support System (DSS)), dated March 24, 2015.
- g. VHA Directive 2007-033, Telephone Service for Clinical Care, dated October 11, 2007.
- h. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 05, 2014.
- i. VHA Handbook 1140.07, Geriatric Patient-Aligned Care Team (Geri-PACT), dated June 17, 2015.
- j. CPM VA Pulse Page, located at <https://www.vapulse.net/groups/vetlink>. **NOTE:** *This is an internal VA Web site that is not available to the public.*
- k. Telephone Access Improvement Guidebook, located at <https://www.vapulse.net/docs/DOC-103862>. **NOTE:** *This is an internal VA Web site that is not available to the public.*
- l. Access Principles and Strategies Guidebook, located at <https://www.vapulse.net/docs/DOC-100229>. **NOTE:** *This is an internal VA Web site that is not available to the public.*
- m. MyVA Access Implementation Guidebook, located at <https://www.vapulse.net/docs/DOC-94429?q=myva> access guidebook. **NOTE:** *This is an internal VA Web site that is not available to the public.*
- n. CPM SharePoint, located at <https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/CAAO/CMT/default.aspx>, **NOTE:** *This is an internal VA Web site that is not available to the public.*
- o. CPM Implementation Guidebook, located at <https://www.vapulse.net/docs/DOC->

[44799](#). **NOTE:** *This is an internal VA Web site that is not available to the public.*

p. Managerial Cost Accounting, Volume XIII – Chapter 3, Appendix C (VHA Standardization of Stop Codes).