PRODUCTIVITY AND STAFFING IN CLINICAL ENCOUNTERS FOR MENTAL HEALTH PROVIDERS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides policy on individual mental health provider productivity based on clinical encounters for all psychiatrists, psychologists, mental health social workers, clinical pharmacy specialists, nurse practitioners (NP), clinical nurse specialists (CNS), physician assistants (PA), and other licensed independent providers who work in mental health programs and settings. ***NOTE:*** *Nurse practitioners and clinical nurse specialists are both under the umbrella of Advanced Practice Registered Nurses (APRN)*.

2. SUMMARY OF MAJOR CHANGES: This VHA directive has been revised as follows:

a. Updates productivity calculation and annual review to be consistent with Office of Productivity, Efficiency, and Staffing (OPES). Aligns work relative value units (wRVUs) utilized for mental health productivity measurement with values utilized by OPES.

b. Eliminates Office of Mental Health Operations (OMHO) Appendices B (Imputed Work Relative Value Unit) and C (Calculation and Tracking of Individual Provider Productivity) from the original Directive 1161.

c. Expands requirement for individualized productivity targets to providers at all mental health locations, including inpatient, residential, and compensated work therapy settings.

d. Expands individualized productivity targets to include utilization of Current Procedural Terminology (CPT) coding frequency and encounters in situations where CPT codes have zero wRVUs.

e. Updates expectation of bookable time designation as a percent of total clinical labor mapping.

f. Clarifies use of OPES and Office of Mental Health and Suicide Prevention (OMHSP) productivity dashboards.

g. Updates staffing guidance to include consideration of OMHSP outpatient staffing ratio and population adequacy.

h. Removes providers assigned to Homeless Programs from mental health productivity expectations.

3. RELATED ISSUES: VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

4. RESPONSIBLE OFFICE: The Office of the Deputy Under Secretary for Health for Operations and Management for Clinical Operations, Office of Mental Health and Suicide Prevention (10NC5) is responsible for the contents of this directive. Questions may be directed to the Executive Director of the Office of Mental Health and Suicide Prevention at 202-461-4142.

5. RESCISSIONS: VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Providers, dated June 7, 2013, 10N Memorandum, Mental Health Productivity Targets, dated March 11, 2015; 10N Memorandum, Mental Health Productivity Targets, dated March 29, 2016; and 10N Memorandum, Mental Health Productivity Targets, dated May 24, 2016, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of April 2025. This VHA directive will continue to service as national policy until it is recertified or rescinded.

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

/s/ Renee Oshinski
Deputy Under Secretary for Heath
for Management and Operations

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

DISTRIBUTION: Emailed to the VHA Publications Distribution List on April 28, 2020.

CONTENTS

PRODUCTIVITY AND STAFFING IN CLINICAL ENCOUNTERSFOR MENTAL HEALTH PROVIDERS

PRODUCTIVITY AND STAFFING IN CLINICAL ENCOUNTERS FOR MENTAL HEALTH PROVIDERS

1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy on individual mental health provider productivity based on clinical encounters and attained work relative value units (wRVUs) for all psychiatrists, psychologists, nurse practitioners, clinical nurse specialists, physician assistants (PAs), social workers, clinical pharmacy specialists, and other licensed independent providers who work in mental health programs and settings. ***NOTE:*** *Productivity expectations for psychiatrists, psychologists, social workers, counselors, and other staff of VA's Readjustment Counseling Service, or who are assigned to non-mental health settings, such as medical social workers or to Homeless Programs, are excluded from this directive.* Productivity expectations for these providers are defined by the respective Program Office. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1706 and 8110.

2. BACKGROUND

a. In 2016, mental health productivity targets were updated with regard to work relative value units (wRVU) productivity. This update included an acceptable range of specialty productivity (plus or minus one standard deviation from the discipline mean) using tools from the Office of Productivity, Efficiency, and Staffing (OPES) or Mental Health Onboard Clinical (MHOC) data. This directive reiterates these requirements and the process for OPES annual review (which, in 2016 was calculated using the mean, but is now calculated using the median to be consistent with OPES methodology).

b. The Government Accountability Office, in its report "The VHA, Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies," GAO 18-124 (October 2017), required OPES to provide guidance on how to interpret and reconcile two productivity data sets (OPES and MHOC). This policy update continues to align MHOC and OPES processes for productivity calculation.

3. DEFINITIONS

The following definitions are for the purposes of this directive.

a. **Acceptable Specialty Group Practice Range of Productivity.** Acceptable group practice range of productivity is the productivity within the interquartile range (25th to 75th percentile). This range is considered an acceptable range of productivity, taking care not to compromise quality and patient access standards. ***NOTE:*** *The definition distinguishes specialty group practice from individual practice. Specialty Group Practice productivity below the minimum productivity threshold is considered a practice requiring a remediation plan*.

b. **Bookable Clinic Hours.** Bookable clinic hours are the number of hours allotted in each provider's clinic schedule for direct patient care. Bookable clinic hours include face-to-face and virtual patient care time (e.g., telephone visits and tele-health). The

time counted in the calculation must be unrestricted (i.e., no special permission scheduling or blocking of time).

c. **Direct Patient Care Time.** Direct patient care time is defined as the time to prepare, provide for, and follow-up on the clinical care needs of patients. Direct patient care time, or clinical time, is time not occupied by administrative (labor mapped) duties, teaching, or research. ***NOTE:*** *Current labor mapping information is available at this Web site: (http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp). This is an internal VA Web site that is not available to the public.*

d. **Full-Time Equivalent Clinical.** Full Time Equivalent Clinical (FTE(c)) is the portion of a full-time equivalent employee (removing leave) which is devoted to clinical, direct patient care as assigned by Managerial Cost Accounting (MCA) labor mapping.

e. **Individualized Productivity Target.** The Individualized Productivity Target is a productivity target specifically calculated for a provider based upon their assigned work and CPT coding expectations. The individualized productivity target is distinct from the Specialty Group Practice target (median), as the latter is the performance of all specialists, defined by Person Class, in that group. Given the complex nature of clinical work in mental health, the individualized target should be set by an appropriate professional, ideally from the same discipline, using current labor mapping, with concurrence from (or with delegated authority from) the VA medical facility Director, through the appropriate clinical service chief.

f. **Level I Healthcare Common Procedure Coding System or Current Procedural Terminology.** The American Medical Association (AMA) has defined a numerical code for each service and procedure. Level I Healthcare Common Procedure Coding System (HCPCS), also known as CPT codes are five-digit numeric codes updated annually by the AMA which each relate to a specific service or procedure. ***NOTE:*** *In VHA, CPT codes are assigned to an encounter based on the clinical service or procedure performed at the time of the encounter.*

g. **Level II Healthcare Common Procedure Coding System or Current Procedural Terminology.** Level II Healthcare Common Procedure Coding System (HCPCS) is another category of codes, updated annually by the AMA, that may be used in mental health settings for services not covered in the CPT codes. ***NOTE:*** *In VHA, these codes are assigned to an encounter based on the clinical service or procedure performed at the time of the encounter.*

h. **Mental Health Providers.** Mental health providers are defined as all Psychiatrists, Psychologists, Licensed Marriage and Family Therapists (LMFTS), Licensed Professional Mental Health Counselors (LPMHCs), Clinical Pharmacy Specialists (CPS), Licensed Master Social Workers (LMSW) and Advanced Practice Providers (APP) such as: NPs, CNSs, PAs, assigned to mental health programs (see Mental Health Onboard Clinical (MHOC) Education Materials Web Site. https://vaww.portal2.va.gov/sites/PERC/PEC_Portal/SiteAssets/MHOC%20Staffing%20and%20Productivity%20Method%20FULL.pdf. ***NOTE*****:** *For the purposes of this*

directive, mental health providers at VA's Readjustment Counseling Service (Vet Centers) are not included in this definition. Mental health providers at Vet Centers are not included in the productivity expectations of this directive.

i. **Other Professional and Clinical Support Staff.** Clinical support staff are defined as registered nurses (RNs), licensed practical nurses (LPNs), health care technicians and aides, peer support specialists, addiction therapists, rehabilitation counselors, vocational rehabilitation specialists, and other therapists assigned to the mental health service line. Clinical support staff are included in mental health clinical staffing ratios if they generate encounters in mental health stop codes.

j. **Person Class File.** The taxonomy for licensed health care providers who bill for health-related services rendered, and is inclusive for all those who appear on the Centers for Medicare and Medicaid (CMS) Provider Specialty listing. It reflects training, licensure, and scope of practice for that individual. Person Class associations are part of the minimum data set reported to the National Patient Care Database, which is VHA's principal national repository of patient care data.

k. **Relative Value Unit.** The Centers for Medicare & Medicaid Services (CMS) relative value unit (RVU) is a measure of the complexity and time required to perform a professional service. The number of RVUs associated with each CPT code is determined by CMS and published in the Medicare physician fee schedule. The total RVU consists of three components: provider work (wRVU), practice expense and malpractice RVU. For productivity measurement, only the wRVU is utilized. wRVUs used for MH productivity are designated by OPES, and include CMS values, INGENIX Gap Codes, and OPES-derived imputed values. ***NOTE:*** *Work component as defined in 42 U.S.C. 1395 is the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall (i) include activities before and after direct patient contact, and (ii) be defined, with respect to surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services. The RVU used in this directive and by CMS differ from time-based RVUs, defined locally by Managerial Cost Accounting Office (MCAO), which are used to compute VA cost for a rendered service. wRVU tables are available on the Veterans Integrated Service Network (VISN) Support Services Center (VSSC) Web site: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fWorkloadFee%2fEncounters%2fClinicStopsCPT&rs:command=render. This is an internal VA Web site that is not available to the public.*

l. **Specialty Group Practice.** A specialty group practice is defined as the providers in a VA medical facility and its clinics who are providing mental health services. Mental health is an example of a specialty. All of the mental health specialty providers of a given VA medical facility and its associated clinics are considered a group practice for the purposes of this directive. ***NOTE:*** *In some VA medical facilities, mental health providers may be assigned to multiple organizational departments or services but are considered to be in the same practice if providing mental health services. For more information, see Specialty Provider Productivity Standards Performance at,* https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fOPES%2f

SpecialtyProductivityReport%2fProd_Stats&rs:Command=Render. *This is an internal VA Web site that is not available to the public.*

4. POLICY

It is VHA policy that each VA medical facility Director establishes individualized mental health productivity targets based on wRVUs for each Veteran-facing mental health provider to ensure access, quality, and satisfaction are maintained. Where wRVUs are not available, workload expectations may be addressed through assigned workload expectations, such as encounters and uniques.

5. RESPONSIBILITIES

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

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

(1) Communicating the contents of this directive to each of the Veterans Integrated Service Networks (VISNs).

(2) Ensuring that each VISN Director has the sufficient resources to implement this directive in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

(4) Approving and accepting mental health provider productivity standards based on proposals by the Office of Mental Health and Suicide Prevention (OMHSP).

c. **Executive Director, Office of Mental Health and Suicide Prevention.** The Executive Directive, OMHSP is responsible for:

(1) Proposing mental health provider productivity standards based on available data, to include quality and access indicators. ***NOTE****: Standards are updated dependent on CMS coding changes and quality and access indicator updates*.

(2) Maintaining the Mental Health Onboard Clinical Dashboard for monitoring quarterly productivity and providing education and training on productivity practices.

(3) Establishing mental health staffing expectations of high quality, access, and satisfaction. ***NOTE:*** *All staff are to have workload standards established based upon their work assignment, but the productivity based upon wRVU targets, as outlined in this directive, applies to licensed independent providers (LIPs)*.

d. **Director, Office of Productivity, Efficiency, and Staffing.** Director, Office of Productivity, Efficiency, and Staffing (OPES) is responsible for conducting an annual

study of mental health specialty provider group practice productivity. ***NOTE:*** *See VHA Handbook 1065.01, Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015 and VHA Directive 1065 Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015*.

e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Reviewing the annual mental health productivity and staffing report from each VA medical facility.

(2) Reviewing annual corrective action plans (if submitted) by the VISN Chief Mental Health Officer. ***NOTE:*** *Annual Action Plans are due to OPES for facilities not meeting productivity target*.

(3) Verifying staffing meets minimum standards for access, quality, and satisfaction.

f. **Veterans Integrated Service Network Chief Mental Health Officer.** The VISN Chief Mental Health Lead is responsible for:

(1) Reviewing the annual mental health productivity report and corrective action plans addressing those VA medical facilities not meeting productivity targets.

(2) Submitting a corrective action plan (CAP) to the VISN Director, as requested, for those VA medical facilities not meeting productivity targets. ***NOTE****: CAPS are due to OPES for VA medical facilities not meeting productivity targets.*

(3) Verifying staffing meets minimum standards for access, quality, and satisfaction.

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

(1) Ensuring that each VA medical facility Chief of Staff (COS) and all Mental Health Service Chiefs engage in assessment activities including the quarterly review of mental health productivity.

(2) Reviewing the mental health productivity reports and implementing plans to improve provider productivity as appropriate based on these reviews.

(3) Verifying the Person Class Code in the Electronic Health Record (EHR)'s Personnel File for all mental health providers.

(4) Verifying staffing meets minimum standards for access, quality, and satisfaction.

h. **VA Medical Facility Chief of Staff and Associate Director of Patient Care Services.** The VA medical facility COS and Associate Director of Patient Care Services (ADPCS) is responsible for:

(1) Coordinating the activities of Mental Health Service Chiefs and discipline specific leaders on how to assess and measure productivity on a quarterly basis.

(2) Training specific leaders on how to perform needs assessments for the hiring of additional providers (permanent staff, contract, or fee in mental health services).

(3) Collaborating with VA medical facility Mental Health Service Chief or discipline specific chief to interpret and act on needs assessments.

(4) Assigning the fraction of time devoted to clinical care, administration, teaching, and research for each employee in the practice, and updating these values in the Managerial Cost Accounting (MCA) system as duties change.

i. **VA Medical Facility Mental Health Service Chief, Associate Chief of Staff for Mental Health, or Associate Chief Nurse for Mental Health.** The VA medical facility Mental Health Service Chief, Associate Chief of Staff (ACOS) for Mental Health, or Associate Chief Nurse (ACN) for Mental Health is responsible for:

(1) Ensuring annual individualized productivity targets for each provider based upon the assigned work expectations are developed. ***NOTE:*** *For additional information see Appendix A, 1.b.(2). All staff are to have workload standards established based upon their work assignment, but the productivity based upon wRVU targets, as outlined in this directive, applies to licensed independent providers (LIPs).*

(2) Ensuring quarterly productivity monitoring is completed for measuring provider activities and workload, and that individualized productivity targets are updated to reflect changing work assignment(s).

(3) Communicating quarterly and annually productivity activities to respective providers and VA medical facility COS.

(4) Coordinating with the VA medical facility COS to ensure that all monitoring activities are reported to the VA medical facility Director at least annually.

(5) Developing action plans based on the results of the monitoring activities to adjust provider productivity and staffing requested by the VA medical facility Director.

(6) Collaborates with discipline-specific leaders (e.g., Social Work Chief or Executive; ACN for Mental Health; Psychology Chief) to ensure appropriate professional practice standards, such as those of the American Psychiatric Association, American Psychiatric Nurses Association, American Psychological Association, National Association of Social Work, etc. are maintained.

j. **VA Medical Facility Mental Health Service Provider.** The VA medical facility Mental Health Service provider is responsible for documenting services delivered to the patient in the electronic medical record in accordance with VHA Handbook 1907.01 Health Information Management and Health Records, dated March 19, 2015.

6. TRAINING

There are no formal training requirements associated with this directive. Training presentations addressing productivity calculation, coding practices, and labor mapping are available on the Office of Mental Health and Suicide Prevention (10NC5) Business Operations SharePoint: https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

8. REFERENCES

a. 38 U.S.C. 1706 and 8110.

b. VHA Directive 1065(1), Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015.

c. VHA Directive 1115, Military Sexual Trauma (MST) Program, dated May 8, 2018.

d. VHA Directive 1163, Psychosocial Rehabilitation and Recovery, dated August 13, 2019.

e. VHA Handbook 1065.01, Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015.

f. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

g. VHA Handbook 1160.05, Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions, dated December 8, 2015.

h. VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 13, 2013.

i. VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), dated December 22, 2010.

j. VHA Handbook 1162.06, Veterans Justice, dated September 27, 2017.

k. VHA Handbook 1400.01, Supervision of Physician, Dental, Optometry,

Chiropractic, and Podiatry Residents, dated November 7 , 2019.

l. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

m. VHA Handbook 1500.01, Readjustment Counseling Service (RCS) Vet Center Program, dated September 8, 2010.

n. VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.

o. ARC Interactive Reports: HCPCS and CPT Codes CMS Description and Work RVUs. Web site: http://vaww.arc.med.va.gov/vapublic/cpt_input.html. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

p. CMS Medicare Fee Schedule Web site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/.

q. Government Accountability Office. GAO 18-024. Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. October 2017: https://www.gao.gov/assets/690/687853.pdf.

r. Mental Health Management System Web site*:* https://spsites.cdw.va.gov/sites/OMHO_MHMP/_layouts/15/ReportServer/RSViewerPage.aspx?rv%3aRelativeReportUrl=/sites/OMHO_MHMP/AnalyticsReports/MHMS/MHMS_SummaryReport.rdl&rv%3aheaderarea=none. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

s. Mental Health Onboard Clinical (MHOC) Education Materials Web Site: https://spsites.cdw.va.gov/sites/OMHO_MHMP/Pages/Staffing_HomePage.aspx. ***NOTE:*** *This is an internal VA web site that is not available to the public.*

t. OMHSP Business Operations SharePoint Web site: https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

u. Program Documents Processing and Auditing. U.S. Department of Veterans Affairs: http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

v. Specialty Provider Productivity Standards Performance*:* https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fOPES%2fSpecialtyProductivityReport%2fProd_Stats&rs:Command=Render. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

w. Veterans Equitable Resource Allocations: Methodology Web site: http://vaww.arc.med.va.gov/reports/vera/final_vera2019_nov_toc.asp***.*** ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

x. Veterans Equitable Resource Allocations Patient Classification Handbook Appendix F Web site: http://vaww.arc.med.va.gov/references/Handbook18/imputed_rvus_17F.htm. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

y. VHA Health Information Management Clinical Coding Program Guide Version 1.4: https://vaww.vha.vaco.portal.va.gov/sites/HDI/HIM/vaco_HIM/subsite5/subsite3/HIM%20Handbooks/VHA%20HIM%20Clinical%20Coding%20Program%20Guide%20Version%201.4%20September%207,%202018.pdf. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

z. VHA Office of Productivity, Efficiency, & Staffing (OPES): http://opes.vssc.med.va.gov/Pages/Default.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

aa. Workforce Planning. HR Code Requirements for Nurse Practitioners and Clinical Nurse Specialists : http://workforceplanning.wmc.va.gov/Pages/Nursing-Assignment-Codes.aspx. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

RECOMMENDATIONS FOR MENTAL HEALTH PROVIDER PRODUCTIVITY STANDARDS, STAFFING, AND MONITORING

1. PRODUCTIVITY STANDARDS

a. **Specialty Group Practice Standards.** When making specialty group comparisons with external organizations the Office of Productivity, Efficiency & Staffing (OPES) data must be used. This data is based upon standard wRVUs by CMS, Ingenix Gap Codes, and specified imputed wRVUs

(1) OPES data is based upon Person Class assignment and the overall median may include providers assigned to non-mental health programs, including Homeless, Pain Management, and Compensation & Pension Programs.

(2) Specialty Group Practice targets are updated on the VHA OPES Web site: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/OPES/SpecialtyProductivityReport/Prod_Stats&rs:Command=Render. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(3) In accordance with VHA Handbook 1065.01, Productivity and Staffing Guidance for Specialty Provider Group Practice, dated May 4, 2015, and VHA Directive 1065(1) Productivity and Staffing Guidance Specialty Provider Group Practices, dated May 4, 2015, specialty group practice must be in line with national targets plus or minus 1.25 standard deviations from median.

(4) The measurement of productivity against national norms for the mental health specialty (e.g., psychiatry, psychology, social work, etc.) must be utilized only to evaluate productivity of all specialists combined within that group practice.

b. **Individual Productivity Targets.**

(1) There is no national minimum productivity standard; VA medical facility Mental Health Service Chiefs must establish and track the productivity of each associated mental health provider to ensure the productivity meets local expectations and the guidelines in this directive. Variation in valued workload associated with important program assignment and type of work must be considered in evaluating individual associated mental health provider productivity. It must be recognized that a high level of productivity variability from the median may occur and may be quite appropriate depending on the program assignment of the particular provider (e.g., Intensive Community Mental Health Recovery (IMCHR), Home-Based Primary Care (HBPC), Community Living Center (CLC), and Suicide Prevention Programs providing other than direct clinical care would have target expectations adjusted).

(2) The Mental Health Onboard Clinical (MHOC) Dashboard is available for internal, mental health program-specific productivity evaluation. For detailed information, please see MHOC educational materials,

https://spsites.cdw.va.gov/sites/OMHO_MHMP/Pages/Staffing_HomePage.aspx.
NOTE: *This is an internal VA Web site that is not available to the public.*

(a) MHOC limits wRVU-generated productivity to workload generated in mental health programs (see Mental Health Onboard Clinical (MHOC) Education Materials Web Site list above).

(b) MHOC identifies and tracks provider productivity across settings, including outpatient mental health, residential, inpatient, and homeless programs.

(3) Some mental health providers deliver services that are associated with current procedural terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) Level II codes with zero wRVU value, yet these services are integral, desirable components of mental health care. Where clinical practice involves utilization of CPT codes assigned by CMS with zero wRVU value, productivity is to be established utilizing expected CPT code frequency and encounter data. In these cases, the Allocation Resource Center (ARC) has calculated wRVUs for select Level I and Level II HCPCS codes for Veterans Equitable Resource Allocations (VERA) patient classification and workload generation. ***NOTE:*** *See VERA Handbook 18 Appendix F, http://vaww.arc.med.va.gov/references/Handbook/toc19.html. For an explanation of VERA methodology, see Web site: http://vaww.arc.med.va.gov/reports/vera/final_vera2019_nov_toc.asp. These are internal VA Web sites that are not available to the public.*

(4) The expected wRVU productivity of any VA mental health provider must be considered in relation to the work assignment as well as the average wRVUs/ Outpatient Clinical Full-time Equivalent (FTE(c)) of the total practice.

(5) Individual productivity targets must be established by VA medical facility Service Chief or designee (e.g., someone in the mental health service line) for all providers and individual productivity performance must be reviewed with each provider on a quarterly basis. For providers attaining less than 80 percent or more than 120 percent of their individualized productivity target, a corrective action plan (remediation) plan must be developed in order to optimize provider utilization. Guidance on the establishment of individualized productivity standards can be found in the OMHSP Business Operations SharePoint: (https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(6) Productivity must support management in optimizing mental health treatment, access, and staffing. Information on the workload productivity of providers and teams is useful for managers to optimize staffing across levels of care and subspecialty programs, scheduling, mapping, and cost-efficiency.

(7) Specialty Group Practice and individual provider productivity data must be used to identify shortages or excess in specific provider types or specialty programs, and areas in need of systems redesign, particularly when these data are used in

combination with population staffing ratios, program specific wait-times, and access data.

2. OUTPATIENT MENTAL HEALTH STAFFING.

a. **Efficiency-Based Staffing.**

(1) Specialty Group Practice wRVU productivity significantly above or below the specialty group target may reflect respective shortages or excesses in specific provider types or specialty programs.

(2) Specialty Group Practice productivity that is significantly below the median range (minus 1.25 standard deviation) is suggestive of inefficiency of provider utilization. Review of provider workload, CPT coding practices, labor mapping, etc. is necessary in accordance with VHA Handbook 1065.01.

(3) Specialty Group Practice productivity that is significantly above the median range (plus 1.25 standard deviation) increases the risk of burnout of staff members. Workload productivity numbers significantly higher than the median range might suggest a need to reassign staff to assist in clinical areas with increasing service needs and a possible need to adjust future business planning to request additional staffing. In addition, workload productivity numbers outside the median range might reflect improper CPT coding or poorly aligned labor mapping, and service chiefs are encouraged to monitor for compliance with national guidelines.

b. **Population-Based Staffing.** VHA outpatient mental health staffing model focuses on two critical perspectives: (1) having enough staff to treat the patients that have initiated mental health care, and (2) having enough staff to serve the Veterans/VHA patients in the health care systems catchment area. It is vital to have sufficient staffing to appropriately address both of these perspectives.

(1) Efficiency-based staffing models may not reflect actual population penetration or the overall program demand based upon the number of Veterans with identified mental health needs. To establish full access to care for all Veterans with a mental health diagnosis, facilities must strive to maintain efficiency-based staffing productivity, while incorporating population-based staffing needs. In cases where population based staffing and productivity is low, one should consider whether mental health services are functionally accessible and acceptable to patients (e.g. address distance, transportation, scheduling, stigma and other barriers) and whether staff in medical settings are effectively identifying and referring patients to mental health. Strategic efforts to better engage Veterans with mental health needs in VA health care and mental health services may be required reach Veterans at appropriate rates while maintaining clinical productivity.

(2) To ensure treatment is available to provide timely access to care, high-quality mental health services, and patient and employee satisfaction, facilities should make available a minimum of 7.72 outpatient clinical FTE per 1,000 Veterans receiving mental

health care. A minimum of 1.22 psychiatrist FTE assigned to clinical duties per 1,000 Veterans receiving outpatient mental health care is recommended. *To ensure that mental health services are available and accessible to all eligible Veterans, facilities should strategically plan to address gaps in population staffing, measured as outpatient clinical FTE per 1000 facility uniques.* ***NOTE:*** *Current outpatient staffing ratio for each facility is available on the Mental Health Management System:* (https://spsites.cdw.va.gov/sites/OMHO_MHMP/_layouts/15/ReportServer/RSViewerPage.aspx?rv%3aRelativeReportUrl=/sites/OMHO_MHMP/AnalyticsReports/MHMS/MHMS_SummaryReport.rdl&rv%3aheaderarea=none). *This is an internal VA Web site and is not available to the public.*

(a) Primary Care-Mental Health Integration (PCMHI) staffing ratio is established as providers per Patient Aligned Care Team (PACT) Teamlet. A target of 0.67 FTE per PACT Teamlet, consisting of 0.5 FTE co-located collaborative care provider and 0.17 FTE Care Manager, is recommended.

(b) Onboard outpatient clinical mental health FTE excludes staff in delivering services in homeless clinics, to patients currently in inpatient or residential programs, or that do not generate encounters. Mental health specialties, such as Intensive Community Mental Health Recovery (ICMHR) Teams, Suicide Prevention Coordinators, Compensated Work Therapy Programs, residential care, and inpatient settings may have their own program-specific staffing requirements. ***NOTE:*** *See the following documents for guidance related to program-specific staffing guidance: VHA Handbook* 1160.06 *Inpatient Mental Health Services dated September 13, 2013; VHA Handbook 1163.06 Intensive Community Mental Health Recovery Services, dated January 7, 2016; VHA Handbook 1163 Psychosocial Rehabilitation and Recovery Services, dated August 13, 2019; VHA Handbook 1162.02 Mental Health Residential Rehabilitation Treatment Program (MH RRTP), dated December 12, 2010.*

(c) The onboard outpatient staffing ratio may be above or below the recommended minimum ratio based upon local demands and programming needs. VA medical facilities must consider productivity and population-based staffing ratios to ensure that access to care (emergent, engagement, and sustained treatment), quality, and satisfaction are optimal.

(3) Mental Health Services commonly involves high levels of direct (e.g., face-to-face, telephone) care and indirect (e.g., case consultation, report writing, progress notes, graduation summaries, form completion) patient care, which require sufficient staffing to meet the wide variety of mental health care needs. In accordance with the OMSHP recommended staffing model, staff must be available to engage and treat Veterans with identified mental health conditions and to ensure continuity and intensity of treatment during an episode of care.

(4) The onboard outpatient staffing ratio and program-specific staffing guidance does not include administrative support staff. Sufficient administrative support across all mental health programs must be available to ensure all providers are able to work at the top of their license and receive adequate management and supervision.

3. LABOR MAPPING FOR ASSOCIATED MENTAL HEALTH PROVIDERS

a. **Labor Assignments.** The appropriate VA medical facility Service Chief, in consultation with the VA medical facility Chief of Staff, assigns the fraction of time devoted to clinical care, administration, teaching, and research for each employee in the practice, and is responsible for updating these values in the Managerial Cost Accounting (MCA) system in a timely manner as duties change. Labor assignments as entered in by the MCAO staff are the basis for computing FTE(c). Examples of mental health labor mapping assignments are located on the Business Operations SharePoint: https://vaww.cmopnational.va.gov/CR/MentalHealth/MH_Business%20Rules/Forms/AllItems.aspx. The following recommendations are intended to be consistent with guidelines available at this Web site: (http://vaww.dss.med.va.gov/programdocs/pd_ProAud.asp). ***NOTE:*** *These are internal VA Web sites that are not available to the public. The Office of Nursing Services (ONS) and MCAO guidance for mapping APRNs in HBPC to account for travel is to use average travel time mapped to Fixed Direct Labor the (ONS) separately tracks APRN productivity and this mapping is required. Nurse practitioners have specific HR required mapped codes for Mental Health NPs (1064 N4 and for CNS it is 1067 N8).ONS has issued guidance that all NPs and CNS working in MH must use the MH specific person class code that best describes their practice. Nurse practitioners not practicing in the MH setting may not use a MH person class code. ONS benchmarks NP and CNS productivity data using primary care, specialty care and mental health categories.*

b. **Clinical Time.**

(1) Clinical time is the time left when approved administrative, teaching, and research hours have been subtracted. Direct Patient Care time is the time used to prepare, to provide for, and follow-up on the clinical care needs of patients and includes:

(a) Providing direct clinical care.

(b) Reviewing patient data.

(c) Consulting about patient care with colleagues.

(d) Reviewing medical literature.

(e) Contacting the patient or caregivers to discuss their needs.

(f) Evidence-based Psychotherapy (EBP) training and consultation.

(g) Employee Assistance Program (EAP), including time designated for Occupational Health evaluations.

(h) The labor hours provided by a mental health provider who is supervising health profession trainees or other non-LIPs providing care in a clinical setting. ***NOTE:*** *See the following documents for further guidance related to adding the supervisor as the primary provider in these encounters: VHA Handbook 1400.01* Supervision of

Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019*; VHA Handbook 1400.04 Supervision of Associated Health Trainees, dated March 19. 2015; and the current guidance on billing for services provided by supervising practitioners and residents (https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000050100/Section-D-Mental-Health-Reasonable-Charges-and-Billing). This an internal VA Web site that is not available to the public.*

(i) Time for required employee training, continuing education, breaks, staff meetings, team meetings, driving time for clinical care, committee work and other management support activities of a mental health provider without major leadership or administrative responsibilities.

(2) Individualized targets must be established based upon the recommendation that 70 percent to 80 percent of a provider's total clinically mapped time is in face-to-face, telemental health, or telephone care in mental health settings. Bookable hours for community based programs and programs with defined caseload limitations, such as Home Based Primary Care, Compensated Work Therapy, or Mental Health Intensive Case Management, will reflect local expectations for face-to-face time and community services. For a full-time mental health employee, accounting for a 30-minute lunch and two 15-minute breaks, this equates to 28-32 hours for a Provider with 100 percent Clinical Labor Mapping. Collateral duties, such as Clinical Case Review Conferences, morning huddles, non-face-to-face case management, Evidence-Based Psychotherapy certification and consultation training, clinical supervision (not adjusted for in labor mapping) and other non-wRVU generating workload expectations may lower the overall percent of bookable hours. The final determination of bookable time requires consideration of the individual provider's wRVUs, encounters, labor mapping of clinical hours, and unique Veterans served.

c. **Administrative Time.** Administrative labor mapping will vary based upon the local determination of required duties. Excluding specific mental health positions and time designations established by policy, there is no national minimum or maximum Administrative labor mapping assignments. Administrative labor mapping will account for program size and complexity. Administrative time includes time spent in managerial or administrative duties, such as but not limited to, performance plan monitoring, hiring actions, and personnel management, generally at the level of the department, service, VA medical facility, Veterans Integrated Service Network (VISN) or nationally, both within and outside VA that go beyond the requirements of a typical front-line clinician. This time must be mapped for individuals with major and formal administrative and leadership responsibilities that go beyond those of a typical front-line provider. Administrative labor mapping time for non-program leadership responsibilities are based upon required time commitments as outlined below.

(1) Service line and discipline specific service chiefs, clinical program directors, coordinators, and supervisors are examples of positions that would be mapping administrative time.

(2) Time must be mapped administratively for any committee work requiring one hour or more of time for a provider weekly. This includes time to chair an administrative committee like the serving on the Disruptive Behavior Committee (DBC), Employee Threat Assessment Team (ETAT), or other administrative/clinical board that meets regularly and has the equivalent of at least an hour of work per week.

(3) Administrative time will also involve service in a particular role, such as being the Military Sexual Trauma (MST) Coordinator (VHA Directive 1115, Military Sexual Trauma (MST) Program, dated May 8, 2018), Post-Traumatic Stress Disorder (PTSD) Clinical Team Leader, Local Recovery Coordinator (VHA Directive 1163, Psychosocial Rehabilitation and Recovery, dated August 13, 2019), Suicide Prevention Coordinator, VISN PTSD Mentor, Vet Center Liaison (VHA Handbook 1500.01, Readjustment Counseling Service (RCS) Vet Center Program, dated September 8, 2010), or Facility Evidence Based Psychotherapy Coordinators (VHA Handbook 1160.05, Local Implementation of Evidence-Base Psychotherapies for Mental and Behavior Health Conditions, dated December 8, 2015).

d. **Research Time.** Research time is 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 medical facility's research review process. Support activities include time spent by the investigator in direct support of research activities.

e. **Education Time.** Education is time spent by a VA clinical staff preparing and delivering classroom training, formal presentation or lecture as well as time spent managing a resident, fellow or other type of student teaching program (i.e., Director of Clinical Training). Resident, trainee, and non-Licensed Independent Providers (LIPs) clinical supervision is considered direct clinical care time.

4. APPROPRIATE CPT CODING

Mental health providers must document in the electronic health record (EHR) the services delivered. Providers are not to expand the scope of a patients' care, thereby increasing wRVUs, without clinical justification specific to that patient. All providers must follow the precepts of the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative. ***NOTE:*** *See VHA Health Information Management Clinical Coding Program Guide Version 1.4: https://vaww.vha.vaco.portal.va.gov/sites/HDI/HIM/vaco_HIM/subsite5/subsite3/HIM%20Handbooks/VHA%20HIM%20Clinical%20Coding%20Program%20Guide%20Version%201.4%20September%207,%202018.pdf. This is an internal VA Web site that is not available to the public.*

5. MONITORS OF PRODUCTIVITY

a. **Annual Study**. Each year VHA conducts a study of mental health provider productivity in accordance with VHA Handbook 1065.01 Productivity and Staffing Guidance Specialty Provider Group Practices, dated May 4, 2015. ***NOTE:*** *The results*

of this study are posted on the Office of Productivity, Efficiency and Staffing (OPES) Portal: http://vssc.med.va.gov/. This is an internal VA Web site that is not available to the public.

b. **Productivity Monitoring.** If the productivity level of the specialty group practice is found by the annual study to be below the median range (minus 1.25 standard deviation), the VA medical facility Mental Health Service Chief must devise a corrective action plan to align productivity to acceptable levels, which will be submitted to the VA medical facility director for review. This action plan must be developed in collaboration with the appropriate discipline leader(s). Service chiefs must also review for specialty group productivity above the median range (plus 1.25 standard deviation), in particular to assess for burnout of staff members. Workload productivity numbers significantly higher than the median range might suggest a need to reassign staff to assist in clinical areas with increasing service needs and a possible need to adjust future business planning to request additional staffing. In addition, workload productivity numbers outside the median range might reflect improper CPT coding and or poorly aligned labor mapping, and service chiefs are encouraged to monitor for compliance with national guidelines.

c. **Establishing Monitoring.** The service chief or service line director, in collaboration with the discipline leaders and program supervisors, must use the productivity monitor (OPES or MHOC) to help ensure equitable assignments, as appropriate, to each individual provider. ***NOTE:*** *The productivity monitor does not account for the frequency or difficulty of on-call responsibilities, the specific program to which the provider is assigned, or the presence or lack of productivity modifiers such as number of clinical support staff (see following paragraph) or complexity level of the VA medical facility.* These and other additional factors are used in an informal way when comparing productivities and setting duty assignments. In addition, these indicators of productivity are useful when assigning duties, such as teaching and research, as relevant to the mission of the service. It must be recognized, however, that a high level of variability around the median found at the individual provider level may be appropriate and expected depending on their program assignment (e.g., driving time for Mental Health Intensive Case Management providers, Home-Based Primary Care providers, and Health Behavior Coordinators need to have target expectations adjusted).

d. **Specialty Groups.** The specialty group practice productivity performance standard applies to the entire practice; service chiefs, discipline lead, program supervisor, or other designee must track productivity for each mental health provider. The individual productivity record is to be produced and reviewed quarterly with each provider in collaboration with the discipline leaders.

e. **Exempt Provider.** The following providers do not need to be tracked in the quarterly report:

(1) Providers who have no clinical assignment.

(2) Providers who work without compensation.

(3) Providers who are either paid per encounter or procedure, rather than by the hour or FTE.

(4) Providers that cover on-call emergency duties only.

(5) Provider that is staffed for fewer than 5 days of service per quarter. ***NOTE:*** *When deciding whether position(s) are staffed fewer than 5 days per quarter, the VA medical facility Director must add the days of attendance of all providers in the contract.*

6. UPDATED wRVU GUIDANCE

Annual updates for CPT codes and wRVUs used by CMS are available at ARC Interactive Reports: HCPCS and CPT Codes CMS Description and Work RVUs at the Web site: http://vaww.arc.med.va.gov/vapublic/cpt_input.html. ***NOTE*****:** *This is an internal VA Web site that is not available to the public.*