

H. AMBULATORY PROVIDER PRODUCTIVITY BENCHMARKS

H.1 “PRODUCTIVITY”

The rate at which providers see patients is often called productivity. However, many factors other than provider effort or efficiency influence this productivity. Two factors that significantly influence the rate at which providers see patients are patient morbidity and education of trainees. Older, sicker, and more complicated patients cannot be seen as quickly as young, healthy patients. The teaching function often tends to slow patient evaluation because each case must be individually discussed with the trainee. On the other hand, senior residents and fellows often function at a very high level of competency and can enhance rather than reduce the clinical productivity of the attending physician.

“Productivity” is a value-laden word, and high productivity is generally considered better than low productivity. However, a provider *can* work too fast—it takes time to listen to patients and answer their questions. In the discussion that follows, we use the word productivity in the context of what is appropriate for good care.

H.2 PRODUCTIVITY BENCHMARKS AND CAPITAL ASSET PLANNING

Productivity is important to consider when planning a facility because it has a direct bearing on space utilization. More “productive” providers see more patients in a given time and fewer providers are needed. Healthcare architects use the number of providers as one of the “defining characteristics” of an appropriately sized ambulatory facility. Modifications are made for teaching and non-teaching environments so that trainees can be accommodated in space planning.

Space configuration is not only driven by productivity assumptions, space configuration also drives future productivity. A provider who only has one exam room cannot maximize his or her productivity. Maximization requires at least two exam rooms per attending physician, which is the standard we used. The appropriate benchmarks, therefore, lay the strategic groundwork for reduced scheduling and waiting times stipulated in the Discriminating Criteria. Actually achieving these goals further relies on implementation and management decisions.

H.3 DERIVATION OF AMBULATORY PRODUCTIVITY BENCHMARKS FOR STRATEGIC PLANNING

We used the benchmarks described in Exhibit H-1 in the strategic planning process. First, we gathered a number of existing benchmarks that aggregated a spectrum of care environments including the private sector, academic environments, military, and VA. These included the Medical Group Management Association’s Physician Production and Compensation Survey, the Bristol Resource Planning Model based on Military Healthcare Optimization Standards, the Bristol database of civilian healthcare organizations (community hospitals–academic medical centers), and Longshore and Simmons article in the March 1995 edition of *Health Care Strategic Management* on base rate physician need.

Next, we customized the approach for each the four categories of care: primary care, specialty medical care, specialty surgical care, and psychiatric care. After arriving at a benchmark, we built a 20 percent planning range around it, consistent with the strategic nature of the process. After formulation, these benchmarks were reviewed with VA clinical experts.

Exhibit H-1. Productivity Benchmarks and Ranges for Ambulatory Space Planning

Service	Benchmarks (Medians)	BA&H Target for Space Planning ¹	Planning Range
Primary Care	3,275	3,300 ⁴	3,000-3,600
Medical Specialties	2,580 ²	2,145 ⁵	1,930-2,360
Surgery Specialties	3,359 ²	2,950 ⁵	2,655-3,245
Mental Health	1,750 ³	1,750	1,575-1,925

1) The target was developed in consideration of the VA's patient acuity in comparison to private sector and the training activities conducted at many VA medical centers.

2) Adjusted for projected volume distribution among specialties.

3) Expert consensus, consistent with VISN 12 strategic plan.

4) Midpoint between calculated workload for panel size of 1,000 and 1,200.

5) Midpoint between adjusted median and adjusted 25th percentile.

- Primary Care.** The benchmarks used were the VAHQ panel size standard of 1,000 patients per physician and the VISN 12 panel size standard of 1,200 patients per physician. These panels were projected to generate a range of 3,000 to 3,600 visits per year. The midpoint, 3,300, compared favorably to the median private sector academic aggregated benchmark.
- Medical Specialty Care.** This includes a broad range of specialties from cardiology to dermatology to nephrology and others. Panel sizes are less appropriate in specialty care because it is often episodic rather than longitudinal in nature. No VA standards for medical specialty productivity exist so we used an aggregated private sector academic standard. After examining that standard, the consensus of physician consultants was that VA currently operates closer to the 25th percentile and had the potential to improve productivity but was unlikely to reach the 50th percentile. Three principle reasons for the lower range of productivity were: increased patient morbidity, teaching missions, and lack of financial incentives.

Using actuary demand projections for each service, we assigned to each subspecialty an appropriate quantitative weight reflecting the contribution of that subspecialty to the overall workload in the medical subspecialty category. We adjusted the 25th and 50th percentiles using those weights. We then selected a point midway between the adjusted 25th and 50th percentiles and build a 20-percent planning range around it.

- Surgical Specialty Care.** Surgical specialty care is similar to the process for medical subspecialty described above, but we used private sector academic surgical benchmarks adjusted for the actuary's outpatient surgical demand projections.

- **Psychiatric Care.** Because there is no adequate private sector correlate of the VA mental health population, and private sector services do not mirror the VA spectrum of services, we felt private sector academic benchmarks were not as useful in this category. In this case, we relied on mental health experts from VA, the VISN, and other sectors to arrive at a reasonable estimate. For delivering mental health services in the VA, the consensus was that a team approach, using a mix of psychologists, social workers/counselors, and psychiatrists, would be most appropriate. In this structure, psychiatrists focus primarily on medication management and seeing patients more quickly, while other providers focus on counseling, which is more time-consuming. The benchmark range represents an aggregate of these differing “productivity” rates.