

PRIMARY CARE DIRECT PATIENT CARE TIME

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines policy for requiring that VHA primary care practices enter data into the Primary Care Management Module (PCMM) about Primary Care Provider (PCP) and Associate Provider (AP) resources using a standardized approach.

2. BACKGROUND

a. This VHA Directive builds on past directives that have required PCPs and APs to use PCMM to assign patients to providers as part of the management of outpatient primary care. PCPs manage the overall care provided to the majority of veterans in the Department of Veterans Affairs (VA) health care system and are an important factor in determining the total number of patients that can be cared for in the system. This Directive requires the entry and transmission of two key fields of information that allow quantification of primary care capacity. It is imperative that the recording of primary care capacity be done in a standardized and consistent way throughout the VA health care system. A national roll-up of this information is not meaningful unless each site follows the same standardized rules for recording this information.

b. The first key piece of information is Primary Care Direct Patient Care (PCDPC), defined as the time providers have to prepare, provide for, and follow-up on the clinical care needs of outpatient, primary care patients, expressed as a portion of a Full-time Equivalent (FTE) employee. PCDPC is not intended to represent, exclusively, time spent in providing face-to-face care with primary care patients. It represents the portion of a full-time 40-hour FTE that each provider spends in providing primary care to the provider's panel. The PCDPC Guidelines, found in Attachment A, are business rules written to establish a uniform method of documenting primary care time within VHA. They reflect the method chosen by a group of physicians and PCMM coordinators after a great deal of deliberation and discussion. It is critical that sites follow the standardized rules provided in this Directive when recording information relating to PCDPC Time.

c. The second key piece of information is the expected maximum panel size for each provider. It represents the total maximum number of patients each provider is expected to care for on their panel. This number is determined locally, as it is recognized that panel sizes vary depending on such factors as the disease burden of the patients on the panel, the number of support staff, the number of clinic rooms, and the time available for direct patient primary care. Maximum panel size, when aggregated, represents the actual primary care capacity that is available in the system.

d. The PCP assumes responsibility for planning, coordinating, and ensuring continuity of care for the patient including maintenance of health and treatment of illness. Only medical

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doctors and Doctors of Osteopathy can be designated as PCPs, as well as nurse practitioners (NPs) or physician assistants (PAs) when their scope of practice or locally-established privileges encompasses the skills and responsibilities required to provide primary care to the patient. Only NPs, PAs, and resident physicians can be designated as APs. For the purposes of this policy, “resident physicians” refers to physicians in postgraduate training, including interns. Fellows may be designated as APs or, if board certifiable, as PCPs. Other clinicians on the primary care team, e.g., social workers, dietitians, podiatrists, nurses, and administrative personnel are not to be identified as PCPs or APs; therefore, the “Direct PC FTE” is not entered for these positions. The PCMM “Direct PC FTE Report” lists all primary care providers and can be used to identify clinicians and administrative personnel who incorrectly have the “Can Provide Primary Care?” box checked.

3. POLICY: It is VHA policy that, for each PCP and AP, the amount of time spent in providing direct patient care to their panel of primary care outpatients, PCDPC must be entered in the “Direct PC FTE” field (404.52, .09) in PCMM, and the maximum panel size representing the maximum number of patients to whom this provider delivers primary care must be entered in the “patients per physician allowed” field (404.51, .08) in PCMM.

4. ACTION

a. **Veterans Integrated Service Network (VISN) Director.** The VISN Director must ensure that the PCMM software is maintained and updated on all medical centers' Veterans Health Information Systems and Technology Architecture (VistA) systems, in accordance with nationally-distributed software and software patches.

b. **Facility Director.** The facility Director, or designee is responsible for ensuring that:

(1) “Direct PC FTE” field (404.52, .09) is entered for each PCP and AP in PCMM and is kept current and accurate. The “PCDPC Guidelines for PCMM” in Attachment A must be used to ensure that a correct “Direct PC FTE” is derived for each PCP and AP. PCDPC FTE is to be constructed using rules defined in Attachment A. In addition, for each PCP and AP, the maximum panel size represents the maximum number of active patients to whom this provider should deliver primary care. This needs to be entered into the PCMM field “patients per physician allowed” (404.51, .08), and transmitted to the Austin Automation Center (AAC) on a regular basis.

(2) The PCMM Direct PC FTE Report, available only through PCMM VistA, must be used to identify personnel incorrectly identified as PCPs, e.g., dietitians, social workers, administrative staff, etc. The “PCMM Enhancements for Direct Primary Care User Guide” provides detailed instructions on entering the data and printing the “PCMM Direct PC FTE” report. This user guide and other PCMM manuals are available in the VistA Document Library on the VHA intranet at: <http://www.va.gov/vdl/application.asp?appid=95>

(3) The maximum panel size, “Patients for Position Allowed” field (404.51, .08) is entered for each PCP and AP in the PCMM at the time a panel is created and is updated whenever the maximum panel size for a given provider changes.

(4) Additions and changes in the “Direct PC FTE” and “Patients for Position: Allowed” field (404.51, .08) are transmitted to the AAC each night.

(5) Institutions entered in PCMM are in the nationally-available Institution file (4). *NOTE: Institutions that have been added only to a site-specific Institution File, and entered in the PCMM Institution Field, will cause HL7 transmission errors from AAC.*

(6) Each PCP’s and AP’s direct primary care hours in the Decision Support System (DSS) are validated; that they are current, accurate, and comparable to PCMM’s “Direct PC FTE;” and that the accuracy of the data is maintained. *NOTE: This issue may not be applicable for all resident physicians, as resident physicians’ time is generally not labor mapped in DSS.*

(7) The PCMM patches SD*5.3*264, SD*5.3*278, SD*5.3*272, SD*5.3*280, and associated patches, provided in the patch messages and documentation, are installed.

(8) Accurate and timely transmission, validation, and error rejection corrections of “Direct PC FTE” and “Maximum Panel Size” data occur. The following requirements must be validated periodically:

(a) Nightly transmissions are done via option PCMM HL7 Transmission.

(b) Mail group PCMM WORKLOAD FTEE MAIL GROUP is appropriately set up.

(c) PCMM reject transmission menu options are used regularly to review, correct, and retransmit PCMM workload errors.

(d) PCMM WORK logical link is transmitting data and that outgoing mail transmission queues to the AAC are functioning.

(9) The transmission of the “Direct PC FTE and “Patients for Position Allowed,” data is monitored at regular intervals with the “HL7 Main Menu” and the “PCMM Reject Transmission Menu” options. Additionally, frequent monitoring of the PCMM HL7 mail groups and retransmission of rejected messages needs to occur.

(10) Each first line supervisor of the Primary Care Providers and Associate Providers validates the accuracy of the “Direct PC FTE” and “Maximum Panel Size” entered for their providers; and that it is updated when changes occur. The “PCDPC Guidelines for PCMM” in Attachment A must be used to ensure that a correct “Direct PC FTE” is derived for each PCP.

5. REFERENCES: Implementation Guide and PCMM manuals. Available on the Department of Veterans Affairs (VA) intranet at the web address, at: <http://www.va.gov/vdl/#clinical>.

6. FOLLOW-UP RESPONSIBILITY. The Office of Primary Care (11PC) is responsible for the contents of this Directive. Questions may be directed to (202) 273-8558.

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7. RESCISSIONS: VHA Directive 2003-022, dated May 15, 2003, is rescinded. This VHA Directive expires November 30, 2011.

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Attachment

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ATTACHMENT A

PRIMARY CARE DIRECT PATIENT CARE GUIDELINES FOR THE PRIMARY CARE MANAGEMENT MODULE (PCMM)

The Primary Care Direct Patient Care (PCDPC) Guidelines are business rules written to establish a uniform method of documenting primary care time within the Veterans Health Administration (VHA). These Guidelines, written in response to the pressing need for consistent and accurate data, reflect the capacity of the system to make care available to patients. The most reliable way to collect data is for each facility to document direct patient care time and non-patient care time in the same manner. The PCDPC Guidelines reflect the method chosen by a group of physicians and Primary Care Management Module (PCMM) coordinators after a great deal of deliberation and discussion. *NOTE: These Guidelines are not meant to determine how a facility staffs its clinics. The rules do not take into account the vast differences in staffing and physical structure experienced by different facilities. It is hoped that the Guidelines provide the kind of information needed to augment improvements in the delivery system of care.*

1. PURPOSE. This VHA Attachment sends clear and consistent guidelines necessary for VHA primary care practices to standardize the entry of data on Primary Care Provider (PCP) and Associate Provider (AP) resources into the PCMM across all Veterans Integrated Service Networks (VISNs).

2. BACKGROUND

a. The PCMM application assists facilities in implementing and managing primary care activities. Users may establish teams, assign staff to positions within a team, and assign patients to a team and to PCPs and APs. The PCP and PC team information is captured in PCMM in the local database. Data rolled up to the national level is manipulated and is stored in the Austin Automation Center (AAC) for use in national reporting and performance measures.

b. The Assistant Deputy Under Secretary for Health for Operations and Management in a memo to the Chief Information Officer (CIO), February 1, 2002, expressed concern that “we do not know what our capacity is within the system to take care of patients who seek Department of Veterans Affairs (VA) care. One of the primary vehicles we use to assess capacity is the Veterans Health Information Systems and Technology Architecture (VistA) PCMM. This software is used to assign patients to PCPs and APs and is an important component of waiting time reduction.” This memo set forth the task to include in PCMM the number of hours per week that the PCP is available to see patients in their primary care clinics.

c. A user group made up of physicians and PCMM users was formed to create a standardized definition for use to enter data on available PCP and AP resources into the PCMM. It is recognized that there is no single best way to determine primary care clinic capacity, but a standardized approach throughout VHA was necessary.

3. METHODOLOGY

a. This Attachment incorporates Decision Support System (DSS) guidelines into the definition of PCDPC. DSS already has an established set of guidelines for the definition of Direct Patient Care that can be made applicable to PCDPC. *NOTE: The advantage of using the DSS guidelines is that these guidelines have been in use and have been tested over time. This provides a consistent characterization of direct care. For example, telephone care is direct care in VISN 1, in VISN 13, and in VISN 16.* The basis for entering PCDPC is to be the same throughout the VISNs.

b. Each facility must ensure that it has the DSS subgroup “Primary Care” under Direct Patient Care, and that this is used to map the time PCPs and APs spent in taking care of primary care panels.

c. This methodology incorporates the definitions of administration, education, and research specified by DSS into the PCDPC guidelines.

d. Local facilities must continue to determine panel size for their individual providers. It is only on the local level that it is known what the level of support staff, space, team structure, etc., exists that may affect appropriate panel expectations. Because all facilities are using the same definition of PCDPC, time allotted to non-direct care is consistent (see par. 5).

e. Each facility must review their DSS mapping to ensure that activities of each clinician are allocated to the appropriate service. Many clinicians, for example, provide PC and specialty care services.

f. It is important to note that the disadvantage of using DSS guidelines is that DSS guidelines need modification to more accurately capture all clinician activities. When a problem with the guidance provided in the DSS guidelines is found, those issues need to be referred jointly to DSS and to the VA Central Office Primary Care Service for resolution. Once there is resolution, this document should be revised.

4. ASSUMPTIONS

a. Rather than adding up available hours, DSS works from the approach that a clinical provider's time is involved in those tasks that are necessary to provide clinical care. Resources are subtracted only if the individual is doing something that meets the criteria for exclusions to direct patient care (see par. 5). The definition of hours worked for a full-time PCP or AP assumes that vacation time, sick time, break time, and other incidental times are taken into account when determining workload.

b. Available provider resources, as measured by PCDPC, are only one factor that can be taken into consideration when determining the expected panel for individual providers. Numerous other factors, such as level of support staff, space, and administrative support and

team roles, can legitimately affect the determination of an appropriate panel size. Expected panel size is determined at the local level and is not calculated automatically from PCDPC.

NOTE: This document should not be construed as the absolute final position, but instead it serves to move multiple parts of the health care system toward the ultimate goal.

c. DSS and PCMM are not integrated systems. Although comparisons of the data are not expected to match exactly, discrepancies between the two systems present the opportunity for validation that could reveal areas for improvement in either or both systems.

5. DEFINITIONS. The following definitions are taken from the DSS definitions of Direct Patient Care, Administration, Research, and Education.

a. **Direct Patient Care.** Direct patient care is defined as the time to prepare, provide for, and follow-up on the clinical care needs of patients. This will include all time spent in reviewing patient data, discussions about the care with colleagues, reviewing the medical literature, and contacting the patient or caregivers to discuss their needs. In DSS, this time is allocated to various direct care departments in proportion to the time spent in each of these activities. Examples are:

(1) Time spent rendering care to a patient by physicians, nurses, residents, technicians, and other allied health personnel.

(2) Time spent in direct supervision of house staff providing direct patient care. For example, serving as an attending for house-staff clinics.

(3) Time spent charting patient treatment, as well as ordering and reviewing patient tests and consultations.

b. **PCDPC.** PCDPC is defined as the time to prepare, provide for, and follow-up on the clinical care needs of outpatient PC patients.

(1) PCDPC covers all those activities involved in providing PC to a panel of patients. These include:

(a) Time with patients and family in clinic.

(b) Review of patient records.

(c) Documentation of patient care.

(d) Telephone care.

(e) Group clinics.

(f) Discussion of patient care issues with consultants and other staff members.

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- (g) Attendance at educational programs aimed at maintaining or improving clinical skills.
- (h) Participation in staff meetings that are focused on the delivery of PC.
- (i) Time spent in delivering patient care with medical students present.
- (j) Precepting residents while they deliver PC.
- (k) Precepting mid-level providers while they deliver PC.

(2) Activities that should not be mapped to PCDPC include:

(a) The provision of specialty care to patients who are not in the individual's PC panel.

(b) Inpatient hospital care (even for the facility's own primary care patients). To maintain comparability across the system, the decision has been made that determination of PC panel size should be based on outpatient care only.

(c) Activities that meet criteria for Administration.

(d) Activities that meet criteria for Education.

(e) Activities that meet criteria for Research.

c. **Administration.** Administrative time includes time spent on managerial or administrative duties generally at the level of the service, medical center, or nationally, both within and outside VA. This time for professional staff is allocated as administrative time. Examples are:

(1) Time spent in support of service-wide administrative activities, such as completing performance reviews, and medical center and VA Central Office reporting requirements.

(2) Time spent managing a program within the service or hospital-wide.

(3) Time spent working on service or hospital-wide committees.

(4) Time spent working on medical school committees.

(5) Time spent serving on state and national committees, advisory boards, or professional societies.

d. **Education.** Education is defined as time spent in formal training activities (didactic education) generally not directly involving patient care. This can include preparation and actual classroom or lecture time for educators or presenters. If the education is directly related to the staff's patient care responsibilities or an expectation of their supervisor to maintain their

employment, it is considered the cost of direct patient care. For example, learning about the operation of new equipment in the cardiac catheterization laboratory or attending a mandatory Quality Management in-service session are both considered the cost of direct patient care activities and not education. In addition, time spent on house staff teaching rounds is considered the cost of direct patient care and not education. Examples are:

- (1) Time spent giving conferences in the community or nationally.
- (2) Time spent in classroom teaching medical school curriculum.
- (3) Time spent in classroom teaching of residents and fellows.
- (4) Time spent in managing a resident, fellow, or student teaching program.

e. **Research.** Research is defined as the time spent performing formal, approved research or in activities directly in support of approved research. Formal, approved research is research that either is approved through the hospital research review process or has the approval of the employee's service chief. Support activities include time spent by the investigator in direct support of research activities. Research can be laboratory, clinical or health services research. Examples are:

- (1) Time spent working in an actual research laboratory or controlled type setting that involves no direct patient care or treatment.
- (2) Time spent serving on hospital or affiliate research committees.
- (3) Time spent in supervision of student, resident, or fellow research.
- (4) Time spent writing for publication.
- (5) Time spent attending meetings explicitly related to research activities.
- (6) Time spent presenting papers at research meetings.
- (7) Time spent sitting on a national study section or grant approving board.

6. EXAMPLES OF MAPPING PCP'S TIME. The following examples help illustrate how to map the time of PCPs with a range of different responsibilities:

a. **Full-time Primary Care**

(1) Dr. Jones is a full-time VA staff physician working in a Community-based Outpatient Clinic (CBOC). His clinical responsibilities consist entirely of providing outpatient PC to a panel of patients. He does not provide any specialty care or inpatient care. He is not responsible for managing any programs and does not serve on any medical center or VISN committees. He is not involved in any educational programs or research.

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(2) **Dr. Jones should be mapped as 1.00 Full-time Equivalent (FTE) PCDPC.**

b. Administration

(1) Dr. Sanchez is the Associate Chief of Staff (ACOS) for Ambulatory Care (AC) at a VA medical center. She spends half of her time handling administrative responsibilities as ACOS/AC. She manages the outpatient programs and serves on a variety of medical center and VISN committees. She spends the other half of her time as a PCP and follows a panel of patients that is half the size of the full-time PCPs at her practice site. She does not provide any specialty care or inpatient care. She is not involved in any educational programs or research.

(2) **Dr. Sanchez should be mapped 0.50 FTE PCDPC and 0.50 FTE Administration.**

c. Education

(1) Dr. Shah is an academic primary care general internist working at a VA medical center affiliated with a medical school. He is the Clerkship Director for the third-year medical student Ambulatory Care rotation. He spends 1 hour per day giving a lecture to the 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 spends the remaining 80 percent of his time providing primary care to a panel of patients that is 80 percent of the size of full-time PCPs in his practice. He provides no specialty or inpatient care and is not involved in research.

(2) **Dr. Shah should be mapped 0.80 FTE PCDPC and 0.20 FTE Education.**

d. Research

(1) Dr. Orlovsky is a VA staff physician who recently received a full-time Career Development Award in health services research. She continues to see patients and provide primary care to a panel of patients 1 day per week. The other 4 days per week she spends involved in her research activities. She provides no specialty care or inpatient care. She is not involved in any educational activities.

(2) **Dr. Orlovsky should be mapped 0.20 FTE PCDPC and 0.80 FTE Research.**

e. Specialty Care

(1) Dr. Li is a full-time VA staff physician who spends 50 percent of his time providing primary care to a panel of patients and 50 percent of his time as a pulmonary consultant providing consultation on patients followed by other PCPs. He is assigned a panel 50 percent the size of the full-time PCPs in his practice. He provides no inpatient care. He is not involved in any educational programs or research.

(2) Dr. Li should be mapped 0.50 FTE PCDPC and 0.50 FTE to Pulmonary Medicine Direct Patient Care.

f. **Inpatient Care**

(1) Dr. Smith is a full-time staff physician at a VA medical center that has an inpatient medical acute care unit. For about 6 months of the year, she serves as attending physician for one of the inpatient medicine teams. This activity takes about 4 hours per day so, when she is attending, she spends about 50 percent of her time on inpatient care and 50 percent on outpatient PC. During the 6 months when she is not attending, she spends full time providing care to her panel of PC patients. She follows a panel that is 75 percent of the size of full-time PCPs. She does not provide any specialty care and is not involved in any educational programs or research.

(2) Dr. Smith should be mapped 0.75 FTE PCDPC and 0.25 FTE to Acute Inpatient Direct Patient Care.

7. ASSOCIATE PROVIDERS (APs)

a. APs are either resident physicians, NPs or PAs who are practicing primary care under the supervision of a Precepting PCP. All resident physicians who are not board certifiable must be APs. NPs and PAs can practice either as PCPs, if their scope of practice or locally-established privileges encompasses the skills and responsibilities required to provide primary care to the patient, or as APs. PCDPC FTE must be entered for all APs, including resident or intern physicians, as well as NPs and PAs.

b. For NPs and PAs, PCDPC FTE is determined using the method and the same business rules as for PCPs' described in paragraph 6.

c. For residents, FTE is based on the proportion of a 40-hour outpatient clinic work week they dedicate to a primary care continuity clinic. For example, if residents spend two afternoons (half days) a week, providing patient care in a primary care continuity clinic, PCDPC FTE would be 0.2. If they spent one afternoon a week, it would be 0.10 FTE, and if one afternoon every other week, it would be 0.05 FTE. For those residents whose assignments vary month-to-month, one should base their time in clinic on the assumption that 1.0 PCDPC works an average of 44 weeks per year (52 weeks minus holidays, annual leave, authorized absence and sick leave). Thus, a resident who spends a total of 33 afternoons in primary care continuity clinic over the course of the year would be considered 0.075 FTE.

d. Some practices assign specific patients and panels to APs. When this approach is used, the maximum panel size for the AP is to be entered into the field "maximum patients allowed." In such cases, maximum patients allowed for the precepting physician must include only those patients whom the precepting physician follows on the precepting physician's own.

e. Other practices prefer to assign all the patients to the precepting physician and not assign specific panels to the AP. This is acceptable. However, PCDPC FTE still needs to be entered into PC for those APs, reflecting the time they contribute to the primary care of their precepting

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physician's panel. When this approach is used, "maximum patients allowed" is to be entered as zero for the APs. In such cases, the maximum patients allowed for the precepting physician would include all the patients in the panel and reflect the total capacity of the team (PCP + APs).

8. FREQUENTLY ASKED QUESTIONS (FAQs)

a. **"Administrative Time."** The providers at our clinic are given ½ day per week where no patients are scheduled into their clinics. This allows them to catch up on telephone calls, filling out forms, writing letters, etc. We have called this "Administrative Time." Should this be mapped to administrative time or to PCDPC?

Response. It should be mapped to PCDPC. Administrative time includes the management of medical center programs or participation at medical center-, VISN-, etc., level committees. Providing primary care to a panel of patients involves a significant amount of activity outside of face-to-face time with the patients in the clinic office. The activities described for this "administrative time" relate to providing patient care to a panel of patients. These other activities are important components of direct patient care and need to be included in the time mapped to PCDPC.

b. **Telephone Care.** Is the time taken to return phone calls from my patients considered direct patient care?

Response. Yes. Time to return phone calls or complete telephone follow-up for your patients is part of providing PC to a panel of patients and should be included as part of PCDPC. If you schedule a "Telephone Visit" with a patient in lieu of a face-to-face visit or create a "Telephone Visit Clinic," this time is included in PCDPC hours. This type of visit or clinic is one of the high-leverage changes included in the Advanced Clinic Access program and may serve to decompress a provider's schedule and, in some cases, may save the patient from having to travel a long distance for a clinic visit.

c. **Appointment Length.** Does the length of the patient's appointment, or the use of "carve outs" (open time without prescheduled appointments) for urgent visits affect the measurement of PCDPC?

Response. No. PCDPC represents the net total of the time dedicated to providing PC to a panel of patients. Some providers find 15 or 20 minute appointments work best for their practice style and others find 30 minutes is needed. Some providers use "carve outs" (time in clinic is kept open for urgent visits) and others have all their time available in the scheduling package. In either case, the idea is to manage your patient panel, not visits.

d. **Mid-level Supervision.** I have a certain number of hours set aside to supervise mid-levels while they provide care in the PC clinic. Should this be counted as PCDPC?

Response. Yes. Mid-level supervision usually occurs one of two ways: either scheduled interaction time, or questions that are asked in the midst of the clinic day, between patient visits. In either case, it is time dedicated to the provision of PC to a panel of PC patients. Of note, in

PCMM, a mid-level can be either a PCP, or an Associate Provider with a Precepting Physician. This decision is up to local discretion. If the medical center decides to have the mid-level as an Associate Provider, and the M.D. as the Precepting Physician, the patients would be included in the M.D.'s panel, as precepted patients, with the mid-level as the Associate Provider.

e. **Precepting Students and Residents in the Clinic.** Sometimes in clinic I have a medical student accompanying me while I see patients. I also spend ½ day per week precepting residents while they see patients in a residency PC continuity clinic. Should this time be mapped to education?

***Response.** No. Even if the students or residents are present, the time spent providing direct patient care is mapped to Direct Patient Care. Education time should only include time that does not involve providing patient care. See definitions and criteria given in paragraph 5.*

f. **Continuing Medical Education (CME).** Our staff generally spends an hour per week at a Medical Grand Rounds. The topics are clinical and related to their patient care responsibilities. Should these be mapped to education?

***Response.** No. CME that is related to direct patient care falls into the Direct Patient Care category. Education activities should include only those activities such as giving lectures or managing educational programs that do not involve providing care to patients. See the definitions and criteria given in paragraph 5.*

g. **Level of Clinic Support.** There are two CBOCs at our medical center. In each CBOC, there is one full-time physician and one full-time nurse practitioner. At CBOC #A, there is a high level of support staff. There are seven exam rooms, two for each of the providers and one for each of the support staff. The providers are allowed to dictate their notes. In CBOC #B, there is only one medical clerk, one room for each provider and no dictation. Should the amount of provider time in PCDPC be different in the two CBOCs?

***Response.** No. In each CBOC, the amount of provider resources is the same: 1.0 M.D. and 1.0 NP. However, many factors affect the appropriate number of patients that should be in a provider's panel. The amount of support staff, space, and administrative support can affect the number of patients that a given provider can follow. Therefore, VA does not set a national policy on the specific number of patients that must be provided for each provider FTE. This is left as a local decision. Determination of the amount of provider resources, as measured by PCDPC, is only one factor that determines the appropriate panel size.*

h. **Staff Meetings.** Our staff meets on a regular basis to discuss management of the clinic. We review policies related to and problems encountered in delivering patient care. Should this be mapped to administrative time or direct patient care?

***Response.** Conceptually, the administration category involves responsibilities and activities that are distinct from patient care responsibilities. Examples include time required to manage a program (writing policies, collecting Quality Assurance (QA) data, attending meetings, planning meetings, etc.). A certain number of team and staff meetings are required for communication*

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among a team providing direct patient care. Staff meetings involving PCPs, which focus on the functioning of the clinic and the delivery of direct patient care, are most appropriately included in PCDPC Time. It is acknowledged that sometimes the border between these activities is difficult to delineate and a degree of local decision-making and differentiation is allowed for such decisions.

i. **Salary Source.** We have a career development award winner who spends 1 day per week providing care to a panel of PC patients. This physician's salary comes from a Career Development Award and is not part of our PC Service Budget. Should this individual's time still be mapped to PCDPC?

***Response.** Yes. The key point is this individual's time is available to provide PC to a panel of patients. In some cases, the salary may be paid by other clinical services, by Research, by contract or the employee may even be a Without Compensation (WOC) volunteer physician. However, in all cases, the provider's time is available to provide PC to a panel of patients and thus should be included in PCMM as PCDPC, regardless of the source of their salary.*

j. **Contract Clinics.** We have a CBOC that provides PC under a contract. Should these patients be entered into PCMM and how should we handle the mapping of provider resources and expected panel?

***Response.** VA would like all patients being provided PC to be entered into PCMM and assigned a provider and team. This is true for contract PC services as well as services provided by VA staff. Therefore, in the case of a contract clinic, a PCMM team should be created and these patients enrolled into that team. A best estimate of the provider FTE and the number of patients that can be followed at that clinic should be made and entered into PCMM.*

k. **Women's Clinic.** How do I account for Women's Clinic?

***Response.** It depends upon whether the Women's Clinic in question is providing PC or specialty care. Some women's clinics serve as PC clinics, providing ongoing PC for women, including preventive care and care for common outpatient gynecological problems (see VHA Handbook 1330.1). Such clinics should have the DSS clinic stop code 322, and the provider's time included in PCDPC. Other Women's Clinics function as specialty consult clinics for Obstetrics (OB) and/or Gynecology (GYN) problems. A specialist evaluates problems outside the scope of the patient's PCP's expertise. Such clinics should have the DSS clinic stop code 404.*

l. **Inpatient Attending Months.** At our medical center, many PC physicians spend 2 months per year as an inpatient attending. Should the amount of time mapped to PCDPC be changed for those 2 months, or can we average it over the year?

***Response.** For many providers, their responsibilities can change from month to month. Providing PC involves establishing an ongoing relationship, and the expected panel size cannot be expected to change from month to month. In most institutions, responsibilities such as these are assigned on a yearly schedule. It is better to consider time allocation on a yearly basis.*