Department of Veterans Affairs **VHA DIRECTIVE 2005-057**
Veterans Health Administration
Washington, DC 20420 **December 1, 2005**

PHYSICIAN AND DENTIST LABOR MAPPING

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides business rules to standardize physician and dentist labor mapping across all VHA Networks in the Decision Support System (DSS). ***NOTE*****:** *The practice of designating a percentage of physician and dentist time as "Fixed Direct Labor" is no longer permitted. Activities that were formerly mapped to Fixed Direct Labor must be mapped to Administration, Education, or Research per the guidelines contained in this Directive.*

2. BACKGROUND

a. The Deputy Under Secretary for Health for Operations and Management, in a memo dated January 25, 2005, directed the Specialty Care Subcommittee of the VHA Advisory Group on Physician Productivity and Staffing to continue development of a Relative Value Unit (RVU)-based productivity model for specialists. The goal is to create a Physician and Dentist Data Reporting System that links data from several sources to obtain an accurate accounting of physician and dentist work activity. During Fiscal Year (FY) 2004, the Workload Group of the Specialty Care Subcommittee conducted an exhaustive review of all systems that VHA uses to document the amount of time VHA-employed physicians and dentists dedicate to patient care activities. The labor mapping and workload reporting capabilities of DSS were judged to be the most accurate and flexible to use. Time spent in direct patient care activities forms the Full-time Equivalent (FTE) employee component of the physician and dentist productivity measure.

b. DSS supports several options for mapping physician and dentist labor into categories to support productivity analysis. Within DSS, all costs including physician and dentist labor are mapped into Account Level Budgeter Cost Centers (ALBCCs). Labor ALBCCs are mapped to the Direct Patient Care or Indirect Administration, Education, or Research account codes that represent production units for related work activities. After analysis of the DSS options and the requirements of physician and dentist productivity, the decision was made that the time spent by all full and part-time VHA-employed physicians and dentists would be categorized into Direct Patient Care, Administration, Research, and/or Education. The percentage of time for each physician and dentist spent in each of these categories is captured in ALBCCs. The Physician and Dentist Labor Mapping Business Rules in this Directive reflect the method chosen by the Specialty Care Subcommittee of the VHA Advisory Group on Physician Productivity and Staffing and VHA Decision Support Office (DSO) Directors to measure clinical time in a standardized method. ***NOTE:*** *DSO regularly reviews, evaluates, and revises these rules to improve data accuracy in VHA reports. Approved coding of ALBCCs and DSS Departments are posted in the ALBCC Master List available at* *http://vaww.dss.med.va.gov/programdocs/pd_depts.asp.*

c. Prior to the issuance of this Directive, the time mapped to Direct Patient Care Departments was allowed to be further divided into both Variable Labor (VL) and Fixed Direct

Labor (FDL). VL contains all hours actually spent providing patient care services. FDL was a means of mapping time spent in activities such as managerial and administrative tasks (e.g., by a Section Chief or Department Director). The advantage of this practice was that the physician and dentist fixed costs could be recorded in the specific departments where the person was providing the fixed labor, rather than at the clinical service where the costs would be spread out over all departments within the service. Although providing accurate full product costs within departments, this accounting practice makes it difficult to quantify time spent on direct patient care (i.e., workload tied directly to a patient's Social Security Number). The use of FDL and VL also introduced inconsistencies into the types of activities that were mapped into Administration, Research, and Education support, versus FDL in a direct department. For the purpose of more accurate staff productivity measures for individual staff, time when physicians are not available for direct patient care is best captured in Administration, Research, and/or Education Department ALBCCs. ***NOTE*****:** *The practice of designating a percentage of physician and dentist time as FDL is no longer permitted. Activities that were formerly mapped to FDL will be mapped to Administration, Education, or Research per the guidelines contained in this Directive.*

d. The total labor hours available are those reported in a direct feed from the Personnel Accounting Integrated Data (PAID) system. The PAID data feed is automatically provided at the close of each pay period.

e. In order to accurately generate cost data, DSS spreads physician and dentist salaries through a standardized process of mapping the hours reported in the PAID system into an ALBCC. All ALBCCs are classified into one of the following categories: Direct Patient Care, Administration, Research, or Education. The responsibility for accurate physician and dentist labor mapping belongs to the Director of each Department of Veterans Affairs (VA) medical center.

f. To ensure accuracy, the labor hours reported in DSS are applied back to the data feed from PAID, by the DSS site team at each VA medical center.

g. **Definitions**

(1) **Direct Patient Care**

(a) Direct Patient Care is defined as the time to prepare, to provide for, and follow-up on the clinical care needs of patients and includes:

1. Time spent in reviewing patient data.

2. Consulting about patient care with colleagues.

3. Reviewing medical literature.

4. Contacting the patient or caregivers to discuss their needs.

5. The labor hours provided by a physician or dentist who is supervising house staff residents providing care in a clinical setting.

(b) Direct Patient Care time is allocated to various direct care departments via direct care ALBCCs in proportion to the time spent in each of these activities, and is important because Veterans Information System and Technology Architecture (VistA) workload packages do not exclude this workload. Examples of Direct Patient Care are time spent:

1. Rendering care to a patient and their family.

2. Supervising residents who are providing care in a clinical setting.

3. In "telephone clinics" or on telephone calls, or group clinic time discussing patient care issues with consultants and/or other staff members.

4. Reviewing medical records, charting patient treatments, and ordering and reviewing patient tests and consultations.

5. Supervising medical students while providing patient care.

6. Attending educational programs aimed at maintaining or improving clinical skills or participation in staff meetings that are focused on the delivery of patient care.

7. In any of the above activities where the patient care is for research purposes, regardless of how VistA encounter workload is recorded.

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

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

(b) Managing a program within a clinical department, service, or hospital.

(c) Working on service or hospital-wide committees.

(d) Serving on state and national committees, advisory boards, or professional societies.

(3) **Education.** Education is defined as time spent providing formal training (didactic education). This includes preparation as well as actual classroom or lecture time for educators or presenters. ***NOTE:*** *Time spent receiving training is considered a cost of direct patient care.* Education examples are time spent:

(a) Giving conferences in the community or nationally.

(b) In a classroom teaching medical school curriculum.

(c) In a classroom teaching residents and fellows.

(d) In managing a resident, fellow, or other type of student teaching program.

(e) Working on medical school committees.

(4) **Research.** Research is defined as time spent performing formal, approved health care research, or in activities in direct support of approved research. Formal, approved research is research that is approved through the hospital's research review process. Support activities include time spent by the investigator in direct support of research activities. Research can be laboratory, clinical, or health services research. However, direct VHA patient care research time must be mapped as direct patient care time when workload is recorded in VistA as an encounter. Research examples are time spent:

(a) Working on research projects that have been approved by the local VA medical center Research and Development Committee which does not produce recorded patient care encounter workload in VistA.

(b) Working in an actual research laboratory or controlled type setting that involves no direct patient care or treatment.

(c) Serving on hospital or affiliate research committees.

(d) Supervising a student's, resident's, or fellow's non-clinical research.

(e) Writing for publications or grants.

(f) Attending meetings explicitly related to research activities.

(g) Presenting papers at research meetings.

(h) Sitting on a national study section or grant approving board.

3. POLICY: It is VHA policy that DSS labor mapping for all full and part-time physicians and dentists employed by VHA be both accurate and current within 3 working days after the close of the calendar month.

4. ACTION

a. **Network Directors.** Network Directors are responsible for ensuring that:

(1) Their assigned VA medical center directors are mapping the PAID hours of all VHA-employed full and part-time physicians and dentists per the guidelines contained in this Directive.

(2) A letter verifying the accuracy of the previous fiscal year's DSS labor mapping is prepared and submitted to the Deputy Under Secretary for Health for Operations and Management (10N), no later than January 31st of each year.

(3) Their Network DSS Coordinators are tasked to ensure that the DSS Site Teams fully understand the process for and can perform labor mapping activities with the highest levels of effectiveness and efficiency.

b. **VA Medical Center Directors.** Each VA medical center Director is responsible for ensuring that:

(1) The PAID hours of every assigned, VHA-employed, full and part-time physician and dentist is accurately mapped. The labor hours of personnel spending all or part of their time at affiliated Community-based Outpatient Clinics are to be included, along with those providing patient care services exclusively at the parent VA medical center. Changes to labor mapping must be made no later than 3 working days after the close of the calendar month.

(2) The labor mapping of physicians and dentists is accomplished in conjunction with the appropriate clinical service or section chief, product line manager, or program manager.

(3) Their DSS teams possess the technical knowledge required to make effective and timely labor table mapping adjustments.

(4) Their DSS teams respond that the service administrative officers are certifying labor mapping on a monthly basis, or as requested.

(5) The facility's entire physician and dentist labor mapping portfolio is reviewed and corrected, if necessary, by October 1st of each fiscal year.

(6) Guidelines provided for capturing physician and dentist supervision of residents in the clinical setting are followed (see Att. A.).

c. **VHA Decision Support Office (DSO).** The DSO is responsible for:

(1) The development, presentation, and publishing of written guidance and training on labor mapping in DSS.

(2) The preparation and dissemination of guidance and training aids required to assist the DSS teams at each VA medical center to setup and map appropriate direct patient care ALBCCs and DSS Departments.

5. REFERENCE: DSS FY Conversion Guidelines are available on the VA intranet at the web address, http://vaww.dss.med.va.gov/programdocs/pd_conversion.asp.

6. FOLLOW-UP RESPONSIBILITY: The Associate Chief Financial Officer, Decision Support Office (175), is responsible for the contents of this Directive. Questions may be directed to 202-273-5606.

7. RESCISSIONS: None. This VHA Directive expires December 31, 2010.

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Under Secretary for Health

Attachments

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ATTACHMENT A

PHYSICIAN AND DENTIST LABOR MAPPING SCENARIOS

The following examples illustrate how to map the time of physicians and dentists with a range of different responsibilities:

1. Direct Patient Care

a. Dr. Andrew is a full-time Department of Veterans Affairs (VA) staff psychiatrist working in a Community-based Outpatient Clinic (CBOC) whose clinical responsibilities consist entirely of providing care to a panel of patients. He is not responsible for managing any programs and does not serve on any medical center or Network committees. He is not involved in any educational programs or research. **In the preceding scenario, Dr. Andrew's Personnel Accounting Integrated Data (PAID) hours need to be mapped to Direct Patient Care Account Level Budgeter Cost Centers (ALBCCs).**

b. Dr. Lonie is a full-time VA staff cardiologist who spends 50 percent of his time providing primary care to a panel of patients and 50 percent of his time providing cardiology consults. He is not involved in any educational programs or research. **In the preceding scenario, Dr. Lonie's PAID hours need to be mapped to Direct Patient Care ALBCCs**.

2. Administration

Dr. Hallinan 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 Network 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 is not involved in any educational programs or research. **In the preceding scenario, 50 percent of Dr. Hallinan's PAID hours need to be mapped to ALBCCs in Administration and 50 percent of those hours need to be mapped to Direct Patient Care ALBCCs.**

3. Education

Dr. Alexander is an academic internist working at a VA medical center affiliated with a medical school. He is the Clerkship Director for the third-year medical students. 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 care to a panel of patients. He is not involved in research. **In the preceding scenario, 20 percent of Dr. Alexander's PAID hours need to be mapped to ALBCCs in Education and 80 percent of those hours need to be mapped to Direct Patient Care ALBCCs.**

4. Research

Dr. Kavanagh is a VA staff physician who recently received a full-time Career Development Award in health services research. He continues to see patients in an endocrinology clinic two half-days a week. The other 4 days per week he spends involved in his research activities. He is not involved in any educational activities. **In the preceding scenario, 80 percent of Dr. Kavanagh's PAID hours need to be mapped to ALBCCs in Research and 20 percent of those hours need to be mapped to Direct Patient Care ALBCCs.**

5. Other Scenarios

		Direct Patient Care Percentage	Administration Percentage	Education Percentage	Research Percentage
a.	Dr. Brady is a full-time Ophthalmologist who spends one hour monthly at the hospital education department completing a mandatory review course. Dr. Brady also attends a weekly 1 hour in-service related to patient care delivery.	100	0	0	0
b.	Dr. Belichick is a new member of the Cardiology Clinic of a large VA medical center. This physician is currently receiving full-time orientation training by working side-by-side with a co-worker in the department.	100	0	0	0
c.	Dr. Vinatieri has an adjunct professor appointment at a nearby university; however, VA pays this Oncologist a full time salary. Dr. Vinatieri spends 100 percent of his PAID hours supervising and teaching residents on the wards.	100	0	0	0

d.	Dr. Bruschi is a staff Nephrologist who spends 80 percent of her time in renal clinic and providing inpatient renal consults. She is not a service or department chief. Dr. Bruschi also has expertise in pharmacology and chairs the medical center and Network Pharmacy and Therapeutics committees. In addition, she serves on national committees dealing with pharmacology policy issues. These responsibilities take up to 20 percent of her time.	80	20	0	0
e.	Dr. Harrison is a Psychiatrist who spends 80 percent of his time writing grants and papers. He spends 1 day a week in a clinic seeing scheduled patients who are coming to the clinic as part of research protocols. The patients' clinic visits are recorded in Veterans Information System and Technology Architecture (VistA), Computerized Patient Record System (CPRS), and workload credit is given to the medical center for these visits.	20	0	0	80

ATTACHMENT B

FREQUENTLY ASKED QUESTIONS

1. "Administrative Time" and Direct Patient Care. The physicians at our clinic are given one-half day per week where no patients are scheduled. This allows them to catch up on patient care-related telephone calls, filling out forms, writing letters, etc. We have called this "Administrative Time." Should this be mapped to Administration or to Direct Patient Care?

Response. *The block of time should be mapped to Direct Patient Care Account Level Budgeter Cost Centers (ALBCCs) unless the telephone calls, forms, and letters are not patient related.*

2. Telephone Care. Is time to return phone calls from my patients Direct Patient Care?

Response. *Yes. Time to return phone calls or complete telephone follow-up for your patients is part of providing care and should be included as part of Direct Patient Care. 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 the appropriate Direct Patient Care ALBCC.*

3. Appointment Length. Does patient appointment length or the use of "carve outs" (open time without prescheduled appointments) for urgent visits affect the measurement of Direct Patient Care?

Response. *No. Direct Patient Care represents the net total of the time dedicated to providing medical services to 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.*

4. Precepting Students. Sometimes in clinic I have a medical student accompanying me while I see patients. Should this time be mapped to Education?

Response. *No. Even if students or residents are present, time spent providing direct patient care is mapped to Direct Patient Care. Follow Decision Support Office published instructions for reporting this workload. Education time should only include time that does not involve providing patient care (see subpar. 2g of the Dir.).*

5. 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.*

6. 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 Administration or Direct Patient Care?

Response. *Since this meeting is about the management of and process improvements required to provide quality medical services, it should be charged to 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 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. 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.*

7. Clinical Research. One of our staff has a Career Development Award, which includes following patients for whom clinical workload is collected in his Hematology/Oncology Clinic. Since this is research supported time, shouldn't this be mapped as Research?

Response. *No. There are conflicting interests in how to map clinical care research time. Mapping this as research time allows for better tabulation of all research costs. However, the workload would still be reported as clinical care so excluding the associated labor costs would artificially decrease the clinic's direct unit costs. Additionally, indirect costs are generally allocated by total costs so there would be an artificial reduction in the clinic's indirect costs. Since one of the principles of governmental accounting that the Decision Support System (DSS) complies with is to fully and accurately cost workload, this principle would be compromised. On the other hand, if the time was mapped as direct clinical care time, the research costs in the Veterans Health Administration would not be easily identified but the other principles would be met.*

8. Inpatient Attending Months. At our medical center, many physicians cover different responsibilities, such as inpatient attending or outpatient consult service, on a monthly rotation. Do we need to change their labor mapping every time they rotate, or can we average it over the year?

Response. *For many providers, their responsibilities can 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. DSS labor mapping would need to change only if there was permanent change in the allocation among different responsibilities.*