

PRIMARY CARE MANAGEMENT MODULE (PCMM)

1. PURPOSE. This Veterans Health Administration (VHA) Handbook establishes the guidelines for use of PCMM at all VHA Primary Care sites of care. Following these guidelines will ensure that the data entered into the program is reliable and consistent across the system.

2. SUMMARY OF CHANGES. This VHA Handbook, a compilation of the Directives annotated in paragraph 5, removes duplicative information, and provides updated guidance on the software utilized for this panel management program. This update:

a. Removes the expectation that the PCMM coordinator defines the preferred site of care in collaboration with the patient and ensures updates of the Health Eligibility Center (HEC) database.

b. Discourages use of PCMM data to guide reimbursement for contract Community-based Outpatient Clinics (CBOCs) under a capitated model.

c. Ensures data validation occurs monthly so the output is as refined as possible for executive decision making purposes.

d. Establishes the policy for tracking severely injured or ill Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans using the non-primary care team function in PCMM for case management purposes.

3. RELATED ISSUES. VHA Handbook 1010.01.

4. FOLLOW-UP RESPONSIBILITY. The Office of Patient Care Services – Primary Care (11PC) is responsible for the contents of this Handbook. Questions may be directed to the Chief Primary Care Consultant at 202-461-7182.

5. RESCISSIONS. VHA Directives 99-065, 2004-031, 2006-059, and 2006-060, are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working date of March 2014.

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PRIMARY CARE MANAGEMENT MODULE (PCMM)

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures relating to the Primary Care Management Module (PCMM) software program at all VHA Primary Care (PC) facilities. Following these procedures ensures the data entered into the program is reliable and consistent across the system allowing meaningful comparisons between facilities.

2. BACKGROUND

a. Over time, the VHA has developed a primary care system that balances productivity with quality, access, and patient service. Management of patient panels in PC through mandatory and consistent use of the PCMM has supported this system redesign, and allows facilities to track patients and their assigned Primary Care Providers (PCPs) throughout the system. When the data is entered in a standardized manner, it is used to analyze the system and PCP workload nationally, by Veteran Integrated Service Network (VISN), and by facility and its substations.

b. PCPs manage the overall care provided to a majority of veterans in the Department of Veterans Affairs (VA) health care system and their workload capacity is an important factor in determining the total number of patients that can be cared for in the system. In response to the growing number of Veterans wanting to use VA health care services, there is a need to quantify the primary care capacity that is available, so that demand and supply can be better aligned.

c. PCMM allows users to set up and define a health care team, assign staff to positions within the team, assign patients to the team, and assign patients to practitioners. The PCP and primary care team information captured in PCMM is transmitted and stored at the Austin Corporate Franchise Datacenter (CFD), and is used for national reporting and performance measurement.

d. PCMM is managed by assigned PCMM coordinators at each facility. On a regular basis, PCMM data reports are posted on the VHA Support Service Center (VSSC) Web site at: <http://vssc.med.va.gov>. Validation of the data is completed monthly to ensure that definitions and decisions are subjected to ongoing evaluation and consistent interpretation.

e. PC teams from contract Community-based Outpatient Clinics (CBOCs) are tracked in PCMM with the data related to panel size, staff available, rooms available, etc. maintained as accurately as possible. **NOTE:** *Use of PCMM panel data to guide monthly reimbursement rates for contract CBOCs is discouraged.*

f. Injured or ill Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) active duty servicemembers are transitioned seamlessly from Military Treatment Facilities to VHA facilities for care that is coordinated, monitored, and tracked. All OEF and OIF servicemembers and Veterans are screened for the need for case management services by the OEF-OIF Case Management Program. PCMM provides a case management tracking mechanism

for any OEF or OIF Veteran that is being case managed by the OEF-OIF Case Management Team by utilizing the Non-Primary Care OEF-OIF Transition Team setup.

3. SCOPE

a. This Handbook provides a programmatic overview of primary care panel management in VHA by standardizing the definitions for data input and providing guidance to PC leaders and PCMM coordinators in interpreting the information reported, and providing tracking capabilities to specific case managers.

b. PCMM is used to identify the PCP assigned to care for each PC patient. Current primary care panel capacity can be measured using PCMM by determining the number of active primary care patients assigned to a PCP. Recording primary care assignments is 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 rules for recording this information.

4. DEFINITIONS

a. **Primary Care Management Module (PCMM)**. PCMM is a Veterans Health Information Systems and Technology Architecture (VistA) application that allows input of facility specific and panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes.

b. **Primary Care Provider (PCP)**. PCPs are physicians, nurse practitioners, and physician assistants who provide ongoing and comprehensive primary care as defined by their privileges or scope of practice and licensure to a panel of assigned patients. ***NOTE:** Physicians in Fellowship programs may be PCPs if they are Board Eligible.*

c. **Associate Provider (AP)**. APs are residents, nurse practitioners, and physician assistants who provide ongoing and comprehensive primary care in collaboration with a physician provider as a member of a primary care team for a panel of assigned patients. They practice under the supervision of a precepting PCP.

d. **Primary Care Panel**. A Primary Care Panel is the group of Veterans assigned to a specific PCP or PC team.

e. **Seriously Injured or Ill OEF or OIF Veteran**. A seriously Injured or ill OEF or OIF Veteran is defined as having one or more of the following diagnoses or medical conditions: burns, spinal cord injury (SCI), amputation, Post-Traumatic Stress Disorder (PTSD), visual impairment, and traumatic brain injury (TBI).

f. **OEF-OIF Case Management Teams**. OEF-OIF Case Management Teams are non-primary care teams composed of OEF or OIF Program Managers, Clinical Case Managers, and Transition Patient Advocates. Assignment to these non-primary care teams is separate and distinct from assignment to primary care teams in PCMM.

g. **Primary Care Direct Patient Care (PCDPC) Time.** PCDPC time is the time to prepare for, provide, and follow-up on the clinical needs of PC patients. This includes all time spent in reviewing patient data; discussions about the care with colleagues; reviewing the medical literature; contacting the patient, family or other surrogate decision-makers, or caregivers to discuss their concerns or needs; and collaborating with potential and actual non-VA, community-based health agencies and facilities on patients' behalf. In the Decision Support System (DSS), this time is allocated to primary care departments in proportion to the time spent in each of these activities.

(1) Examples of activities involved in providing PC to a panel of patients are: time with patients, caregivers, and family or other surrogate decision-makers in clinic and over the phone; a review of patient records; documentation of care; telephone care group clinics; discussion of patient care issues with consultants and other staff members; attendance at educational programs focused on maintaining or improving clinical skills; participation in staff meetings that are focused on the delivery of PC; communicating and collaborating with non-VA professionals, agencies, and facilities involved or potentially involved with patients' care; time spent in patient care delivery with medical students present; precepting residents while they deliver PC; and precepting mid-level providers while they deliver PC, etc.

(2) Activities that are not considered PCDPC are the provision of specialty care to patients who are not in the provider's PC panel, inpatient hospital care (even if for a provider's own PC patients), administrative activities, research activities, and education activities.

h. **Primary Care Intensity Score.** VHA has analyzed patient characteristics to identify factors that affect demand for PC services.

(1) These factors included a wide-range of demographic variables including patient age, sex, priority group, insurance status, as well as diagnoses (categorized on the basis of Diagnostic Cost Groups (DCGs), a well-established diagnostic classification known to be correlated with health care utilization). These factors reflect a combination of complexity of illness and reliance on VHA.

(2) Using the data in the VHA visit file for primary care clinics, a model has been developed that predicts the average number of primary care visits an identified primary care population is likely to make, given its patient characteristics. This predicted number of visits is compared to the VHA average, providing a "Primary Care Intensity Score."

i. **Modeled Panel Size.** The baseline expected panel is 1,200 patients for a full-time physician provider.

(1) The VSSC uses Primary Care Intensity Scores and current levels of clinic room and clinic support staff for each site to calculate adjustments to primary care panel size based on criteria enumerated in paragraph 9. The model used is approved by the VHA Advisory Group on Physician Productivity and Staffing. **NOTE:** *Due to the difficulty of obtaining and monitoring data from contract CBOC sites, they are excluded from this calculation.*

(2) In the case of a Primary Care Panel that is dominantly or entirely populated by patients with specific, complex diseases or care needs (such as a Geriatric Primary Care panel, a SCI Panel, a Women's Primary Care panel, or an Infectious Disease or Human Immunodeficiency Virus (HIV) panel) the Primary Care Intensity Score may not provide a sufficient adjustment to recommended panel size and local, regional and national guidelines may be the basis for adjusting the recommended panel size.

5. RESPONSIBILITIES OF THE VISN DIRECTOR

The VISN Director is responsible for:

- a. Ensuring that the PCMM software is installed, updated, and maintained on all medical center Veterans Health Information and Technology Architecture (VistA) systems.
- b. Identifying a VISN PCMM Coordinator.

6. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The facility Director, or designee, is responsible for:

- a. Identifying the facility PCMM Coordinator.
- b. Ensuring that the PCMM software is fully utilized and maintained.
- c. Ensuring that all OEF and OIF Veterans, being case managed by the OEF-OIF Case Management Team, are assigned to Non-Primary Care OEF-OIF Transition Team using the PCMM software patch SD*5.3*515, which was released on September 26, 2007.
- d. Having a method of ensuring that the initial PCMM assignment takes place with the first visit to the facility.
- e. Mapping PCDPC time (see par. 16).

7. RESPONSIBILITIES OF THE FACILITY CHIEF OF STAFF

The facility Chief of Staff is responsible for:

- a. Determining the time allocation for each PCP dedicated to patient care, and maximum panel expectations.
- b. Reviewing PCMM data related to efficiency, workload, and staffing. The Chief of Staff may delegate this responsibility to a PC clinical leader or designee. At larger sites with PC teams in more than one clinical service (e.g., PC and SCI Service), the Chief of Staff may designate this responsibility to more than one primary care clinical leader.

8. RESPONSIBILITIES OF THE FACILITY PCMM COORDINATOR

The facility PCMM Coordinator is the designated staff member at each parent facility who maintains the currency of the information in the PCMM database and responds to data updates reported in VSSC. The PCMM Coordinator is responsible for:

- a. Working with and responding to the PC clinical leader, or designee, to ensure that the data input accurately reflects the current status of PC at the parent station and substations.
- b. Following PCMM Guidelines and patch-specific information for use of PCMM software as posted on the VHA Software Document Library at:
<http://www.va.gov/vdl/application.asp?appid=95>.
- c. Ensuring PCMM software patches are installed when released to ensure ongoing, reliable, and comparative data.
- d. Following the procedures in paragraphs 10, 11, and 12.

9. RESPONSIBILITIES OF THE FACILITY DSS COORDINATOR

The facility DSS Coordinator is responsible for ensuring that the activities of each clinician are mapped to the appropriate service. The PCMM Coordinator and the DSS Coordinator ensure consistency of the Full-time Equivalent (FTE) employee allocations used by each.

10. RESPONSIBILITIES OF THE FACILITY OEF-OIF PROGRAM MANAGER

The Facility OEF-OIF Program Manager is responsible for:

- a. Meeting with the PCMM Coordinator to assign staff to the OEF-OIF Transition Team positions.
- b. Keeping all team positions and patient assignments up to date. Patients will not be inactivated from the OEF-OIF team automatically, as occurs with PC teams.
- c. Ensuring OEF and OIF Veterans who are managed by the OEF-OIF Case Management Team are assigned to the PCMM Non-Primary Care OEF-OIF Transition Team and associated positions or staff until they no longer are case managed. At that point, the patient is unassigned.
- d. Ensuring data from the Non-Primary Care OEF-OIF Transition Teams is transmitted to the Austin CFD in the same manner as PC data for national reporting purposes. **NOTE:** *It is not integrated into the PCMM data used for executive decision making for PC.*

11. PATIENT ASSIGNMENT IN PCMM

- a. All patients receiving primary care services in a VA medical center or CBOC (VA staffed or contracted) must be assigned as active patients in PCMM. Patients are assigned as an active

patient in PCMM at the time they present for their first PC appointment and not when the first appointment is scheduled. A method of ensuring that this assignment takes place with the first visit must be implemented at each site.

b. Each patient must have only one assigned PCP within the VA system.

(1) If a patient receives specialty care at a facility other than the one at which the patient receives primary care, the patient is not assigned a separate PCP at the facility providing specialty care.

(2) Patients who seek care from a VA site while traveling or need only episodic care are not assigned a second PCP at the sites of episodic care. Care must be coordinated between the secondary or episodic site of care and the home site of PC. Exceptions include:

(a) Exception 1. If a Veteran receives care between two sites of residence (i.e., south in winter, north in summer) and requires complex PC management (as assessed by the PC clinical leader, or designee, at the patient's preferred site), the Veteran may be assigned an identified PCP at each of the geographically distant residences. However, if these patients have a clear primary residence, the second PCP should not be assigned (see current VHA policy for further guidance).

(b) Exception 2. Veterans with spinal cord injuries and disorders (SCI&D) who are receiving highly-complex dual care (such as in a "hub and spokes" system of care) may be assigned two PCPs at the two sites of SCI&D care.

(3) When assigning a new patient in PCMM, it must first be determined if a patient is already assigned in PC at another facility. If the patient is enrolled in PC at another site of care, the decision whether to also assign the patient at the current site of care is made by the PC clinical leader, or designee.

(a) If the criteria for exceptions 1 or 2 are not met, the PCMM Coordinator at the receiving site communicates with the PCMM Coordinator at the prior site of care requesting PCMM unassignment. The patient is then reassigned at the new site of care. **NOTE:** A PCMM Coordinator list is posted at <http://klfmenu.med.va.gov/pcmm/>.

(b) If the criteria for exceptions 1 or 2 are met, the staff where the patient is being newly assigned designates the patient as appropriate for dual assignment on the VSSC-PCMM webpage at: vssc.med.va.gov. **NOTE:** A tutorial on this process is available at the National Training and Education Office Advanced Clinic Access Training Home Page <http://vaww.vistau.med.va.gov/vistau/aca/>.

12. INACTIVATION OF PRIMARY CARE PATIENTS FROM A PCMM PANEL

Inactivation of PC patients from a PCMM panel occurs in the following cases:

a. The patient expires. This function is automated to occur when a date of death is annotated in the Registration package, but may also be completed manually when notification of a patient death is received.

b. Established patients that have been assigned to the PCP panel for more than 12 months, but have not been seen by their current or prior PCP or AP in the past 24 months are to be considered inactive.

c. Newly assigned patients who have not been seen by their PCP or AP in the past 12 months are to be considered inactive. **NOTE:** Patch SD *5.3*.297 (released December, 2006) *inactivates patients from their PC team and position or provider panels who have not seen their PCP for specified lengths of time.*

(1) Inactive patients are assigned scheduled inactivation dates if their PC team assignment has been established for 11 months and they have not been seen in those 11 months by a provider assigned to the PCP or AP positions. After 30 days, these patients are inactivated from their Team Position assignment if they still have not been seen. Similarly, PCMM patients that have been assigned to a PC team for 12 months or longer and have not been seen within the last 23 months by a provider (assigned to the PCP or AP positions assigned to the patient on that team) are to be given scheduled inactivation dates. After 30 days, these patients are inactivated from their Team and Position assignment if they have not been seen. PCMM patients that have been identified for inactivation can be given one 60-day extension on an individual basis. **NOTE:** *Reports are available detailing inactivation activities.*

(2) Patients appropriate for removal from a PCMM panel are identified and inactivated at least monthly, although more frequent updating of PCMM is encouraged.

(a) A list of patients who meet the criteria for inactivation is available on the VSSC Web site (<http://klfmenu.med.va.gov/pmab/panel1.asp>).

(b) A list of patients who have more than one PCMM assignment is available on the VSSC Web site (<http://klfmenu.med.va.gov/pmab/assignnduplicate.asp>)

d. Patients who decide to discontinue VA care or relocate and no longer require ongoing VA primary care at the location where they are currently assigned a PCP. When staff becomes aware that a patient is planning to transfer care to another VA site, they need to assist in the transfer by contacting the accepting VA facility's referral coordinator to communicate the patient's plan and care needs. **NOTE:** *A referral case manager list is located at:* <http://klfmenu.med.va.gov/pcmm/>.

13. PROVIDER DATA ENTRY IN PCMM (PCDPC)

PCDPC is the time providers utilize to prepare for, provide, and follow-up on the clinical care needs of outpatient PC patients. It is not exclusively face-to-face time with patients, but the portion of a full time, 40-hour FTE employee that each provider spends in managing patient care.

a. PCDPC data (field 404.52, .09) is entered for each Primary Care Physician and Associate Physician in PCMM and is kept current and accurate.

(1) PCDPC data is entered as a portion of a FTE employee.

(2) The PCMM Direct PC FTE Report (available through PCMM) can be used to identify personnel who are incorrectly identified as PCPs (e.g., dietitians, social workers, administrative staff, etc.).

NOTE: Detailed instructions on entering the data and printing the PCMM Direct PC FTE report are available in the PCMM Enhancements for Direct Primary Care User Guide located at <http://www.va.gov/vdl/application.asp?appid=95%20>.

b. The maximum panel size (PATIENTS FOR POSITION – ALLOWED, field #404.57, .08) is entered for each PCP and AP in PCMM at the time a panel is created, and is updated whenever the maximum panel size for a provider changes.

(1) The maximum panel size represents the maximum number of patients each provider is expected to care for on their panel.

(2) The maximum panel size is locally determined by the Chief of Staff or designee as it is dependent on such factors as disease burden, number of support staff, number of clinic rooms, time available for direct patient PC, etc. (see par. 7). It is the actual PC panel capacity that is available in the system.

(3) Additions and changes in the DIRECT PC FTE and PATIENTS FOR POSTION – ALLOWED fields are transmitted to the Austin CFD each night.

(4) Accurate and timely transmission, validation, and error rejection corrections of DIRECT PC FTE and MAXIMUM PANEL SIZE data must occur. The following requirements must be validated periodically:

(1) Nightly transmissions are completed using option PCMM HL7 Transmission.

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

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

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

1. The transmission of the DIRECT PC FTE and PATIENTS FOR POSTIION – ALLOWED data is monitored at regular intervals with the Health Level (HL)7 Main Menu and the PCMM Reject Transmission Menu options. Additionally, frequent monitoring of the HL7 mail groups and retransmission of rejected messages needs to occur.

2. Each PCP's and AP's direct PC hours in the Decision Support System (DSS) are validated to ensure that they are current, accurate, and comparable to PCMM DIRECT PC FTE, and that the accuracy of the data is maintained. **NOTE:** *This issue may not be applicable for all resident physicians since their time is not generally labor mapped in DSS.*

14. NON-PRIMARY CARE TEAMS FOR THE MANAGEMENT AND TRACKING OF SEVERELY INJURED OR ILL OEF AND OIF VETERANS

Non-Primary Care teams in PCMM may be established and used to ensure appropriate management and tracking of severely injured or ill OEF and OIF Veterans or other groups. In these cases the:

a. Facility PCMM Coordinator is responsible for:

(1) Setting up the OEF-OIF Transition Team using the new TEAM PURPOSE of OEF/OIF option. The institution chosen for the team must be the parent facility. Duplicate teams for CBOCs are not be created.

(2) Setting up TEAM POSITIONS for the following personnel: OEF-OIF Program Manager, OEF-OIF Clinical Case Manager(s), OEF-OIF Transition Patient Advocate(s). In addition, other team positions and associated team members may be assigned to the OEF-OIF Transition Team.

(3) Assigning each patient identified by the Facility OEF-OIF Program Manager as belonging to the PCMM OEF-OIF Case Management team to the Program Manager in PCMM. Additionally, each patient must be assigned in PCMM to the Transition Patient Advocate (TPA) or the Case Manager who actively manages the patient. Other OEF-OIF team members may be assigned in PCMM at the facility's discretion. If a TPA works at multiple facilities, the TPA must be set up in the New Person file at each facility in which the TPA works.

(4) Assisting with team position assignment maintenance. Patient assignments must be made with the PCMM Graphical Use Interface (GUI) or the "Team/Position Assignment/Re-assignment" option. Access to the patient assignment option needs to be limited and all users delegated this ability must be thoroughly trained in its use.

b. Facility OEF-OIF Program Manager is responsible for:

(1) Meeting with the PCMM Coordinator to assign staff to the OEF-OIF Transition Team positions.

(2) Keeping all team position and patient assignments up to date. Patients are not inactivated from the OEF-OIF team automatically, as occurs with PC teams.

(3) Ensuring OEF and OIF Veterans who are managed by the OEF-OIF Case Management Team are assigned to the PCMM Non-Primary Care OEF-OIF Transition Team and associated positions or staff until they no longer are case managed. At that point, the patient is unassigned.

NOTE: Data from the Non-Primary Care OEF-OIF Transition Teams is transmitted to the Austin CFD in the same manner as PC data for national reporting purposes. It is not integrated into the PCMM data used for executive decision making for PC.

15. DATA VALIDATION

a. Each PC clinical lead, or designee, is responsible for:

(1) Validating the accuracy of the DIRECT PC FTE and MAXIMUM PANEL SIZE entered for their providers when it is updated as changes occur or monthly thereafter.

(2) Validating the accuracy of the data related to number of rooms, number of staff, etc. entered for their PC site, and when it is updated as changes occur or monthly thereafter.

b. PCMM coordinators validate the accuracy of the data impacting the VSSC reports for performance monitors monthly.

c. PPC sites identified as contract in the VA Site Tracking (VAST) database are not included in the roll up of PCMM data for VSSC reports for performance monitors. However, all contract sites of PC delivery must be included in PCMM with validation of the data input at least quarterly.

16. MAPPING PCDPC TIME

a. The Facility Director, or designee, is responsible for:

(1) Ensuring that it has the DSS subgroup PRIMARY CARE under DIRECT PATIENT CARE and that this is used to map the time PCPs and APs spend in managing care for their patient panels. This methodology incorporates the definitions of administration, education, and research into the PCDPC guidelines.

(2) Reviewing the facility's DSS mapping to ensure that activities of each clinician are allocated to the appropriate service. Some clinicians provide both PC and specialty care.

b. Clinical provider 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. **NOTE:** When determining workload, it is assumed that annual leave (AL), sick leave (SL), work breaks and incidental times are taken into consideration.

(1) The facility can best determine the expected panel sizes for individual providers given local factors as described in paragraph 18.

(2) DSS and PCMM are not integrated systems. Discrepancies found between the data in the two separate systems is an opportunity for validation that could reveal areas for improvement in one or both systems.

c. All resident physicians who are not board eligible must be APs.

d. Nurse practitioners (NPs) and PAs can practice either as PCPs (if their scope of practice or locally established privileges includes the skills and responsibilities required to provide primary care to the patients) or as APs. PCDPC FTE must be entered for all APs.

e. For NPs and PAs, PCDPC FTE is determined using the same business rules as for physician PCPs.

f. For residents, FTE is based on the proportion of a 40-hour outpatient clinic work week they dedicate to a PC continuity clinic. For example, if a resident spends two afternoons (half days) a week providing patient care in a PC continuity clinic, PCDPC FTE would be 0.20. If a resident spends one afternoon a week, it would be 0.10 FTE, and one afternoon every other week would be 0.05 FTE. For those residents whose assignments vary month to month, their time is based on the assumption that 1.0 FTE PCDPC works an average of 44-hours per week per year (52 weeks minus holidays, AL, administrative absence (AA), and SL). Thus, a resident who spends a total of 33 afternoons in PC continuity clinic over the course of a year would be considered as 0.075 FTE.

g. Some practices assign specific patients and panels to APs. When this approach is used, the maximum panel size for the AP is entered into the MAXIMUM PATIENTS ALLOWED field. In such cases, the maximum patients allowed for the precepting physician can include only those patients that the precepting physician personally follows in the precepting physician panel.

h. Some practices prefer to assign all patients to the precepting physician and not assign specific panels to the AP. In that case, PCDPC FTE must still be entered for those APs documenting the time they contribute to the PC of their precepting physician's panel. When this approach is used, MAXIMUM PATIENTS ALLOWED is entered as "0" for the APs. The maximum patients allowed for the precepting physician includes all of the patients in the panel and reflects the total capacity of the team (PCP and APs).

17. PRIMARY CARE PANEL SIZE

a. VHA primary care practices must establish maximum panel sizes for all PCPs and APs identified in the PCMM software. This panel consists of "active patients" for whom the provider delivers PC. In the case of a contract clinic, a best estimate of the provider FTE and the number of patients that can be followed at that clinic needs to be made and entered into PCMM.

b. **Undifferentiated PC Clinics.** Expected panel sizes for undifferentiated PC clinics (with PC DSS stop code 323) vary from site to site depending upon patient characteristics of the PC population and level of system support. For sites with a patient population reflecting the norms for disease severity and reliance on VHA and who have current norms of 2.17 support staff per 1.0 FTE provider and 3.0 clinic rooms per 1.0 FTE provider, an expected panel would be 1,200 patients for a full-time, established PC physician. After adjustment for the factors identified, expected panels for VHA PC providers largely fall in the range of 1,000 to 1,400.

c. **Specialized Panels.** Some providers may serve as PCPs for specialized panels of patients with specific, complex diseases. For example, Infectious Disease specialists may serve as PCPs

for panels of patients with HIV infection; Spinal Cord specialists may serve as PCPs for panels of SCI patients; and geriatricians, NPs, and PAs with advanced training or particular expertise in geriatrics may serve as the PCPs for Geriatric Primary Care clinics. Designated Women's Primary Care panels represent another population with specialized care requirements.

(1) The model for the Primary Care Intensity Score is not designed to account for such highly-specialized panels. It is recognized that panel sizes for specialized panels may need to be smaller than for undifferentiated PC panels. This is acceptable and the maximum panel size for these providers and panels needs to be determined locally, incorporating guidance from national programs where available. **NOTE:** *If a specialist is providing PC to an undifferentiated general PC population, there should be no adjustment for expected panel size simply because of additional specialty training; such providers need to follow the usual PC panel.*

(2) Additional clinic rooms are needed when residents, students, and trainees from other disciplines are participating in clinical activities in PC. In some cases, such as in larger resident clinics, additional support staff is needed, as well. The educational mission of VHA is critical, and provision of the appropriate clinic environment is a necessity for this mission. **NOTE:** *It is worth noting that, within VHA as a whole, the presence of resident clinics is associated with larger panel sizes for their attending physicians, since residents' patients are counted in their attending panels per current VHA policy. However, due to the great variation in the nature and scope of training programs, general guidance on adjustments for these activities is not provided. Whether and how much a site needs to adjust panel size when staff is supervising residents needs to be determined locally.*

d. **Support Staff Ratio.** Support staff ratio is the number of staff (FTE) present in the clinic area assisting providers with delivery of PC per 1.0 FTE provider.

(1) Support staff consists of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), pharmacists (including Doctor of Pharmacology (PharmDs)) medical assistants, health technicians, as well as medical clerks in the clinic. Staff involved in the Anticoagulation Clinic and Telephone Care for the PC patients during regular clinic hours need to be counted, even if located in a separate area.

(a) Time spent in the following activities must be included in the determination of support staff of FTE providers:

1. Checking patients in and out of PC appointments;
2. Obtaining vital signs;
3. Collecting medical information, and completing health screening questionnaires;
4. Clinic nursing activities, such as patient education, nursing evaluations, injections, and other office procedures;
5. Independent follow-up visits by nurses and registered pharmacists for the management of blood pressure, diabetes, cholesterol, etc.;

6. Managing coumadin; and

7. Telephone calls for PC patients.

(b) Staff time dedicated to Business Office functions, file room activities, or supporting non-PC clinics should not be included or should be pro-rated for the amount of time spent supporting PC.

(c) Dietitians, social workers, and PC-mental health integration staff are valuable members of the PC team, but for the purposes of obtaining comparable measurement of support staff across all sites, should not be included in this count.

(d) Time spent in the following activities should not be included:

1. Phlebotomy;

2. Business Office functions, such as enrolling new patients, means testing, registration, and billing;

3. Support for specialty or mental health clinics;

4. Support for dietitians, social workers, or other health care providers not working directly with the PCPs; and

5. Time spent with pharmacists filling prescriptions (e.g., at a satellite clinic or CBOC).

(2) Pro-rating support staff FTE is used when the support staff performs more than one function or supports non-PC clinics, as well as PC. Support staff is pro-rated for the time they spend in PC support versus time spent in other activities.

(3) Vacant positions are positions that are not currently filled. Such positions are not counted since inclusion would not provide an accurate measurement of the system support actually provided to PCPs. Positions may be considered filled if hiring of staff is imminent.

e. **Physical Support**

(1) Exam rooms are defined as fully-equipped rooms in which providers and other staff interview and assess patients. The total number of exam rooms in the clinic is counted. ***NOTE:*** *The question is not whether each provider uses one or two exam rooms while working in the clinic but the total number of rooms available in the clinic.* Clinic management determines how patient care flows and how many rooms the provider uses.

(2) Pro-rating rooms occurs when the clinic area is used for other activities in addition to PC, or if rooms are only in use part time. For example, if a specialty clinic provider uses an exam room 20 hours per week and PC uses the same exam room 20 hours per week, the exam room

counts 0.5 in the exam room count. Another example is an exam room used for a clinic that meets for a full day three times a week. The exam room counts as 0.6 in the exam room count.

(3) Interview rooms are clinic rooms used by clinical (not administrative) staff, but which are not fully-equipped exam rooms. The interview room count follows the same rules as exam rooms.

f. **Examples**

(1) Rural Area CBOC is a VA-staffed CBOC with two physicians dedicated full time to clinical PC (2.0 FTE PCDPC). In the clinic there is 1.0 RN, 1.0 LPN, and 1.0 medical clerk. There are no specialty clinics at the CBOC. VA staff is not involved in phlebotomy or Business Office functions.

(a) The support staff handles all telephone care for their PC population and the RN manages coumadin care with physician supervision.

(b) Each of the providers has one exam room, the RN has an exam room, and the LPN uses an interview room that is not a fully-equipped exam room. The medical clerk works in the check in-check out area.

(c) The count for this clinic would be:

RN	1.0
LPN	1.0
Pharmacist	0.0
Medical Assistant or Health Technician	0.0
Medical Clerk	1.0
Separate Telephone Care	0.0
Separate Coumadin Care	0.0
<i>Total support staff</i>	<i>3.0 FTE</i>
<i>Support staff per provider</i>	<i>1.5 FTE</i>
Exam rooms	3
Interview rooms	1
<i>Total rooms</i>	<i>4</i>
<i>Rooms per provider FTE</i>	<i>2</i>

NOTE: Clinic support is based on the total number of support staff and total number of rooms available, not the number of exam rooms each provider is using during clinic or the number of staff assigned to a specific provider.

(2) A small town CBOC is staffed by two medical doctors (MDs) and one PA, each dedicated full time to clinical PC (3.0 FTE PCDPC). There are two RNs, four LPNs, three medical clerks (3.0 FTE), and one Social Worker (SW) who provides mental health counseling. Two LPNs spend 4 hours each morning providing phlebotomy (8 hours per day or one FTE).

One of the medical clerks spends 4 hours per day doing Business Office functions (enrollment, means tests, etc.).

(a) The support staff handles all telephone care for their PC population and the RNs manage coumadin care with physician supervision.

(b) Each provider has three exam rooms and the RNs have one exam room each. The LPNs prep patients in the provider's empty exam rooms. The SW has an interview room. The medical clerks work in the check in-check out area.

(c) The count for this clinic would be:

RN	2.0
LPN (1 FTE – phlebotomy)	3.0
Pharmacist	0
Medical Assistant or Health Technician	0
Med clerk (0.5 – Business Office tasks)	2.5
<i>Total support staff</i>	<i>7.5 FTE</i>
<i>Support staff per PCP</i>	<i>2.5 FTE</i>
Exam rooms	11
Interview room (SW not PC)	0
<i>Total rooms</i>	<i>11</i>
<i>Rooms per provider FTE</i>	<i>3.67</i>

NOTE: Pro-rate the FTE for those staff that are spending time in non-PC activities. Do not include social workers or dietitians or the rooms they require as these are not PC activities.

(3) Big City VA Medical Center is an academically-affiliated metropolitan hospital. PC is delivered through two teams, the “Red Stripes” team located on the east wing and the “Blue Stars” team located on the west wing of the medical center.

(a) Red Stripes team has ten physicians and each spends 0.5 time dedicated to PC (5.0 PCDPC FTE). Some afternoons, physicians supervise residents in a PC clinic during their clinic time. There are 2.5 FTE RNs, three LPNs, and three medical clerks.

(b) Blue Stars team has five physicians dedicated full time to PC (5.0 PCDPC FTE). There are two RNs, two LPNs, and two medical clerks.

(c) Telephone care for both practices is provided by a telephone call center staffed by one RN and one medical clerk.

(d) A separate coumadin care clinic is staffed by one pharmacist and provides care for both teams.

(e) Red Stripes has fifteen exam rooms and Blue Stars have ten exam rooms.

(f) Three PC physicians are infectious disease, renal, and spinal cord specialists. They each serve as PCPs for small panels of patients with specialized conditions (HIV, dialysis, SCI) and have panels for these patients in the PCMM. However, they see these patients in their specialty clinics that are held in another part of the medical center and are not part of the Red Stripes and Blue Stars practice.

	<i>Red Stripes</i>	<i>Blue Stars</i>
RN	2.5	2
LPN	3	2
Pharmacist	0	0
Medical Assistant or Health Technician	0	0
Med clerk	3	2
Telephone care (TC) RN	0.5	0.5
TC LPN	0	0
TC Pharmacist	0	0
TC Medical Assistant or Health Technician	0	0
TC Medical clerk	0.5	0.5
Coumadin care (CC) RN	0	0
CC LPN	0	0
CC Pharmacist	0.5	0.5
CC Medical Assistant or Health Technician	0	0
CC Medical Clerk	0	0
Total support staff	10.0	7.5
Exam rooms	15	10
Interview rooms	0	0
Total rooms	15	10
<i>Total support staff</i>	<i>17.5</i>	
<i>Total rooms for site</i>	<i>25</i>	
<i>Rooms per PCP FTE</i>	<i>2.5</i>	

(5) Staff providing telephone support or CC to PC staff and patients needs to be counted even if not physically located in the PC clinic area. If telephone support or CC staff provide support to more than one PC site, their time is divided among the sites they serve and pro-rated by the amount of time they spend providing support to the patients from the different sites. The counts and adjustments do not apply to specialists who provide PC to specialized subsets of patients (and have panels in PCMM), but practice outside the PC clinic area.

18. ADJUSTMENTS TO PANEL SIZE

a. VHA and private data indicate that current levels of support staff in VHA are often below the level of private sector practices and are at a level that may reduce the productivity of individual providers. At least 2.5 FTE support staff or providers have been recommended for VHA primary care clinics. A mix of approximately 0.5 RN, 1.0 LPN or medical assistant, and

1.0 medical clerk represents a reasonable combination of staff. **NOTE:** *Levels above 2.5 FTE per 1.0 MDs may lead to further improvements in productivity and are encouraged.* Adjustment in panel size from the baseline of 1,200 for levels of support staff need to be made based on the ranges shown:

<i>Support Staff per PC FTE</i>	<i>Adjustment to Panel Size</i>
≥ 0.0 and < 1.20	- 10 percent
≥ 1.20 and < 1.40	- 7.5 percent
≥ 1.40 and < 1.60	- 5.0 percent
≥ 1.60 and < 1.80	- 2.5 percent
≥ 1.80 and < 2.20	No adjustment
≥ 2.20 and < 2.40	+ 2.5 percent
≥ 2.40 and < 2.60	+ 5.0 percent
≥ 2.60 and < 2.80	+ 7.5 percent
≥ 2.80	+ 10 percent

b. **Space.** Clinic rooms include fully-equipped exam rooms, as well as interview rooms reserved for clinical staff. Levels of 2.5 rooms per 1.0 FTE provider have been recommended as a minimum for VHA. Adjustment in panel size for room availability for a baseline panel of 1,200 needs to be made as follows:

<i>Rooms per PCP FTE</i>	<i>Adjustment to Panel Size</i>
≥ 0.0 and < 2.0	- 5 percent
≥ 2.0 and < 2.75	- 2.5 percent
≥ 2.75 and < 3.25	No adjustment
≥ 3.25 and < 3.75	+ 2.5 percent
≥ 3.75	+ 5 percent

(1) A Primary Care Intensity Score of 1.0 represents the norm for VHA. A score above 1.0 indicates a patient population that is sicker or more reliant on VHA than the VHA average, and a higher number of PC visits is expected. A score below 1.0 indicates that the patient population has a lower burden of illness or less reliance on VHA than the VHA average. Adjustment in panel size for patient characteristics needs to be made as follows:

<i>PC Intensity Score</i>	<i>Adjustment in Panel Size</i>
< 0.6	+ 10 percent
≥ 0.6 and < 0.7	+ 7.5 percent
≥ 0.7 and < 0.8	+ 5 percent
≥ 0.8 and < 0.9	+ 2.5 percent
≥ 0.9 and < 1.1	No adjustment
≥ 1.1 and < 1.2	- 2.5 percent
≥ 1.2 and < 1.3	- 5 percent
≥ 1.3 and < 1.4	- 7.5 percent
≥ 1.4	- 10 percent

(2) 1.0 FTE non-physician provider (NP or PA) is expected to carry a panel 75 percent the size of a 1.0 FTE MD. However, ratios of support staff and space should be the same for a 1.0 FTE non-physician provider as for a 1.0 FTE MD provider.

(3) Panel size should be pro-rated to the time the provider spends in PCDPC.

c. **Newly- Hired Providers**

(1) Newly-hired providers who are building a panel of new patients may take 12 to 15 months to achieve a full panel equal to that of an established provider. For the purposes of pro-rating capacity, maximum panel size for such providers needs to be set at 50 percent of a fully-established provider for the first 6 months, at 75 percent for the second 6 months, and then at 12 months increased to 100 percent.

(2) If the newly-hired provider is assuming responsibility for an established panel, approximately 9 months is allowed before that provider has the ability to care for the panel of a fully-established provider. For purposes of pro-rating capacity, the maximum panel size of such providers needs to be set at 75 percent of an established provider for these 9 months.

d. **VISN Data.** To track panel management data, the VSSC posts data on its Web site at: <http://klfmenu.med.va.gov/primarycarestaffing/>. **NOTE:** *This is an internal VA link not available to the public.* Selected staff in each VISN designated by their VISN Chief Medical Officer (CMO), working in conjunction with VSSC, has the ability to update this information on an ongoing basis. At the beginning of each fiscal year, confirmation is required from each VISN that the information on the Web site has been updated on an ongoing basis and is accurate. On an annual basis, VSSC, working in conjunction with the Chief Consultant for Primary Care, is responsible for revising the Primary Care Intensity Score Model, using data from the preceding fiscal year and providing revised Primary Care Intensity Scores for each site.

19. MONITORING AND REPORTING

a. **Performance Monitor 1.** Adjusted MD Equivalent Observed Panel versus Adjusted MD Equivalent Capacity. The target score is 0.90 to 1.05.

(1) **Goal.** The goal is to determine PC capacity in VA by dividing the number of actual patients assigned to PCPs (observed panel) by the number of potential patients that can be assigned to PCPs (maximum number of patients allowed or expected panel sizes).

(2) **Definitions**

(a) **Observed Panels.** Observed panels are the unprecepted and precepted (or shared) active panels for the PCP; i.e., the actual number of Veterans assigned to a panel in PCMM. The maximum number of patients allowed is the PC capacity at a given reporting level (e.g., facility, VISN, national) determined by summing the maximum number of patients that can be assigned to a panel. That this number accurately represents the expected panel size for each provider in PCMM, must be ensured by each site.

(b) Numerator. The numerator is the Adjusted MD Equivalent Observed Panel. It is the average of the active patients for all providers at a given reporting level (e.g., facility, VISN, national). This average is determined by summing all of the individual provider panel counts and dividing by the total FTE for these same providers (with NPs and PAs counted as 0.75 MD FTE).

(c) Denominator. The denominator is the Adjusted MD Equivalent Capacity. It is the average of the Maximum Panel Size (locally determined and input) for all providers at the given reporting level. This average is determined by summing all of the individual provider capacity values and dividing by the total FTE for these same providers (with NPs and PAs counted as 0.75 MD FTE).

(d) Observed to Capacity Ratio. The Observed to Capacity ratio is the ratio of the average observed to the average capacity for all of the providers at the given reporting level.

b. **Performance Monitor 2**. The Adjusted MD Equivalent Capacity (denominator) versus the Modeled Capacity. The target score is 0.80 to 1.20.

(1) **Goal**. The goal is to determine the predicted panel sizes based on patient characteristics, amount of support staff, and number of exam rooms.

(2) **Definitions of Modeled Capacity**. Modeled Capacity is the result of (and the VSSC has the responsibility for this) the Revision of Adjustment Factors. The VSSC must post a listing of PCP FTE, Primary Care Intensity Scores, and current levels of clinic room and clinic support staff for each site on its Web site at <http://klfmenu.med.va.gov/primarycarestaffing/>. **NOTE:** *This is an internal VA link not available to the public.*

**FREQUENTLY ASKED QUESTIONS RELATED TO PRIMARY CARE DIRECT
PATIENT CARE (PCDPC)**

1. Administrative Time. The providers at our clinic are given ½ day per week when 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 Primary Care Direct Patient Care (PCDPC)?

It should be mapped to PCDPC. Administrative time includes the management of medical center programs or participation at medical center level, Veterans Integrated Service Network (VISN) level, etc., 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.

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

Yes. Time to return phone calls or complete telephone follow-up for your patients is part of providing primary care (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.

3. 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?

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.

4. 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?

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, or 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 Primary Care Provider (PCP), or an Associate Provider (AP) with a Precepting Physician. This decision is up to local discretion. If the facility Director decides to

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have the mid-level as an AP and the medical doctor (MD) as the Precepting Physician, the patients would be included in the MD's panel as precepted patients with the mid-level as the AP.

5. 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 resident PC continuity clinic. Should this time be mapped to education?

No. Even if the students or residents are present, the time spent providing direct patient care is mapped to Direct Patient Care. Education time only includes time that does not involve providing patient care.

6. Continuing Medical Education (CME). Our staff generally spends 1 hour a week at a Medical Grand Rounds. The topics are clinical and related to their patient care responsibilities. Should these be mapped to education?

No. CME that is related to direct patient care falls into the Direct Patient Care category. Education activities are to include only those activities as giving lectures or managing educational programs that do not involve providing care to patients.

7. Level of Clinic Support. There are two Community-based Outpatient Clinics (CBOCs) at our medical center. In each CBOC, there is one full-time physician and one full-time nurse practitioner (NP). 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?

No. In each CBOC, the amount of provider resources is the same: 1.0 MD 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, the Department of Veterans Affairs (VA) does not set a national policy on the specific number of patients that must be provided for each provider Full-time Equivalent (FTE) employee. This is a local decision. Determination of the amount of provider resources, as measured by PCDPC, is only one factor that determines the appropriate panel size.

8. 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?

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 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 distinction between these activities is difficult to delineate and a degree of local decision-making and differentiation is allowed for such decisions.

9. 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?

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 needs to be included in the Primary Care Management Module (PCMM) as PCDPC regardless of the source of their salary.

10. 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?

All patients being provided PC are 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 needs to 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 is to be made and entered into PCMM. The PC contract may state the number of veterans to be seen within specific parameters to fulfill the contract. The PCMM coordinator may use this number to set a maximum panel in PCMM.

11. Women's Clinic. How do I account for Women's Clinic?

*It depends on whether the clinic provides primary care including gender specific care, or only specialty care. Increasing numbers of women's clinics serve as PC clinics, providing ongoing PC for women; including preventive care and care for common outpatient gender-specific problems (see VHA Handbook 1330.1). Such clinics may have the Decision Support System (DSS) clinic stop code 323 or 322 and the provider's time is to be included in PCDPC. Comprehensive women's clinics utilize the 322 code primarily for its DSS functionality. **NOTE:** Other Women's Clinics function primarily to provide preventive health care, or as specialty consult clinics for Obstetrics (OB) or Gynecology (GYN). A specialist evaluates problems outside the scope of the patient's PCP's expertise. Such clinics need to have the DSS clinic stop code 322 or 404 (gynecology), or 704 (for pap clinic)*

12. 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?

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.

EXAMPLES OF MAPPING PRIMARY CARE PROVIDER (PCP) TIME IN THE DECISION SUPPORT SYSTEM (DSS)

1. Full time Primary Care. Dr. Allen Adler is a full- time Department of Veterans Affairs (VA) staff physician working in a Community-based Outpatient Clinic (CBOC). His clinical responsibilities consist entirely of providing outpatient Primary Care (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 Veterans Integrated Service Network (VISN) committees. He is not involved in any educational programs or research. *Dr. Adler is mapped as 1.00 Full-time Equivalent (FTE) Primary Care Direct Patient Care (PCDPC).*

2. Administrative. Dr. Betsy Bell 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 for 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 Primary Care Provider (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. *Dr. Bell is mapped as 0.50 FTE PCDPC and 0.50 FTE Administration.*

3. Education. Dr. Charles Cary is an academic PC general internist working at a VA medical center affiliated with a medical school. He is the Clerkship Director for the third-year medical student AC 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 PC 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. *Dr. Cary is mapped as 0.80 FTE PCDPC and 0.20 FTE Education.*

4. Research. Dr. Doris Delaney 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 PC 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. *Dr. Delaney is mapped 0.20 FTE PCDPC and 0.80 FTE Research.*

5. Specialty Care. Dr. Evan Ellis is a full time VA staff physician who spends 50 percent of his time providing PC 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. *Dr. Ellis is mapped 0.50 FTE PCDPC and 0.50 FTE to Pulmonary Medicine Direct Patient Care.*

6. Inpatient Care. Dr. Francis Fuller 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. *Dr. Fuller is mapped 0.75 FTE PCDPC and 0.25 FTE to Acute Inpatient Direct Patient Care.*

FREQUENTLY ASKED QUESTIONS RELATED TO PANEL SUPPORT

1. How should we count staff in centralized check in or check out?

Staffs in these areas contribute support to Primary Care (PC). An estimate of the time they spend supporting PC is made, and that percentage of the Full-time Equivalent (FTE) is included in the PC support staff. The number of appointments in primary care versus appointments in other clinics can serve as a useful guide to that percentage.

2. We have a full time Registered Nurse (RN) clinic administrator who does not work directly in the clinic seeing patients. Should this person be counted?

No. Only staff working directly in the clinic and supporting the providers are included. If the clinic administrator spends part of the clinic administrator's time in the clinic delivering care, working as a PC RN, that portion of the clinic administrator's time can be counted.

3. Our PC clinics participate in the PC-mental health integration program. We have co-located mental health staff (physically located in our clinics), as well as collaborating mental health staff located elsewhere doing telephone mental health assessment and care management. Should these mental health staff (or their clinic rooms when co-located) be included in calculating support staff ratios or provider resources?

No. While direct collaboration with primary care staff is an important component of these programs, primary care-mental health integration staff should not be included in Primary Care Management Module (PCMM) staffing ratios. Similarly, clinic rooms of co-located mental health staff are not to be included in calculating PCMM provider resources.

4. Our providers work out of only one room when in clinic although there are additional rooms used by support staff. Shouldn't the exam room ratio be 1.0 per 1.0 FTE provider?

No. The total number of exam rooms in the clinic is what is being counted.

5. What should we do when reporting contract Community-based Outpatient Clinics (CBOCs)?

If you have reliable information regarding staff support and rooms in contract CBOCs, that information should be reported following the same rules as for Department of Veterans Affairs (VA)-staffed clinics. However, some contracts are with non-VA medical group practices and the particulars about support staff numbers, and exam rooms are completely unknown to VA staff. As contracts generally work on a per patient (capitated) or fee-for-service basis, there is not the same need for VA to set specific panel expectations for individual providers at contract CBOCs. However, all patients being provided VA PC are entered into PCMM and assigned a provider and team. This is true for contract PC services and 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 needs to be made and entered into PCMM. This allows the Veterans Health

Administration(VHA) to determine its total capacity for PC, including care delivered at contract clinics.

6. Some of our rooms are used by medical students. Should they be counted?

Yes.

7. We have a 24-hour a day, 7-day a week nurse telephone advice line. Should we count the FTE working during the weekend, holiday, evening, and night (WHEN) hours?

No. This count is measuring support available to the PCPs when they are in clinic.

8. We have approved support staff positions that are temporarily vacant. Should we change the expected panel sizes while recruitment is in process?

No. Turnover of support staff is an expected occurrence. It is not necessary to adjust panel sizes during temporary vacancies provided active recruitment of these vacancies is underway. The principle is to accurately measure support staff in place for the providers over the long term.

9. A PC physician recently retired and we have hired locums to cover the PC physician's panel. Should locums be counted in the PCP FTE count?

Yes. As with support staff, turnover of providers is an expected occurrence. It is not necessary to adjust support staff and room ratios during temporary vacancies, provided active recruitment of these vacancies is underway. The principle is to accurately measure support levels over the long term.

10. We have a Coumadin Clinic and a Telephone Call Center based at the medical center that also provides support to the PC programs in the CBOCs. Should some of the Coumadin Clinic and Telephone Care staff be counted in the CBOC counts?

Yes. The portion of time the staff spends in supporting the PC patient population based at the CBOCs needs to be counted to the CBOCs.