



Workforce Succession Strategic Plan

2013

- ▶ Strategic Direction
- ▶ Workforce Projections
- ▶ Critical Occupations
- ▶ Recruitment & Retention
- ▶ Diversity & Inclusion
- ▶ Employee Development
- ▶ Organizational Health
- ▶ Leadership Succession



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It is my pleasure to present the eleventh publication of the Veterans Health Administration's Workforce Succession Strategic Plan for Fiscal Years 2013 – 2019. This plan provides a strategic way forward to meeting the human capital management and workforce needs for VHA that is patient-centered, data driven, team-based, continuously improving and population-based.

The VHA Workforce Plan is built upon the latest workforce succession plans from each VA Medical Center, VISN and VHA Program Office. These plans provide a structure for the strategic alignment of workforce planning needs and action plans at every level of the organization. Those in responsible leadership and management positions will find it a valuable resource to make certain that VHA strategies and business planning cycles integrate present and future human resource requirements, which in turn ensures our organization's future workforce readiness.

In addition to the standard analysis of workforce and leadership succession needs in VHA, this year's plan also addresses critical initiatives to improve Veteran's mental health and access to rural health care, modernize VHA's administrative infrastructure, streamline hiring practices, attract a more diverse workforce, and create a world-class organization of Veterans serving Veterans.

An electronic version of this plan can be found on the VHA Succession Planning SharePoint at http://vaww.succession.va.gov/Workforce_Planning/default.aspx. I encourage you to read this plan, become familiar with its contents, share it with your employees, and use it to help guide your local workforce and succession planning and decision making.

If you have questions or wish additional information, please contact Stephanie Kondrick, VHA's Director of Workforce Planning, Healthcare Talent Management (405-552-4338).

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Overview

Workforce planning is a systematic process for identifying the employees required to meet organizational goals, developing the strategies to meet those requirements and developing competencies to address workforce issues over time. Succession planning focuses on building the organization's bench strength and succession pipeline to ensure continuity in key positions and encourage individual advancement. Its goal is to match the organization's existing talent to its future needs and to ensure that the lessons of organizational experience will be preserved to achieve continuous improvement in work results. VHA joins both concepts of workforce and succession planning to get the right people with the right skills, abilities, and competencies in the right jobs at the right time. VHA's workforce succession goal is to recruit, develop and retain a competent, committed, and diverse workforce that provides high quality services to Veterans and their families in a healthy, ethical environment.

The annual VHA Workforce Succession Strategic Plan is built upon the latest workforce succession plans from each VA Medical Center, VISN and VHA Program Office. These plans provide a structure for the strategic alignment of workforce planning needs and action plans at every level of the organization. Appendix A, Governance of VHA Workforce Succession Planning Process, outlines the VHA governance structure and leadership for the national initiatives and programs recommended in this plan. That structure is aligned through the Succession and Workforce Development Management Subcommittee (SWDMS) of the Workforce Committee (WC) and National Leadership Council (NLC).

Leaders at every level play a key role in ensuring that a strong link exists between their organization's workforce succession plan and the overall organizational mission and vision. They help to ensure that the resources needed to complete the plan are provided, and that responsible parties are held accountable for the action plans described within each plan. This information is critical to producing a national plan that is reflective of the challenges and realities faced by the front-line clinical and administrative workforce who cares for our Nation's Veterans and their families and for ensuring that barriers and anticipated gaps in the succession pipeline are appropriately addressed.

The Strategic Direction chapter of this plan highlights VA's mission, vision, and major initiatives along with an overarching set of VA Core Values and Characteristics. Supported by these Department-level constructs, VHA's mission, vision, and transformation initiatives, together with the strategic context, supply the foundation for the VHA Workforce Succession Strategic Plan.

Chapter 2, VHA Culture and Organizational Health, offers specific behaviors and suggestions for leaders to create a culture of transformation and organizational health.

Chapters 3, 4, 5 and 6 offer a variety of workforce analyses, including supervisory and executive leadership positions; the VHA Program Office workforce; the top occupations and specialties for recruitment and retention in VHA; and emerging occupational priorities and initiatives. The depth and breadth of analysis in these chapters represents another major strength in VHA workforce succession planning.

Chapters 7, 8, and 9 of the plan describe the initiatives and programs in place for workforce and leadership development, recruitment and retention, and specific initiatives for workforce succession planning undertaken at the national level, including legislative and policy changes. Together these chapters represent what VHA is doing to meet the workforce and succession challenges of the future.

Chapter 1: Workforce Succession Strategic Direction

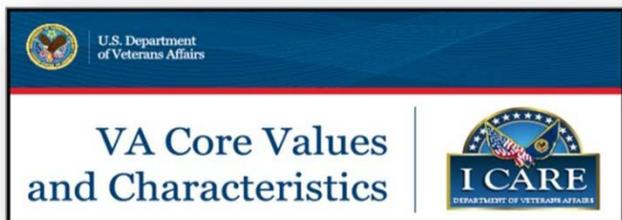
The VHA Workforce Succession Strategic Plan is the action planning tool for VHA leaders. The Plan guides VHA, ensuring an ample pool of talent with the right skills, experiences, and competencies is recruited, developed, and retained. Strategic succession planning is essential to have a workforce that can support the mission of VA and take VHA to the forefront of health care delivery. This chapter provides the foundation for succession planning in the mission, vision, strategic goals, and initiatives of the organization and defines the strategic context, priorities, and succession challenges that must be addressed to successfully achieve that mission.

VHA Workforce Succession Goal

To recruit, develop and retain a competent, committed, and diverse workforce that provides high quality services to Veterans and their families in a healthy, ethical environment.

VA Mission and Values

VA's mission is to fulfill President Lincoln's promise, "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans.



The Secretary of Veterans Affairs introduced an overarching set of Core Values and Characteristics to describe VA's culture and character and to serve as a foundation for the way individuals interact with each other and with people outside the organization. These underscore our moral obligation to Veterans, their families, and beneficiaries.

Our Core Values are: **I**ntegrity,

Commitment, **A**dvocacy, **R**espect, and **E**xcellence ("**I CARE**"). Our Characteristics describe what we stand for and what we strive to be as an organization, which is Trustworthy, Accessible, Quality, Innovative, Agile, and Integrated. Our Core Values and Characteristics are an integral part of VA's strategic goals.

VA Strategic Goals

- Improve the quality and accessibility of health care, benefits, and memorial services while optimizing value.
- Increase Veteran client satisfaction with health, education, training, counseling, financial, and burial benefits and services.
- Raise readiness to provide services and protect people and assets continuously and in time of crisis.
- Improve internal customer satisfaction with management systems, support services, and make VA an employer of choice by investing in human capital.

Note: In accordance with VA convention, "clients" refers to Veterans and their families, and "customers" refers to internal users.

VA Major Initiatives

In Fiscal Year (FY) 2010 the VA Secretary outlined the major initiatives for the future. These initiatives establish the priority strategies for the VA health care system and serve as the foundation for VHA planning activities. The highlighted initiatives below are especially relevant to VHA's workforce succession plan.

Secretary of Veterans Affairs Major Initiatives	
1. Eliminate Veteran homelessness.	9. Ensure preparedness to meet emergent needs.
2. Enable 21st century benefits delivery and services.	10. Develop capabilities and enabling systems to drive performance and outcomes.
3. Automate GI Bill benefits.	11. Establish strong VA management infrastructure and integrated operating model.
4. Create Virtual Lifetime Electronic Record by 2012.	12. Transform human capital management.
5. Improve Veterans' mental health.	13. Perform research and development to enhance the long-term health and well-being of Veterans.
6. Build Veteran Relationship Management (VRM) capability to enable convenient, seamless interactions.	14. Optimize the utilization of VA's Capital Portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process.
7. Design a Veteran-centric health care model and infrastructure to help Veterans navigate the health care system and receive coordinated care.	15. Health Care Efficiency: Improving the quality of health care while reducing cost.
8. Enhance the Veteran experience and access to health care.	16. Transform health care delivery through health informatics.

Source: http://www.va.gov/VA_2011-2015_Strategic_Plan_Refresh_wv.pdf

Veteran Employment Initiatives

In November 2011, President Obama signed the Veterans Opportunity to Work (VOW) to Hire Heroes Act, which requires federal agencies to treat active duty Servicemembers seeking employment as preference eligible before their honorable discharge, allowing for a smoother transition to civilian employment following their heroic service.



VA for Vets is a comprehensive career development program designed to help Veterans launch or advance their civilian careers at VA. The mission of the *VA for Vets* program is to create a world-class organization of Veterans serving Veterans. *VA for Vets* will encourage Veterans to join, serve, and stay at VA and will provide the tools to make sure this happens. Through this flagship initiative, the Veteran Employment Services Office (VESO) has developed:

- A Veteran-focused career development program to offer our Nation's Veterans real-time, on-demand, round-the-clock support services to launch or advance their civilian career with VA.

- A robust online Career Center to assist Veterans in translating their military skills into civilian language and building a marketable federal resume with the expert guidance of a professional career coach. www.VAforVets.VA.gov.
- Deployment lifecycle resources and coaching support as well as paths for professional growth through an expanding partnership with MyCareer@VA, which provides self-assessment, career planning, career mapping, and tools to find real VA jobs that fit the individual. www.MyCareeratVA.va.gov
- VA for Vets has also hosted numerous virtual and live hiring events where thousands of Veterans have received one-on-one coaching support, training, and opportunities to network with government agencies and private sector employers.

VHA Mission

Honor America's Veterans by providing exceptional health care that improves their health and well-being.

VHA Vision Statement

VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient centered and evidence based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the Nation's well-being through education, research, and service in national emergencies.

VHA Principles

To achieve health care transformation, our health care system must be:

- Patient Centered
- Team Based
- Data Driven/Evidence Based
- Prevention/Population Health Focused
- Providing Value
- Continuously Improving

VHA Strategic Goals

- Provide Veterans personalized, proactive, patient-driven health care.
- Achieve measureable improvements in health outcomes.
- Align resources to deliver sustained value to Veterans.

VHA Workforce Succession Goal

VHA's workforce succession goal is to recruit, develop and retain a competent, committed, and diverse workforce that provides high quality services to Veterans and their families in a healthy, ethical environment.

Two standards of excellence that VHA continues to support with regard to the workforce succession goal are:

- To ensure an engaged, collaborative, and high-performing workforce to meet the needs of Veterans and their families.
- To promote excellence in the education of the future workforce to drive health care innovation.

Strategic Context

Infrastructure

VHA is the nation's largest integrated health care delivery system with facilities in all 50 states, several U.S. territories, and the District of Columbia.

- 5.3 million Veteran patients
- 21 Veterans Integrated Service Networks (VISNs)
- 152 medical centers
- 971 outpatient clinics
- 133 community living centers
- 98 domiciliary rehabilitation treatment programs
- 300 readjustment counseling centers
- 140 comprehensive home-care programs

eHealth Initiatives

VHA also reaches out to Veterans using technology. Telehealth and telemedicine are major VHA initiatives to reach Veterans in their homes or at facilities closer to their homes where a particular specialty would not otherwise be available. In the last 10 years, the number of telehealth encounters has increased nearly 20-fold from approximately 21,000 to over 400,000 per year. Telehealth is proving to be advantageous to urban Veterans as well as those living in rural and highly rural areas. Social networking is another tool used to improve direct communication to Veterans and give them a venue for providing feedback. Veterans can access their personalized health care information via www.MyHealtheVet.va.gov. "Secure Messaging," a Web-based message service that allows VA patients and their health care teams to communicate non-urgent health related information, is a feature of this site. Secure Messaging is currently available for use by all patients in Primary Care, Specialty Care, and Surgical Care and will be implemented in Mental Health by FY 2013.

Workforce

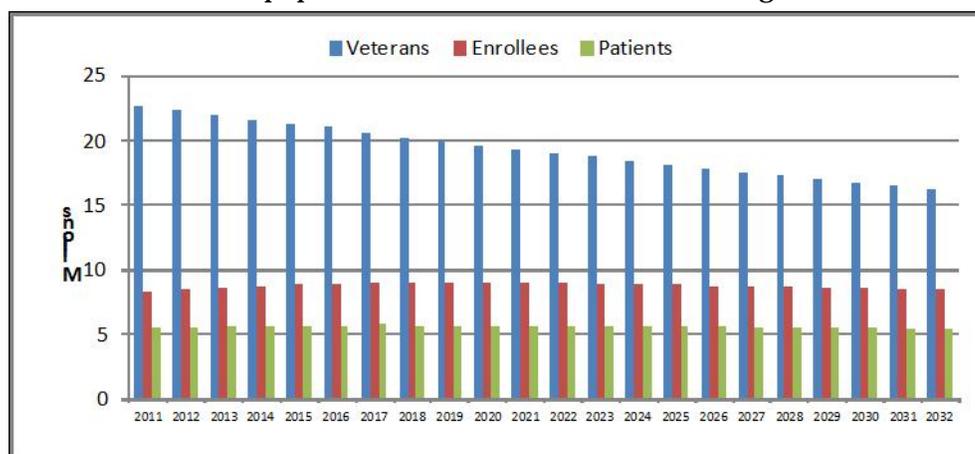
As of the end of FY 2011 VHA had over 269,000 employees, which makes it the second largest civilian employer in the federal government, after the Department of Defense (DoD), and one of the largest health care providers in the world. Additionally, VHA has one of the most complex workforces with

over 300 job series classifications, encompassing professional, technical, administrative, clerical, and trade occupations, covered by two personnel systems established by Title 5 and Title 38 statutes. VHA employees are highly trained and dedicated to providing the highest quality health care to our Nation's Veterans.

To achieve VHA's mission of providing exceptional patient-centric health care to America's Veterans, it is essential to recruit and retain highly skilled and dedicated employees functioning at the top of their competency level as well as to develop a talented succession pipeline. VHA is challenged with ensuring it has the appropriate workforce to meet current and future needs, including widespread shortages and increased competition for health care professionals in hard-to-fill occupations such as physicians, nurses, pharmacists, physical therapists, and mental health providers. In addition to health care professionals, there are challenges associated with retaining and attracting competent administrative professionals including human resources (HR) specialists. Other challenges include rapidly changing technology requiring new skills and an increasing percentage of employees eligible for retirement, particularly in leadership positions. A complete analysis of the total workforce, supervisors, and senior leaders along with projections for planning is provided in Chapter 3 along with an in-depth analysis of the specific issues related to the Senior Executive Service (SES) in Chapter 4, VHA Senior Executive Analysis.

Veteran Population, Enrollees and Patients

Based on projections from the Enrollee Healthcare Projection Model (EHCPM), there will be a decrease in the total Veteran population from 2012 – 2032, resulting in a total of nearly 9.2 million Veteran



enrollees, and a projected increase of over 300,000 Veteran patients.

Anticipating the changing health care needs of Veterans will require VHA staff to possess complex skills and competencies to address those needs. As a result of the growth in the population of female

Veterans, VHA has been working to enhance services, resources, facilities, and the workforce to meet the needs of women Veterans.

Furthermore, broad-based changes in the age and demographics of World War II, Korean, and Vietnam-era Veterans, as well as Veterans of Operations Enduring Freedom, Iraqi Freedom, and New Dawn (OEF/OIF/OND) will require new competencies and skills to address specific needs of the Veteran population. After 2013, the largest segment of the VHA enrollee population will be between 65 and 84 years of age. By 2016, the number of Veteran enrollees age 85 and older will decline from 1.2 million to approximately 800,000. The oldest segment of the Veteran population continues to have significant impact on the demand for health care services, particularly in the areas of geriatrics, long-term care, home-based care, and mental health services.

At the same time, OEF/OIF/OND Veterans may use different kinds of services, particularly in the area of preventive health, than Veterans of previous conflicts. In 2008, combat Veterans discharged or released from active service after 2003 became eligible to enroll for VA health care in Priority Group 6 or higher for five years from the date of discharge or release. This resulted in an increase in enrolled Veterans and provided an introduction to VHA that might not have otherwise occurred at this time in their lives. These Veterans may be more likely to continue to choose VHA for all or part of their health care beyond the initial five-year window.

External Factors

External factors including economic conditions, geographic migration of the Veteran population, flat or declining budgets, current and future conflicts, and national health care reform must be considered as organization drivers in the planning process. While the Affordable Care Act (ACA) or “health care reform” will not affect the current role VA has in the lives of America’s Veterans, it will have an impact on the health care industry, the demand for health care and health care providers, and the choices that Americans will have for their health care. VHA’s advances in the electronic health record and in performance as an integrated health care system are quickly becoming the standard among private sector health care providers.

A confluence of market conditions within health care is increasing demand for services from Baby Boomers and coincides with a shortage of skilled talent. VHA competes directly with the private sector for all categories of health care occupations. Research indicates that health care professionals are changing employers more slowly than in past years. Further, with economic uncertainty, many choose to remain with their current employers longer. However, these factors are variable, and VHA must be prepared to operate in a cyclical job market and be future-oriented regarding employment needs.

Changes in technology, customer expectations and communications are driving patient engagement through the use of hand held devices and other electronic media. Reduction in face-to-face visits and replacing care through remote technology may shift significant workload from outpatient to e-patient care.

VHA Transformation Initiatives

The VHA Transformation Initiatives are based on VA and VHA strategic goals and objectives. These initiatives provide emphasis and programmatic direction for VHA facilities and networks in their strategic workforce succession planning. These initiatives are particularly relevant to the Workforce Succession Planning Process because of their implications for building a skilled workforce to support VA’s mission:

- New Health Care Models
- Enhancing the Veteran Experience and Access to Health Care
- Improving Veteran Mental Health
- Ending Veteran Homelessness
- Improving Health Care Efficiency
- Improving Health Care through Informatics

New Health Care Models

VHA has undertaken a cultural transformation toward Patient-Centered Care (PCC) with the implementation of the Patient-Aligned Care Team (PACT) model, systems redesign, continuous improvement, and quality management principles. PCC honors Veterans' expectations for safe, high quality, and accessible care. It enhances the quality of human interactions and therapeutic alliances, and solicits and respects the Veteran's values, preferences, and needs by incorporating shared decision-making and patient advocacy. The key to providing PCC is to support and sustain an engaged workforce in a safe, ethical environment that empowers employees to take risks, embrace change, and support innovation for the greatest benefit of Veterans and their families, as well as internal customers and co-workers.

The PACT model changes our paradigm of care from episodic, based on illness and patient complaints, to coordinated care and a long-term healing relationship, with a strong emphasis on preventive services, health education, and wellness. In this model, primary care delivered by a coordinated team is central, and as such, PACT will require a workforce with a different skill mix, more support roles, and better communication skills, particularly in terms of listening to the Veteran, including the patient in their health care decisions, and information sharing between team members. Currently, 40% of all PACT staff has received training, and the goal is to complete training for all PACT staff by September 2014. While most VHA Primary Care practices have already adopted many of the features of PCC and PACT, complete achievement will involve strategic assessment and evaluation, careful redeployment of resources if warranted, and major cultural change. To that end, five PACT Demonstration Labs evaluate the effectiveness and impact of the PACT model in VHA, and five Centers of Excellence in Primary Care Education develop and test innovative approaches in training the primary care team for the 21st century.

Enhancing the Veteran Experience and Access to Health Care

In an effort to enhance the Veteran experience and access to health care, VHA has moved from emergency care to more preventive care, from long-term institutional care to non-institutional care options, and from VA hospitals through its expanded network of community-based options. In addition, telemedicine is being used to connect patients wherever they are, creating greater access for patients in rural areas as well as greater convenience for non-rural patients.

VHA partners with each Veteran to create a personalized, proactive strategy to optimize health and well-being, and when needed, provides state-of-the-art disease management. Increasingly, VHA is engaging in joint ventures, collaboration, and affiliation with community partners and other government entities to make the most of resources. VISN 12 created a sharing agreement between the North Chicago VA Medical Center and the Department of Defense, Great Lakes Naval Hospital to create the Lovell Federal Health Care Facility. VHA is also relieving the burden on families through caregiver support programs that provide family caregivers ongoing technical support, marriage and family counseling/family therapy, training, counseling, lodging, and subsistence. VHA provides the "primary" family caregiver with mental health services, respite care, medical care, and a monthly stipend. The National Caregiver Support Line (855-260-3274), established in 2011, has received more than 41,334 calls, averaging 150 calls per day, and a website dedicated to Family Caregivers, www.caregiver.va.gov, averages over 900 visits per day.

The needs of Veterans living in rural areas are a national priority for VHA, with 41% of enrollees living in rural or highly rural areas, which is equivalent to 3.5 million out of 8.6 million enrollees. In FY 2011, VA disbursed \$250 million in support of rural health initiatives. Providing the best care to Veterans in rural communities means adopting creative new approaches to providing health care outside the standard hospital-based model, including greater use of Community Based Outpatient Clinics (CBOC), establishment of Primary Care Telehealth Outpatient Clinics (PcTOC), partnerships with community-based and other state and Federal health care providers, affiliates, and mobile clinics, use of secure Webcasts between patients and providers, as well as telehealth, telemedicine, and virtual technologies. VHA must anticipate and minimize obstacles that rural Veterans may face and continue to provide them the most efficient and highest quality health care. Examples of this include Project ARCH (Access Received Closer to Home), which coordinates care between VA and non-VA entities in rural communities, and Project RANGE (Rural Access Network for Growth Enhancement), which provides care for mentally ill patients in rural areas who are homeless or at risk of becoming homeless.

In lean budget times, it is especially important to focus on retaining a trained and highly-skilled workforce.

Improving Veteran Mental Health

One-third of all enrolled Veterans have a need for mental health care driven by multiple deployments, substance abuse, and suicide in the Veteran population. Mental health care in VHA is comprised of an unparalleled system of comprehensive services to address the individual mental health needs of Veterans as well as the needs of family member caregivers. VHA integrates mental health professional staff into the primary care setting and extends that capability through telemental health capabilities, maintaining strong partnerships with community providers, and ensuring access to specialty mental health services. Telemental health technology is used to treat virtually every mental health diagnosis and takes place at multiple sites of care. From 2003 to 2011, telemental health annual encounters have increased approximately 10-fold from 14,000 to over 140,000 yearly.

The number of OEF/OIF/OND Veterans seeking mental health care has increased dramatically over the past three years. Last year, VHA provided quality, specialty mental health services to over 1.3 million Veterans. VHA is committed to ensuring the safety of our Veterans, especially when they are in crisis. Veterans have universal access to 24/7 emergency care through VHA's Emergency Departments and Crisis Line (1-800-273-8255), which responded to over 600,000 calls and have contributed to saving over 21,000 Veterans' lives. In addition, VA has simplified its rules for Veterans submitting PTSD-related disability claims, which has greatly eased access to care. In FY 2011, approximately 477,000 Veterans with a confirmed PTSD diagnosis received treatment in VA Medical Centers and clinics; as of May 2012, over 4,400 VA mental health professionals have been trained in the most effective known therapies for PTSD, Prolonged Exposure and Cognitive Processing Therapy. VA is also working on a suite of mental health smartphone apps to overcome stigma associated with mental health and allow Veterans to access reliable mental health information and resources whenever and wherever they need them. The first of these apps, the award-winning PTSD Coach, was developed jointly with the Department of Defense and has been downloaded over 61,000 times in more than 60 countries.

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VHA expects continued growth to the number of Veterans seeking mental health care throughout the next decade even as operational missions in Iraq and Afghanistan draw down. To serve this growing population, VA announced in 2012 that it would add 1,600 mental health clinicians to the existing VHA workforce of 20,590 mental health care clinicians to include psychiatrists, psychologists, mental health nurses, social workers, marriage and family therapists, licensed professional mental health counselors, and approximately 800 peer specialist/apprentice positions. In addition, approximately 300 support staff will be added to support the additional clinical staff. A discussion of the occupational considerations for the mental health initiative is provided in Chapter 6, Occupational Priorities, Challenges and Initiatives. Chapter 8, Recruitment and Retention, contains details on the recruitment and marketing efforts for the mental health hiring initiative.

As part of the Uniform Services Handbook requirements, each VA facility must have mental health practitioners embedded in its primary care clinics. The concept of Primary Care-Mental Health Integration has guided development of VA's Patient Aligned Care Teams (PACTs), which now include mental health staff as part of the primary care team. In order to prepare the future health professions workforce for practice in this new environment, the VA Interprofessional Mental Health Education Expansion Initiative was established in 2012. Led by the Office of Academic Affiliations, the initiative will promote ongoing efforts to transform VA's primary and mental health care delivery systems by offering a major expansion of clinical training positions in the following mental health professions for the Academic Year 2013-14:

- General Outpatient Mental Health Interprofessional Teams,
- Primary Care Patient Aligned Care Teams with integrated behavioral health providers,
- Core psychiatry programs (PGY 1-4) that will be connected at some point during the continuum of the training program to the training experiences above.

VHA Workforce Strategy

VHA must continue to pursue a strategic approach to build a diverse and inclusive workforce, and identify high-potential employees for development programs and opportunities. VHA must provide new employees with experiences that encourage a sense of connection to the organization and its mission as well as a full understanding of the benefits of a VHA career. This includes using talent management techniques such as applying direct hire authorities for Veterans. VHA must also be more proactive and creative in recruiting for positions including using national recruiters, targeting students and trainee groups, and using a single system for applicant tracking to capitalize on leads for hard-to-fill positions.

VHA's Workforce Succession Strategic Plan encompasses a comprehensive analysis of the total workforce, leadership positions, Program Office considerations, and top occupations as well as an array of strategies, including employee and leadership development, succession programs, organizational health assessments and initiatives, and recruitment and retention strategies. Initiatives to modernize VHA's administrative infrastructure, transform recruitment, improve new employee experiences and retention, attract and engage a more diverse workforce, and expand knowledge transfer make up some of the foundational elements of this plan. A full list of national deployment strategies, including workforce succession strategic initiatives and legislative/policy initiatives that are undertaken and monitored by the Succession and Workforce Development Management Subcommittee (SWDMS) can be found in Chapter 9, Deployment Strategies.

Chapter 2: VHA Culture and Organizational Health

What is Culture and Why is it Important?

VA's core values are: **I**ntegrity, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence (“**I CARE**”), and our characteristics describe what we strive to be as an organization, which is trustworthy, accessible, quality, innovative, agile, and integrated. Leaders build the culture, through consistent communication and modeling over time. In this way, employees come to know what is expected, what is important, what flexibilities they have, and what will be rewarded.

VHA recognizes the importance of culture in the recruitment and retention of employees, their satisfaction and performance, and in significant business outcomes in a health care environment. Culture is the slow-to-change, powerful, unseen force that shapes everything that happens in an organization. It is the legacy of leadership, and it is the sum of communication, leadership and organizational history that can empower or inhibit accomplishing the mission. Culture is defined as the trusted values, underlying assumptions and expectations; the ‘personality’ of the organization.

Culture provides the context for how employees approach their work and each other to achieve VHA goals and priorities. In an environment of transformational change, VHA's mission, vision and values provide the anchor that supports change. Business outcomes associated with a supportive culture include improvements in recruitment, retention, innovation, agility, patient and employee satisfaction, team performance, development of talent, continuous improvement, and competitive market position.

Creating a culture that supports and nourishes transformation is pivotal to achieving transformation. Commitment to that culture must be seen as authentic and flowing through policy and operational decision making across all levels of leadership.

The challenges facing VHA as described in Chapter 1, Workforce Succession Strategic Direction, include an aging workforce, increased competition for health care providers, an increasing population of younger Veterans with different health care needs, and external factors such as the economy and health care legislation. A culture that delivers patient-centered care through engaged and effective employees with committed leadership provides VHA a competitive edge as reflected in Figure 1. This three-pronged



Figure 1

model incorporates many of the cultural values VHA has embraced and developed over the last decade, such as servant leadership, diversity and inclusion, learning organization, change management, safety, employee wellness, engaged teams, civility and health equity. Exhibiting such positive behaviors reflect a healthy organizational culture.

Culture of Leadership Support

VHA defines organizational health as a state of systemic well-being that nurtures success in multi-dimensional, dynamic, and complex organizations.

Servant Leadership

One framework for providing a healthy organizational culture is servant leadership. Servant leaders put people first, use power ethically, seek consensus when possible, practice foresight, communicate skillfully, regularly withdraw to renew/refresh, practice acceptance and empathy, use conceptual and systems thinking, and lead with moral authority.

Servant Leadership requires strength of self-mastery, strength of action and strength of relationships. Servant leaders operate from courage, integrity, and a strong internal compass. They accomplish measurable results by building informed, thinking, caring, and creative staff who, in turn, are committed to serving. An important principle of servant leadership is that we are all leaders, all of the time (Sipe, J., Frick, D., 2009). Current research finds positive correlation between servant leadership and employee satisfaction and team effectiveness (Irving, J. 2009) and to job confidence, sense of service and perception of fairness (Walumbwa, F.O., Hartnell, C.A., and Oke, A., 2010). In a comparison of companies between 1995 and 2005, the 500 largest companies experienced a 10.8% return on investment (ROI), “Good to Great” companies a 17.5% ROI, and servant-led companies a 24.5% ROI (Keith, 2010). Servant leadership principles have been encouraged by VHA leaders and incorporated into field initiatives, succession plans, educational partnerships, and the VHA Organizational Health Newsletter.

Servant leadership unleashes the potential of the workforce and creates a flourishing work environment.

Diversity & Inclusion

In planning for the workforce of the future, VHA’s goal is to engage, inspire, and empower its employees by making the most of a diverse and inclusive workplace. VHA adheres to all Federal regulatory requirements and policies and does not tolerate discrimination or harassment. VHA’s senior executives and management officials fully support the Equal Employment Opportunity/Affirmative Employment Program (EEO/AEP) as a vital part of the Administration’s business strategy. Equal employment principles are incorporated in recruitment, promotions, awards, training, and conflict management. VHA actively promotes an inclusive work environment by creating opportunities, and taking full advantage of the potential a diverse workforce provides. It involves more than just outreach; it is a deliberate strategy to leverage workforce diversity as a strategic organizational asset.

When working in a team environment, inclusion allows full participation of all individuals in the organization to contribute to the mission. It promotes and creates an atmosphere where creativity is encouraged and innovation takes hold. It is the essence of employee engagement. Senior executives are held accountable to performance that demonstrates measurable improvement in diversity and inclusion.

The VHA Diversity and Inclusion Office, established in 2010, advances and leverages cultural competency and inclusion efforts throughout the organization. The Office partnered with the VHA Diversity and Inclusion Subcommittee to adopt three goals for action planning: 1) Create strategies to promote advancement opportunities; 2) Develop a guide to increase inclusion; and 3) Develop a plan to

integrate educational/experiential opportunities on unconscious bias into leadership development programs. Additional information is available on the VHA Diversity and Inclusion SharePoint Site <http://vaww.wmc.va.gov/Diversity/default.aspx>.

Learning Organization

A learning organization environment is critical in achieving patient and employee satisfaction, aligning corporate goals and priorities, increasing quality and the ability to manage change, and preparing a competent workforce for the future. It is characterized by group vision, team learning, and systems thinking that produces a dynamic culture and allows the organization to learn from itself, recognizing and applying lessons learned and strong practices to a variety of situations (Senge 1990).

Building a learning organization begins with the intentional creation of a supportive and psychologically safe environment that invites, values, and explores new ideas, differences of opinion, and methods of practice. The 2012 Learning Organization Survey identified “Management that Reinforces Learning” as an area for improvement. Moreover, the 2012 All Employee Survey (AES) revealed that approximately one-third of the VHA workforce is self-reporting “burnout,” which indicates a significant organizational challenge. Those potentially being asked to learn something new, accommodate organizational changes, and are subject to oversight in multiple areas of performance can feel overwhelmed. Transformational leaders can affect these scores by intentionally creating psychologically safe environments and making time and space available to reflect on team learning processes.

A key factor in transforming an organization’s culture and keeping it healthy is appropriately managing the changes the organization will inevitably experience.

In a learning organization, leadership provides an environment in which learning occurs as a standard process of daily organizational functioning.

Change Management

Change initiatives commonly fail during implementation due to un-sustained employee engagement and leadership that does not actively manage such change. To increase success at achieving Transformation Initiatives and to support leadership in managing change, the VHA National Center for Organization Development (NCOD) developed the Phases of Change Assessment. This assessment allows leaders to understand the workforce’s reactions to a change process. Additionally, NCOD’s Leading Change Assessment determines how leadership is doing in leveraging key change management strategies. These assessments allow leaders to increase the likelihood of successful transformational change. To date, these assessments have proven successful in change processes related to facility and site activation, reorganizations, and policy changes.

Psychological Safety

Perceived satisfaction with supervisors and co-workers are important predictors of psychological safety. A high level of psychological safety is associated with higher performance measure scores as well as higher levels of patient satisfaction and patient safety. It is a leader's role to create an environment of psychological safety where employees can ask questions, give honest feedback, admit mistakes, take reasonable risks, make reasoned judgments, act creatively, and raise team issues without fear of negative consequences. Psychological safety is consistently one of the lowest rated elements of the AES, Learning Organization survey, and Integrated Ethics survey, with AES scores ranging from 3.28 to 3.37 in the last five years.

Training modules and tools to help managers assess and improve safety in the work environment are currently underway to address and improve psychological safety. Psychological safety is also included in leadership training programs, organizational health presentations and communication and training in clinical areas across the VHA health care system.

Physical Safety

Workplace violence contributes to losses in job performance and productivity. This violence contributes to lost work days and wages, and incurs legal expenses, unnecessary administrative and financial burdens, and increased health care costs. Physical injuries can occur and in the worst possible outcome, even death.

Workplace harassment is a form of discrimination that is explicitly prohibited by Federal law and VA policy. VHA employs primary, secondary, and tertiary prevention strategies, including strict policies prohibiting violence and harassment. VHA makes available resources and procedures for addressing disputes, and provides training for supervisors and employees in programs such as Prevention and Management of Disruptive Behavior (PMDB), a training program for violence prevention and defusing violent situations.

A psychologically safe environment is one that nurtures and inspires employee creativity and innovation.

According to the Bureau of Labor Statistics (2012), the health care industry has one of the highest injury rates of any industry in the United States. The combination of high physical demands, shift work, and work with low error tolerance leads to high physical injury rates. VHA has developed innovative programs to address physical hazards including, most notably, the Safe Patient Handling (SPH) program. The goals are to minimize manual handling of patients, to reduce the risk of injury to patients and employees and to decrease adverse clinical outcomes. Technology, including ceiling mounted lifts, just-in-time safety training, and comprehensive equipment inspection and maintenance programs represent a substantial investment in employee and patient health. A notable highlight of the SPH program is the dramatic reduction of patient handling injuries in nursing by 60%.

VHA recognizes that injured employees require careful assessment, supportive management, and rehabilitation time after injuries. According to the former Director of Occupational Health in VHA, when employees receive care within VHA's health care system following an injury, they generally fare better than when treated by outside providers, experiencing less than half as much lost work time and less than one tenth as many long-term disabilities. VHA's focus on "stay at work", early rehabilitation, and ensuring that the best care is also available to its own employees represents an important commitment to organizational health.

Employee Wellness Initiatives

Employee Wellness describes a holistic approach to promoting physical, psychological, and emotional health and well-being. Results of a recent Voice of VA (VOVA) Employee Wellness survey indicated that more than half of VA employees (57%) consider themselves overweight or obese, and 50% report having taken time off work due to respiratory illness. These results are being used to identify potential interventions to improve employee wellness, and can be tracked over time to evaluate results. VA provides several wellness programs to promote the health of employees and provide resources and referrals for professional, personal, and family issues.

Employee Assistance Program (EAP) is an employee sponsored benefit that provides confidential assessments, counseling, referrals, and follow-up services. EAP provides services for employees experiencing emotional stress, mental health disorders, family or relationship difficulties, financial/legal concerns, and alcohol or drug abuse problems. Participation in EAP is voluntary - <http://vaww1.va.gov/ohrm/WorkLife/HealthWellness/EAP/EAP.htm>.

Wellness Is Now (WIN) is a program which empowers employees with the knowledge, skills, and tools to create a culture of health and wellness. Modeled on private sector corporate wellness programs, WIN supports such activities as employee fitness centers, Yoga, Tai Chi, and wellness coaches. WIN also provides programs focused on tobacco cessation, weight loss, and stress management. Healthy eating and a variety of health promotion/disease prevention strategies are available to improve the health and well-being of VA employees - <https://www.vaemployeewellness.com/>.

WorkLife4You is a benefit paid by the Department of Veteran Affairs to help VA employees with problems related to the job and at home. Topics include team building, creating healthy workforce relationships, referrals to child and elder-care providers, etc. Employees can call a specialist day or night for expert advice, receive personalized information and detailed referrals to local and national resources, or may log on to the WorkLife4You Website for interactive self-service tips and tools, using registration code DVA - <https://www.worklife4you.com/>.

VA provides several wellness programs to promote the health of our employees and provide resources and referrals for professional, personal and family issues.

VHA recognizes that promoting an employee's physical health and a work/life balance results in a more focused and healthy workforce that is engaged and provides the best care to our Veterans.

Culture of Employee Engagement

Team Model

VA excellence in the 21st century will be driven by how well employees learn to work within and across teams as they deliver services and care to Veterans and their families. While Veteran-centered services and care can be demonstrated by individuals, much of the work done today requires employees to work in teams.

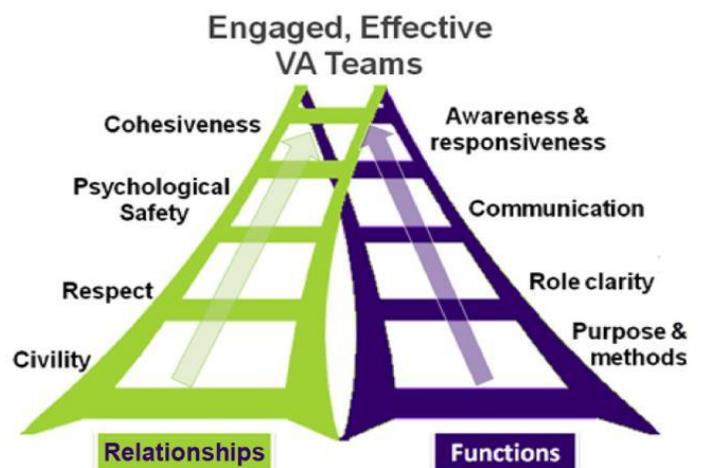


Figure 2

High-performing teams are groups of people whose success depends on meeting two key challenges: (1) team relationships - how they approach one another (team engagement) and (2) team functions - how they approach their tasks (team effectiveness). The interdependence of teams and tasks is represented by a ladder in the Engaged, Effective VA Teams model illustrated in Figure 2. Teams improve by working on both sides of the ladder.

The VA Team Assessment developed by the NCOD allows teams of all sizes to assess how their team is doing in the domains of relationships and functions. This assessment allows teams to identify their strengths and areas for improvements. The feedback provided by the team through this assessment starts the conversations that will be critical in developing a more engaged and effective team. An Executive Team Assessment version has also been developed to support leadership teams at all levels of VHA.

In VHA, employee engagement and satisfaction are measured through the AES, quarterly VOVA surveys, Integrated Ethics surveys, and Learning Organization surveys. Broad communication of survey results, and staff participation in action planning is a leadership performance standard. Effective action plans must be responsive to identified issues. Linking positive change to survey scores reinforces the value of employee feedback, builds employee engagement, and motivates participation in future surveys.

Veterans Canteen Service uses ADR which has resulted in a 20% reduction in complaint activity.

Civility

Civility is an important characteristic of a healthy workplace and is statistically correlated with a safe and high performing work environment, including improved satisfaction for customers and employees. Civility is also related to business indicators such as retention, EEO complaints, sick leave usage, productivity, psychological safety, and patient outcomes. Civility scores have remained relatively stable over the last four years at approximately 3.7 (on a five point scale) despite changes in the health care industry, pay freezes, and other external factors, such as the economic climate.



CREW is a culture change initiative that stands for Civility, Respect, and Engagement in the Workplace. During CREW implementation, workgroups commit to time, attention, and support for ongoing conversations about civility. It is based on facilitating honest conversations in an environment of respect and trust. More than 1,100 workgroups have participated in CREW, with statistically significant improvement in civility scores sustained over time. In VHA, civility translates into respect and engagement in the workplace. In 2011, The Joint Commission (TJC) cited CREW as a national best practice in employee wellness and safety.

Medical Team Training (MTT) is a program of the National Center for Patient Safety which improves the safety and outcomes of clinical care by addressing communication problems in clinical environments and among health care providers. CREW and MTT are effective tools to enhance retention and high-functioning work environments and may be particularly useful in improving civility issues identified in the AES.

Alternative Dispute Resolution (ADR)

In healthy organizations, employees feel safe to raise issues and concerns, and management has the skill to respond constructively. Effective conflict management is a strong predictor of employee satisfaction and high civility. Alternative dispute resolution (ADR) is an option that engages participants in crafting timely and mutually beneficial solutions. The benefits of ADR include time, cost, and resource efficiency for the organization, fair and transparent outcome equity for the employee, and active participation or voice by the employee in the dispute resolution process. Promoting ADR participation and informal resolution of disputes and EEO complaints are performance requirements for VHA senior executives. Demonstrated ability in managing conflict and constructively responding to disputes is one of TJC’s leadership standards.

Education and training play a key role in VHA’s ability to prevent disputes and promote the use of ADR. ADR awareness is a component of new employee orientation and supervisory training. Under the Human Capital Investment Plan, VHA participated in one-day training sessions for labor and management and three-day training sessions for supervisors conducted by the Justice Center of Atlanta (JCA). In 2012, there were 316 labor and management officials who received the one-day training and 357 VA leaders who have attended the three-day training with focus on effective communication, negotiation and problem solving skills. In FY 2011, Veterans Canteen Service (VCS) required all supervisors to attend JCA training. VHA has over 300 certified ADR mediators and annually invests in adding to this pool of resources and further developing their skills through training. VHA has sponsored 10 Basic Mediation Skills, five Advanced Mediation Skills, and one Conflict Coaching training program in the last 12 months.

VA’s ADR Policy was revised in 2012 to afford every individual who initiates an EEO complaint an opportunity to resolve it through ADR. Due to the success of the VHA pilot, ADR was adopted as a Department-wide policy. VHA has led the way in encouraging the use of ADR before formal processes are initiated, and maximizing participation in ADR at the informal stage of the EEO process. Charts below (Figures 3 and 4) reflect VHA’s progress over time in these areas. These efforts avoid the time and cost associated with EEO complaints which, based on a study conducted by the Office of Resolution Management (ORM), is estimated at \$17,000 per case. In October 2011, VHA was recognized for its ADR efforts through the Secretary’s Second Annual ADR Excellence Awards.

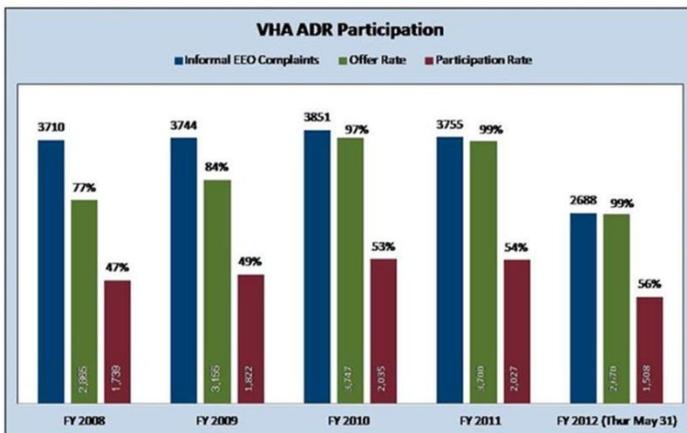


Figure 3

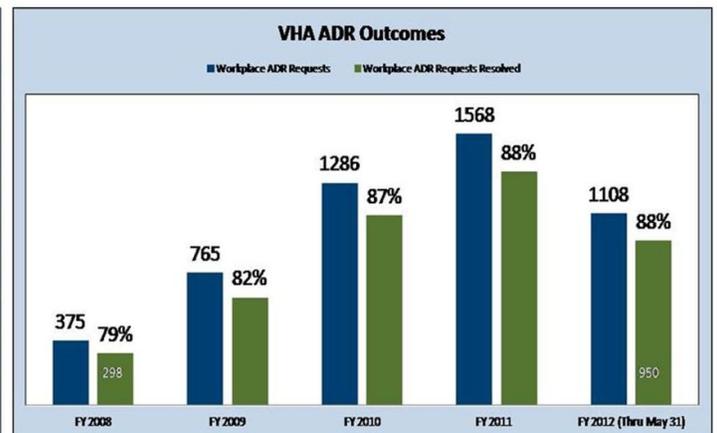


Figure 4

Unconscious Bias

Often discriminatory behavior in organizations is the result of unconscious attitudes and biases that have shaped patterns of behavior over time. They influence how we listen, how we communicate, and how we act. Unconscious bias negatively impacts inclusion and innovation in the workforce. Taking time to reflect on why we feel a certain way about a situation or a person can help us uncover unconscious bias. This in turn leads to greater inclusion, innovative processes and positive outcomes. The VHA Office of Diversity and Inclusion and the Office of Health Equity are developing training programs to educate leaders, clinicians, and staff throughout VHA about unconscious bias.

Discovering personal bias is the cornerstone toward building cultural competency.

Cultural Competence

Cultural competence can be measured on a continuum from cultural destructiveness to cultural proficiency (Cross, T., n.d.). VHA models an environment which values diversity and reflects an inclusive workplace. VHA also educates its workforce to encourage mutual respect of cultural differences. Mission statements, policies, procedures, strategies, hiring, assessment, education, and workforce development demonstrate this core value.

A diverse and culturally competent workforce is better able to recognize inequities and build health equity into our systems.

In 2010, VHA facilities completed cultural competency self-assessments and action plans. Medical centers initiated steps towards developing culturally competent work processes. In 2011, cultural competency, diversity, and inclusion modules were added to many training programs including Patient Centered Care, Rural Health Professions Institute, Content Distribution Network, and a variety of leadership development programs.

Employee Satisfaction

VHA data in Figure 5 show that overall employee satisfaction scores decreased slightly from FY 2010 to FY 2012. The 2012 AES data indicates that about a third of the VHA workforce is self-reporting burnout. AES survey results demonstrate strong correlations between civility, overall satisfaction, and intent to stay with VA. Leadership's commitment to action planning in response to employee feedback significantly shapes employee satisfaction, engagement, and retention, and in turn, impacts delivery of care. Action planning at every level of the organization engages employees and management on key areas for improvement.

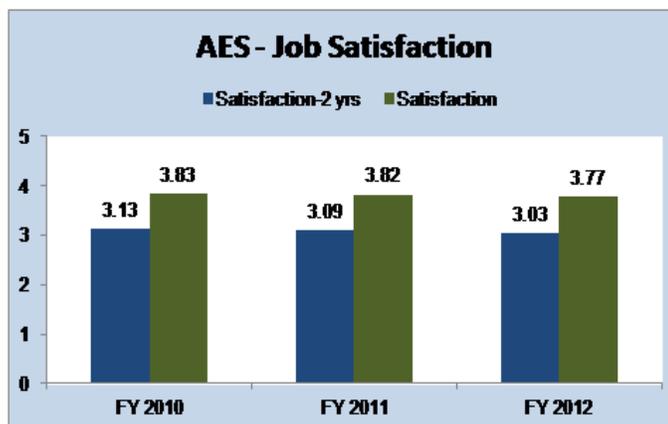


Figure 5

Rewards and Recognition

Rewards and recognition serve to reinforce positive behaviors by acknowledging employees for high levels of service and accomplishment. In the last few years, severe restrictions have been placed on monetary bonuses, awards, and salaries. The lack of tangible awards requires other approaches to recognizing special contributions and performance excellence.

Figure 6 illustrates fairly stable scores on the AES for employee satisfaction with Praise and Rewards. In the current economic climate, managers must be more creative in designing programs and finding opportunities to recognize their employees. An example of exemplary customer service recognition is the Cincinnati VA Medical Center's "Customer Stars" Program, where employees nominate co-workers quarterly. Those "Customer Stars" are highlighted on the Cincinnati VAMC intranet site - <http://vhacinweb1/local/>.

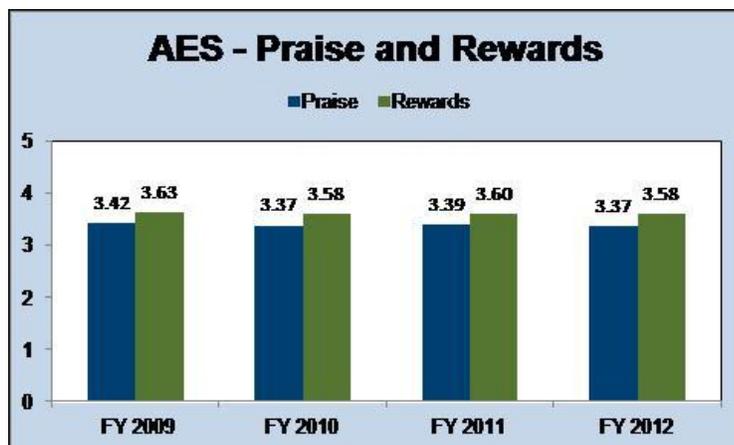


Figure 6

It is more important than ever to acknowledge employee contributions and provide public recognition for a job well done. Praise scores for the AES have tended to be low over the last five years, providing ripe opportunities for innovative recognition efforts that are meaningful to employees.

Culture of Patient Centered Care

Patient Centered Care (PCC) represents a profound cultural change. VHA has undertaken this transformation through systems redesign, continuous improvement, quality management principles, and the Patient-Aligned Care Team (PACT) model. As described in Chapter 1, Workforce Succession Strategic Direction, the PACT model changes our paradigm of care from episodic care based on illness and patient complaints to coordinated care and a long-term healing relationship, with a strong emphasis on preventive services, health education, and wellness. In this model, primary care is delivered by a coordinated team, requiring a workforce with a different skill mix, more support roles, and better communication skills, particularly in terms of listening to Veterans and their families.

PCC goes well beyond primary care to honor Veterans' expectations for safe, high quality, and accessible care of all kinds. It enhances the quality of human interactions and therapeutic alliances, and solicits and respects the Veteran's values, preferences, and needs by incorporating shared decision-making and patient advocacy. The key to providing PCC is to support and sustain an engaged workforce in a safe, ethical environment that empowers employees to take risks, embrace change, and support innovation for the greatest benefit of Veterans and their families, as well as internal customers and co-workers.

PCC and PACT represent a commitment to partnering with Veterans, a significant competitive advantage in an unfolding health care environment, and a profound cultural change to Veteran-centric care delivered by engaged employees working in effective teams, within a context of supportive, servant leadership.



Health Equity

As VHA works to achieve diversity and cultural competence in the workforce, we are also committed to achieving health care equity for Veterans. The Office of Health Equity (OHE) was established in FY 2012 to promote health equity and address health disparities. The office consists of two major components, one focused on Cultural Competency and Communications and one focused on Health Care Outcomes and Data. The OHE brings important focus to VHA efforts to provide a more equitable health care system and improve overall quality of care through the achievement of health equity.

Chapter 3: VHA Total Workforce Analysis

Historical VHA Workforce Analysis

At the end of FY 2011, VHA's total onboard workforce including full- and part-time employees totaled 269,908, making VHA the second largest civilian employer in the Federal government and one of the largest health care providers in the world. In the last five years, onboard strength in VHA increased by 23.7% (51,645 employees). The majority of growth occurred in FY 2008 and 2009. Over the same five years, VHA experienced losses of over 121,000 employees, nearly half (43.5%) of which were the result of resignations and external transfers, and 27.6% of which were from voluntary retirements. To maintain and grow the workforce, a total of 183,957 new hires were required.

After a sharp decline in loss rates in FY 2009, retirements climbed to a five year high of 2.7% for FY 2011, with 7,151 voluntary retirements.

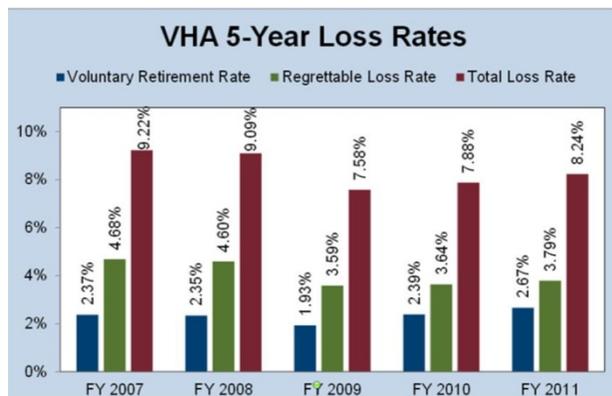


Figure 7

VHA Total Workforce - Historical Data

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Employees Onboard at end of FY	218,263	239,246	253,079	262,713	269,908
<i>Onboard percent change at end of FY</i>	3.40%	9.61%	5.78%	3.81%	2.74%
Average Onboard	211,850.83	228,303.83	247,732.75	257,655.17	267,762.50
FTE at end of FY	210,296.78	230,805.53	244,382.37	253,812.71	261,069.40
Voluntary Retirements	5,029	5,354	4,790	6,166	7,151
Disability retirements	751	718	780	684	683
Special (early out) retirements	276	17	13	29	31
Resignations	9146	9560	7842	8259	9103
Transfers (352G)	772	943	1054	1110	1045
Terminations, Removals, & Separations	3,186	3,741	3,856	3,640	3,565
Deaths	381	430	440	417	488
Total losses	19,541	20,763	18,775	20,305	22,066
Total gains (computed)	26,713	41,746	32,608	29,939	29,261
<i>Voluntary Retirement Rate</i>	2.37%	2.35%	1.93%	2.39%	2.67%
<i>Regrettable Loss Rate</i>	4.68%	4.60%	3.59%	3.64%	3.79%
<i>Total Loss Rate</i>	9.22%	9.09%	7.58%	7.88%	8.24%

Data excludes medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data include permanent & temporary, full-time & part-time employees in a Pay status. Loss data are based on the date the loss was effective. "Total Gains" are

Loss Rate Trends

VHA experienced sharp reductions in resignations and retirements in FY 2009 as a result of the poor economic climate. Since then, however; loss rates have continued to climb (Figure 7). Voluntary retirements were up from a five year low of 1.9% in FY 2009 to a five year high of 2.7% in FY 2011, with a total of 7,151 retirements in a single year. Regrettable loss rates increased from 3.6% in FY 2010 to 3.8% in FY 2011.

computed as current year losses plus growth over the previous year. *Regrettable Loss Rate includes code 317 resignations and 352G transfers; this no longer includes 901 transfers to other VA administrations.

Projected VHA Workforce Analysis

Onboard strength in VHA grew by approximately 2.7% in both FY 2011 and FY 2012. This was approximately 3 percentage points (pp) less than the increase of 5.8% in FY 2009, for a fourth year of decreased growth. Growth of 2.3% is expected in FY 2013, before leveling off to 1% by FY 2018. In total, onboard strength is projected to increase by 10.9% by FY 2018. In addition to the mental health hiring goals, these projections include consideration for the workforce that will be required to meet the continuing needs of Veteran patients, address additional agency initiatives, provide care for an increasing number of female Veterans, and support prevention and population health goals.

VHA Total Workforce – Projected Workforce Data

Data for FY 2012 represent actual numbers as of September 30, 2012.

	FY 2011 (Actual)	FY 2012 (Actual)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Employees Onboard End of FY	269,908	277,152	283,610	287,155	290,600	293,505	296,440	299,405
% change from Previous Year	2.74%	2.68%	2.33%	1.25%	1.20%	1.00%	1.00%	1.00%
Employees Eligible for Regular Retirement			48,253	50,649	52,917	55,365	57,006	58,048
Voluntary Retirements	7,151	7,287	7,967	8,400	8,827	9,274	9,779	10,152
Regrettable Losses	10,148	10,328	10,486	10,673	10,804	10,923	11,032	11,142
All Other Losses	4,767	4,548	4,935	5,023	5,084	5,140	5,192	5,243
Total Losses	22,066	22,163	23,388	24,096	24,715	25,337	26,003	26,537
Total Gains/Gains Needed	29,261	29,407	29,846	27,641	28,160	28,242	28,938	29,502

Losses are aggregated into three categories for summary purposes: voluntary retirements, regrettable losses, and other losses. "Regrettable Losses" include resignations and 352G transfers to other government agencies; they no longer include 901 transfers to other VA Administrations. The majority of "Other Losses" are terminations of appointment, usually due to expiration of a temporary appointment. Other losses also include employees who were removed from their position (fired), deaths, disability retirements, and "early out" retirements (require OPM early-out authority). "Employees Eligible for Retirement" includes only Civil Service Retirement System (CSRS) and Federal Employee Retirement System (FERS) full annuity retirement eligibility. Few FERS Reduced or Deferred Annuity retirement-eligible employees actually retire, therefore, they are not included in computing employees eligible for retirement. "Total Gains/Gains Needed" includes losses plus growth compared to the previous year.

Between FY 2012 and FY 2018, 47% of the full- and part-time workforce will become eligible for regular retirement with 22.9% projected to actually retire. By FY 2018, the retirement rate is expected to increase to 3.4% of the projected onboard. The July 6, 2012, approval of Phased Retirement, which allows federal employees to work part-time while also earning a partial pension, may serve to lessen the impact of pending retirements in the future. For additional information about the phased retirement legislation, see Chapter 8, Recruitment and Retention.

Regrettable losses (or quits) due to resignations and transfers to other government agencies are expected to remain at approximately 3.7% between FY 2013 and FY 2018. All other losses are projected at 1.7% of the average onboard employees. Based on these projections, VHA anticipates the need to hire an average of 28,722 employees annually.

Regrettable Loss Analysis by Year of Employment

Regrettable losses or “quits” include resignations and transfers to other government agencies. This analysis is conducted by tracking new hires forward for five years from their year of employment.

VHA All Occupations – Quits by Year of Employment

Data represent the number of resignations and 352G transfers to other government agencies for each “Gain Year” (i.e., the year the employee was hired) by their year of employment with VHA. Data exclude temporary appointments, medical residents, and trainees with assignment codes T0 through T9, but include temporary assignment for physicians, nurses, and practical nurses. Data Source: SQL Query from PAID and historical databases; not available in ProClarity. No longer includes 901 transfers to other VA administrations.

Gain Year	1st	2nd	3rd	4th	5th
FY 2004	15.17%	7.97%	4.61%	3.48%	1.77%
FY 2005	15.17%	7.41%	4.34%	2.90%	1.67%
FY 2006	14.29%	6.76%	3.30%	2.28%	1.83%
FY 2007	13.05%	5.35%	3.22%	2.55%	
FY 2008	10.41%	5.30%	3.45%		
FY 2009	9.74%	6.24%			
FY 2010	10.18%				

- On average, 31% of new hires in VHA quit in the first five years of employment.
- The rate of quits within the first two years of employment has decreased from 23.1% for FY 2004 new hires to 16% for FY 2009 new hires. However, quits within the first two years still represent more than three quarters of the total losses in the first five years.
- Typically 13% to 15% of new hires quit within their first year of employment; however, that has decreased dramatically in the last three years and was below 10% in FY 2009, but has since increased above 10%.

Successful retention efforts that result in a decrease in resignations will decrease the recruitment and new hire burden.

The Bureau of Labor Statistic’s Job Openings and Labor Turnover Survey (JOLTS) is a monthly survey that has been developed to address the need for data on job openings, hires, and separations. Like VHA’s workforce planning data, it defines the number of employees to include full- and part-time employees; however, unlike VHA data, it also includes intermittent employees. According to the JOLTS database, total losses in the public sector were 41% in calendar year 2011, as compared to 13.1% in the Federal government. Consequently, quits, which are defined by JOLTS as employees who left voluntarily, were also much higher in the public sector, at 20.3% as compared to the Federal government rate of 4%. The JOLTS survey also provides industry-specific loss rate comparisons. Quit rates among the health care and social services industry were 15.5% in calendar year 2011 as compared to 3.9% for VHA.

Another source of comparison data is the OPM Fedscope database. Fedscope combines data submitted by each agency from their personnel system to support statistical analyses of Federal personnel management programs. It contains a number of data elements, to include information on separations. Like the VHA workforce data included in the 2013 Workforce Succession Strategic Plan, it defines quits as voluntary resignations by an employee; however, unlike VHA data, it does not include transfers to other agencies, and does not exclude medical residents, intermittent employees, and trainees. However, the database does provide a method of comparing quits and other losses among government agencies. Using the Fedscope criteria, the VHA rate of 3.7% compares favorably with the

average for all cabinet level agencies (3.8%). Total losses for VHA at 9.8% were slightly lower than the average for all cabinet level agencies (10.8%).

For more information regarding these comparison statistics, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

VHA Exit Survey Results

Response rates for VHA employees to the VA Exit Survey increased from 28.3% in FY 2010 to 31.5% in FY 2011. A summary of all reasons for leaving in FY 2011 indicates that the top three reasons for leaving were:

- 20.9% normal retirement
- 14.7% advancement (unique opportunity elsewhere)
- 11.4% attend school

As illustrated in Figure 8, those choosing not to respond to this question represented the sixth highest category at 6.3%; however this percentage has been declining for the last three years. Exit survey data also indicate that 27.9% of exiting employees experienced a single particular event that caused them to think about leaving VHA. And while 79% of exiting employees would consider working for VA again, only 28% reported that their manager or supervisor tried to get them to change their mind about leaving. This information could be used to improve retention and prevent regrettable losses as well as to educate line managers about the benefits of programs they may not be offering (e.g., alternative work schedules) and the importance of communicating with employees before they decide to leave.

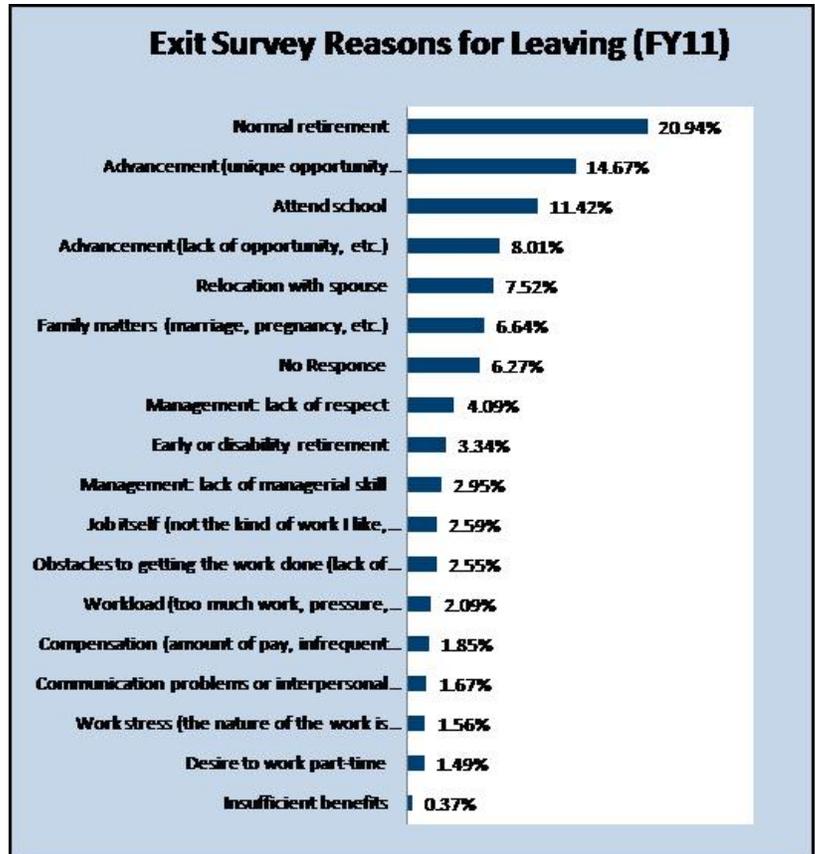


Figure 8

Marketing and making response rate data readily available on the HR Dashboard and providing an email notification through the Healthcare Talent Management (HTM) WebHR system, based on relevant personnel actions (i.e., SF-52) are some of the strategies being pursued to increase participation.

Retirement Outlook & Characteristics of VHA’s Workforce

By the end of FY 2018, 47% of the current (FY 2011) full- and part-time workforce will become eligible for regular retirement with 23% projected to actually retire. In addition, the average age of VHA employees, illustrated in Figure 9, has increased over the last 10 years from 46.9 to 48.2 years. Over the last five years, the percentage of employees age 65 and over increased from 3.1% to 4.3% and those 55 and over increased from 30.1% to 33.3%. The percentage of employees under age 35 has also increased from 12.1% to 14.5% in that same time period.

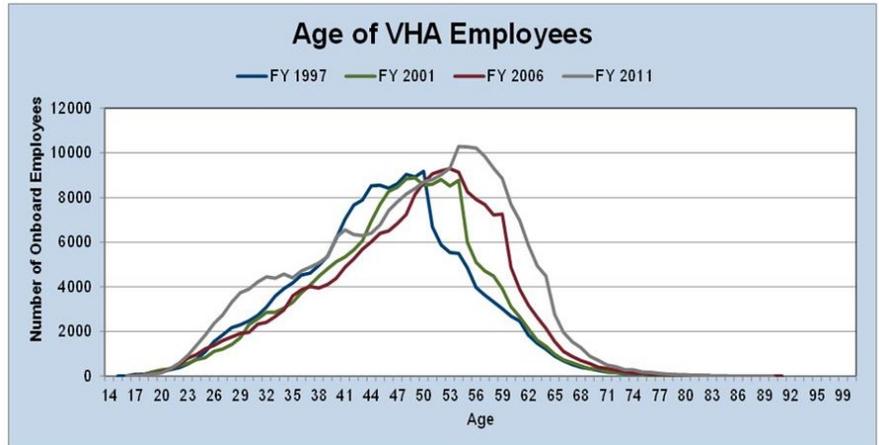


Figure 9

The percentage of employees under age 35 has also increased from 12.1% to 14.5% in that same time period.

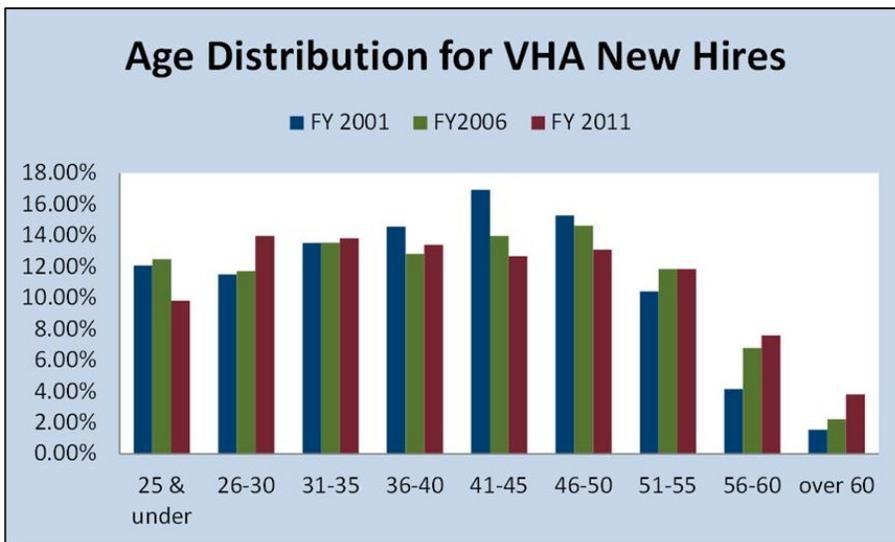


Figure 10

The average age of new hires has increased from 38.5 in FY 2000 to 40.6 in FY 2011. Nevertheless, new hires in VHA are approximately 8 years younger on average than the total onboard (40.6 compared to 48.2 years in FY 2011). The age distribution of VHA new hires is illustrated in Figure 10. The percentage of new hires over age 50 held steady at approximately 23% in FY 2009 through FY 2011, compared to 19% in FY 2005 and only 14% in FY 2000. The percentage of new hires 35 and under, however, increased from 37.1% in FY 2005 to 38.6% in FY 2010, and down to 37.6% in FY 2011.

“Baby Boomers” continue to make up the majority (56.9%) of the VHA workforce, but the percentage is declining by about two percentage points each year. The Traditionalist generation, which as of 2011 is age 67 or older, decreased from 3.7% in FY 2009 to 2.5% in FY 2011. The percentage of “Millennials,” age 31 and under, increased from 7% to 9.5% in the same period.

Generation	Birth Years	Age (as of 2011)	FY 2011 VHA Workforce	Percentage of Workforce	Percentage of Losses
Traditionalists	1922-1944	>=67	6,765	2.51%	25.44%
Baby Boomers	1945-1964	32-46	153,667	56.93%	45.79%
Generation X	1965-1979	47-66	83,754	31.07%	28.54%
Millennial	1980-2000	<=31	25,611	9.49%	0.23%

VHA EEO Analysis for Total Workforce

Workforce distribution data are provided as one element to be reviewed to determine if there are any barriers to full participation. This information is not, under any circumstances, to be used to establish hiring quotas or as the basis for any ultimate hiring decision.

VHA Total Workforce – Race/Gender Summary Data

EEO Category	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Nat'l RCLF	% Difference	Ratio
White Male	24.22%	23.78%	23.76%	23.72%	23.66%	23.66%	0.00%	1.00
White Female	36.59%	36.88%	37.18%	37.18%	37.02%	49.24%	-12.22%	0.75
Black Male	8.95%	8.88%	8.71%	8.70%	8.68%	3.09%	5.59%	2.81
Black Female	14.85%	14.90%	14.70%	14.50%	14.53%	8.30%	6.23%	1.75
Hispanic Male	3.20%	3.13%	3.01%	3.12%	3.09%	3.03%	0.06%	1.02
Hispanic Female	3.59%	3.61%	3.57%	3.73%	3.67%	4.43%	-0.76%	0.83
Asian Male	2.74%	2.71%	2.65%	2.67%	2.69%	2.36%	0.33%	1.14
Asian Female	4.52%	4.57%	4.44%	4.43%	4.48%	3.37%	1.11%	1.33
Native Hawaiian/Pacific Islander Male	0.00%	0.00%	0.07%	0.07%	0.09%	0.03%	0.06%	2.87
Native Hawaiian/Pacific Islander Female	0.00%	0.00%	0.11%	0.11%	0.12%	0.06%	0.06%	2.03
American Indian Male	0.43%	0.47%	0.50%	0.44%	0.44%	0.30%	0.14%	1.45
American Indian Female	0.67%	0.74%	0.79%	0.69%	0.69%	0.65%	0.04%	1.06
Other/Multiple Race Male	0.10%	0.15%	0.20%	0.24%	0.32%	0.33%	-0.01%	0.98
Other/Multiple Race Female	0.14%	0.20%	0.30%	0.40%	0.52%	0.56%	-0.04%	0.93

1) Integration of EEO in the Workforce Strategic Plan does not replace MD 715 requirements (Affirmative Employment Planning)

2) VHA Combined Occupations Relevant Civilian Labor Force (RCLF) is computed from all census occupations used by VHA. Data Source is VSSC RCLF report.

3) All EEO data exclude medical resident, trainees with assignment codes T0 through T9, and intermittent employees. Data include permanent & temporary, full-time & part-time employees in “Pay” status.

4) Native Hawaiian/Pacific Islander became a new category for reporting in FY 2009.

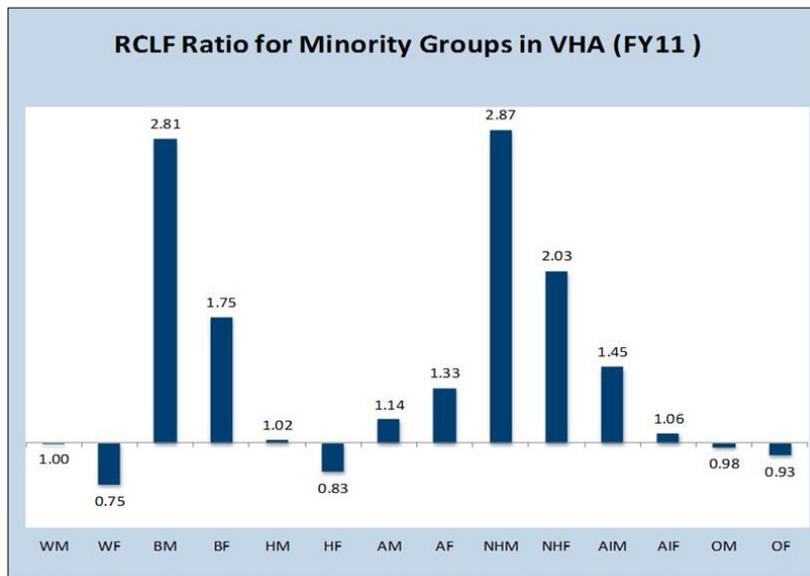


Figure 11 - WM/F-White male/female, BM/F-Black male/female, HM/F-Hispanic male/female, AM/F-Asian male/female, NHM/F-Native Hawaiian/Pacific Islander male/female, AIM/F-American Indian male/female, OM/F-Other/Multiple race

RCLF level. All other minority groups have a participation level that is equal to or greater than the RCLF. White females have an RCLF ratio of 0.75, but this apparent lack of parity is actually a testament to the higher level of diversity VHA has in other race/gender categories, particularly in occupations such as nursing. Indeed, at 37% of the workforce, White females make up the largest single race/gender category in VHA. It is important to keep in mind, however, that when released the 2010 Census will undoubtedly reflect greater diversity of the civilian labor force, emphasizing the need to continue efforts to appeal to a diverse workforce.

VHA Total Workforce – Disability & Veteran Summary Data

EEO Category	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Non-Targeted Disability	7.42%	7.44%	7.78%	8.03%	8.73%
Targeted Disability	1.44%	1.38%	1.38%	1.48%	1.64%
Veteran	30.03%	29.08%	28.68%	28.59%	30.78%

The workforce distribution of individuals with non-targeted disabilities

continued to increase to the current level of 8.7%, while individuals with targeted disabilities increased to 1.6%. Targeted disabilities include deafness, blindness, partial and total paralysis, missing limbs, distorted limbs or spine, mental disabilities, and convulsive disorders. VA has established the goal of 2% for employment of persons with targeted disabilities, and President Obama has ordered Federal agencies to hire 100,000 more employees with disabilities by 2015. Increased effort and attention has resulted in significant increases in the number of employees with disabilities. For more information regarding hiring individuals with disabilities, visit <http://www.diversity.va.gov/programs/pwd.aspx>.

At the end of FY 2011, the percentage of Veterans in the workforce was 30.8%, reflecting an increase from the FY 2007 level of 30%. Veteran hires have steadily increased from 26% of new hires in FY 2007 to 32.7% in FY 2011. Although hiring has increased, so have retirements as more of our older cohort of Veterans becomes eligible to retire. The percentage of Veteran hires in Title 5 positions for FY 2011 is 54% up from 40% in FY 2010. For clinical positions under Title 38, the percentage of Veteran hires for FY 2011 is 11% up from 9% in FY 2010.

Overall, VHA's workforce is 39.3% minority and 61% female. The percentage of minorities has fluctuated slightly from 39.2% in FY 2007 to 39.3% in FY 2011. The Relevant Civilian Labor Force (RCLF) data are based on the 2000 census and reflect the percentage of the workforce in each race/gender category proportionately for the occupations employed in VHA. Hispanic females, at 3.7%, are below the RCLF, as illustrated in Figure 11, with a ratio of 0.8%, indicating they are at 83% of their full RCLF ratio. At 0.3% and 0.5%, the Other/Multiple Race categories are also below the RCLF, but have increased each year to approximately 98% and 93% of their

In recent years, VA’s goal for Veteran employment has been 33%; however, the Veteran Hiring Initiatives call for incremental increases each year to reach a new goal of 40% Veteran employment.

New Hire Analysis

As illustrated in Figure 12, FY 2011 hires were slightly more racially diverse (38.3% total minorities) than FY 2010 (36.8%).

The percentage of Veteran new hires went up steadily from 21.4% in FY 2005 to 32.1% in FY 2011.

The percentage of new hires with targeted (2.1%) and non-targeted (11.2%) disabilities has fluctuated but was the highest

in FY 2011 out of the last five years.

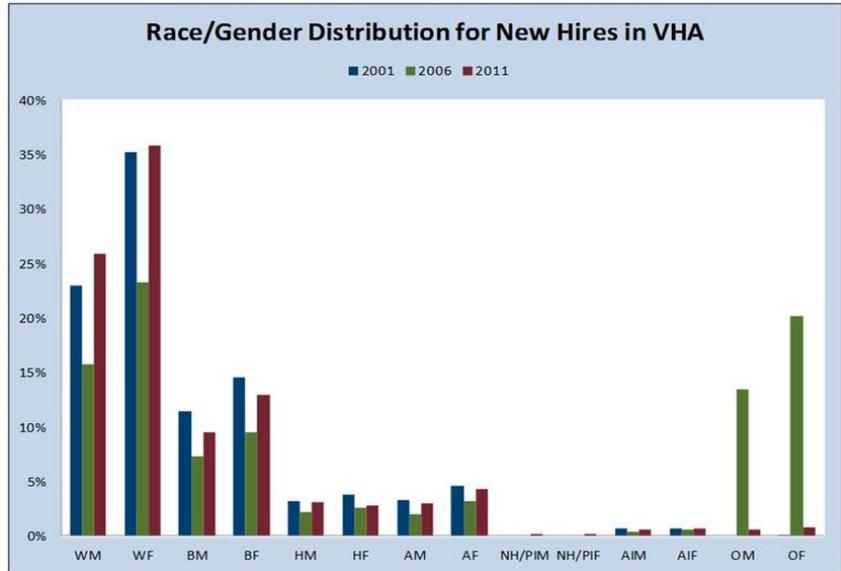


Figure 12

VHA Entrance Survey Results

According to VA Directive 5004, the VA Entrance Survey provides new employees the opportunity to communicate their reasons for choosing employment with VA. These survey results can provide valuable insight into why new hires chose to work for VA, and may help with improving recruitment and marketing efforts.

Response rates for VHA employees to the Entrance Survey increased from 40.1% in FY 2010 to 44.3% in FY 2011. A summary of all reasons for choosing to work at VA in FY 2011, illustrated in Figure 13, indicates that the top three reasons were:

- 21% career opportunity/advancement/professional growth/development
- 17.2% benefits (retirement/health and life insurance, etc.)
- 13% job stability/security

Those choosing not to respond to this question represented the lowest

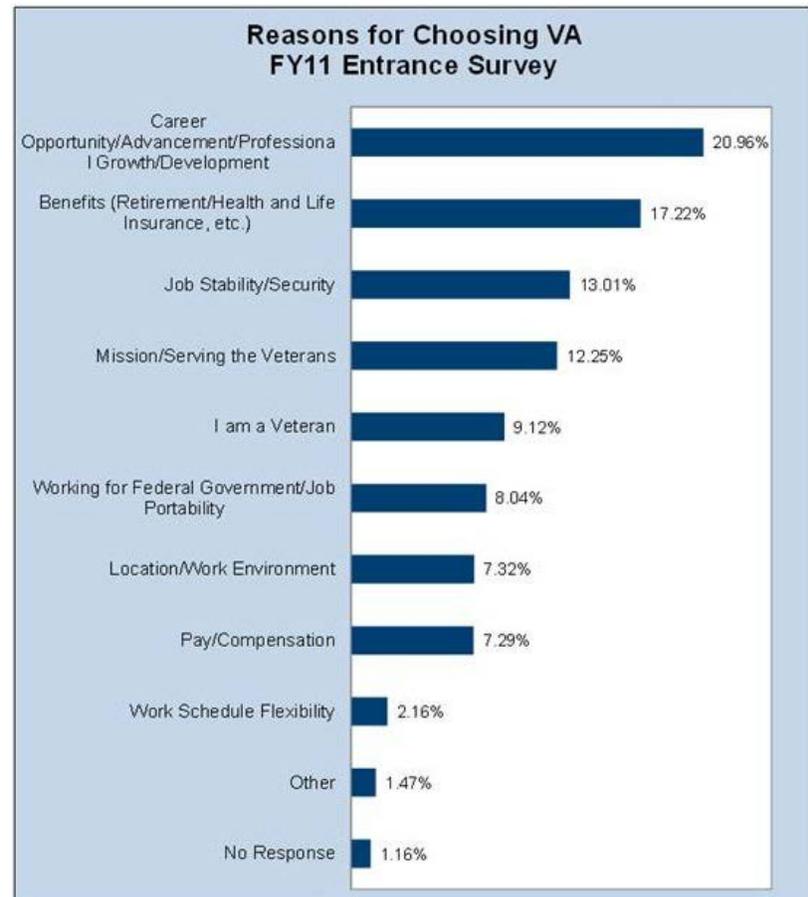


Figure 13

category at 1.2%. Entrance survey data also indicate that 24.8 % of entering employees heard about the job through a VA jobs website, such as VA Careers. The OPM/USA Jobs website was the next largest source of information at 21.9%, followed by VA employees at 17.2%.

Supervisors

The number of supervisors in VHA has increased by 23% over the last five years. The majority of this growth (18%) occurred between FY 2008 to FY 2010. Supervisors currently make up 9% of the total workforce, and the supervisor to worker ratio is about 1:10.

VHA Supervisors – Historical Workforce Data

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Supervisors Onboard at End of FY	19,683	20,936	22,240	23,429	24,266
<i>% Change from Previous Year Onboard</i>	<i>0.97%</i>	<i>6.37%</i>	<i>6.23%</i>	<i>5.35%</i>	<i>3.57%</i>
Average Onboard	19,381.17	20,306.50	21,700.83	22,835.50	23,946.58
FTE at End of FY	19,478.46	20,734.64	22,038.66	23,230.54	24,070.34
Voluntary Retirements (CSRS & FERS)	783	827	710	851	1,052
Disability Retirements	43	52	49	30	40
Special (Early Out) Retirements	47	3	3	2	0
Resignations	300	267	231	297	353
Transfers to Other Govt. Agencies (352G)	52	70	80	97	84
Terminations, Removals, & Separations	43	60	63	65	64
Deaths	36	35	40	30	39
Total Losses	1,304	1,314	1,176	1,372	1,633
Total Gains (Computed)	1,494	2,567	2,480	2,561	2,470
<i>Voluntary Retirement Rate</i>	<i>4.04%</i>	<i>4.07%</i>	<i>3.27%</i>	<i>3.73%</i>	<i>4.39%</i>
<i>Regrettable Loss Rate*</i>	<i>1.82%</i>	<i>1.66%</i>	<i>1.43%</i>	<i>1.73%</i>	<i>1.83%</i>
Total Loss Rate	6.73%	6.47%	5.42%	6.01%	6.82%

*Data exclude medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data includes permanent and temporary, full-time and part-time employees in a Pay status. Loss data are based on the date the loss was effective. "Total Gains" are computed as current year losses plus growth over the previous year. *Regrettable Loss Rate includes 317 resignations and 352G transfers; it no longer includes 901 transfers to other VA administrations.*

The supervisor growth rate decreased from 3.6% in FY 2011 to 2.3% in FY 2012. The number of supervisors is expected to continue to grow for a total increase of 7.8% over the next seven years with growth of 2.3% in FY 2013, before leveling off to approximately 1% by FY 2018. In order to replace losses and increase the onboard number of supervisors as projected, VHA will need to gain approximately 12,321 supervisors by the end of FY 2018, for an average of 2,053 per year. By FY 2018, approximately 55% of current supervisors will be eligible for regular retirement. The primary source of losses for supervisors is retirement, with an FY 2012 retirement rate of 4.4%, reflecting the expected rebound in retirements after the sharp decline in FY 2009.

VHA Supervisors – Projected Workforce Data

	FY 2011 (Actual)	FY 2012 (Actual)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Supervisors Onboard End of FY	24,266	24,815	25,390	25,695	25,980	26,210	26,515	26,750
% Change from Previous Year	3.57%	2.26%	2.32%	1.20%	1.11%	0.89%	1.16%	0.89%
Supervisors Eligible for Regular Retirement			6,494	6,548	6,600	6,619	6,683	6,604
Voluntary Retirements	1,052	1,097	1,091	1,106	1,130	1,141	1,177	1,186
Regrettable Losses	438	465	465	473	478	483	488	493
Other Losses	143	144	146	149	150	152	153	155
Total Losses	1,633	1,706	1,702	1,727	1,758	1,776	1,818	1,834
Total Gains/Gains Needed	2,470	2,255	2,280	2,032	2,043	2,011	2,123	2,069

Exit Survey Results – Supervisors and Managers Top Reasons for Leaving:

- 38.3% normal retirement
- 14.5% advancement (unique opportunity elsewhere)
- 5.8% management (lack of respect)
- 4.7% obstacles to getting the work done

Among the 447 exit survey respondents who identified themselves as supervisors and managers in FY 2011, 27.9% indicated a negative reason for leaving (i.e., lack of advancement opportunities, communication problems, compensation, job itself, lack of respect from management, lack of managerial skill, obstacles to getting the work done, workload, and work stress).

VHA EEO Analysis for Supervisors

Workforce distribution data are provided as one element to be reviewed to determine if there are any barriers to full participation. This information is not, under any circumstances, to be used to establish hiring quotas or as the basis for any ultimate hiring decision.

VHA Supervisors – EEO Summary Data

Race/Gender	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	VHA Total Workforce	% Difference	Ratio
White Male	36.39%	35.55%	34.95%	34.44%	33.91%	23.66%	10.25%	1.43
White Female	33.85%	34.54%	34.82%	35.12%	35.19%	37.02%	-1.83%	0.95
Black Male	8.47%	8.42%	8.30%	8.17%	8.11%	8.68%	-0.57%	0.93
Black Female	9.66%	9.64%	9.80%	9.84%	10.07%	14.53%	-4.46%	0.69
Hispanic Male	3.08%	3.07%	3.01%	3.12%	3.11%	3.09%	0.02%	1.01
Hispanic Female	2.56%	2.48%	2.60%	2.75%	2.65%	3.67%	-1.02%	0.72
Asian Male	2.79%	2.78%	2.68%	2.69%	2.70%	2.69%	0.01%	1.00
Asian Female	2.29%	2.33%	2.32%	2.42%	2.52%	4.48%	-1.95%	0.56
Native Hawaiian/Pacific Islander Male	0.00%	0.00%	0.07%	0.07%	0.06%	0.09%	-0.02%	0.72
Native Hawaiian/Pacific Islander Female	0.00%	0.00%	0.06%	0.06%	0.05%	0.12%	-0.07%	0.44
American Indian Male	0.37%	0.44%	0.44%	0.38%	0.40%	0.44%	-0.03%	0.93
American Indian Female	0.36%	0.45%	0.50%	0.47%	0.46%	0.69%	-0.23%	0.67
Other/Multiple Male	0.09%	0.16%	0.25%	0.23%	0.35%	0.32%	0.02%	1.08
Other/Multiple Female	0.09%	0.13%	0.20%	0.24%	0.41%	0.52%	-0.11%	0.79

Comparisons for EEO supervisor data are based on the VHA workforce overall rather than RCLF.

Examination of the supervisor to workforce ratio reveals a gender gap, such that non-White females are represented at much lower rates in supervisory positions compared with White supervisors and non-White male supervisors. As illustrated in Figure 14, the bars below the 1.00 line represent categories that are below parity with the workforce overall. The bars that are most below parity tend to be for minority female categories. White males have a higher than expected rate in supervisory positions by 1.4 times their rate in the workforce overall. White females and non-White males are also well-represented at 95% to over 100% of their rate in the workforce. Asian and Native Hawaiian/Pacific Islander female supervisors, however, are at approximately half their rate in the workforce (56% and 44%, respectively), while American Indian, Black, and Hispanic female supervisors range from 69% to 72% of their rate in the workforce. Participation for

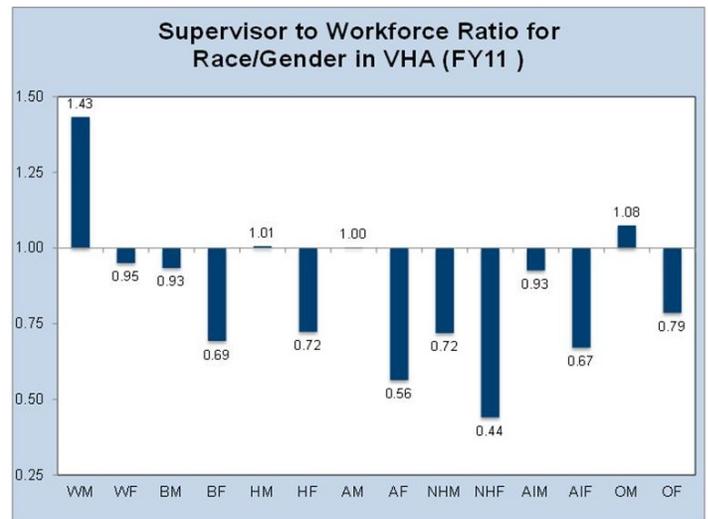


Figure 14 - WM/F-White male/female, BM/F-Black male/female, HM/F-Hispanic male/female, AM/F-Asian male/female, NHM/F-Native Hawaiian/Pacific Islander male/female, AIM/F-American Indian male/female, OM/F-Other/Multiple race male/female

Chapter 4: VHA Senior Executive Analysis

Senior Executive Positions in VHA

VHA uses both Senior Executive Service (SES) and Title 38 SES Equivalent executive positions to assist the Under Secretary for Health in carrying out VHA’s mission to honor America’s Veterans by providing exceptional health care that improves their health and well-being. These positions are centralized to the Secretary who has authority to approve executive appointments, performance ratings, and performance awards.

Senior Executive Service Positions

The SES was established by the 1978 Civil Service Reform Act, with the vision of a senior management corps whose members would have shared values, a broad perspective of government, solid executive skills, and mobility across agencies. The SES was intended to be a corps of executives selected for their leadership qualifications, not technical expertise. Almost 35 years later, SES members are the backbone of Federal executive leadership and play a crucial role in addressing the challenges facing our Nation; making the SES corps a national asset. These leaders possess keen executive skills and share the responsibility of leading transformation in government along with a commitment to public service. As leaders across the Federal government, members of the SES are at the forefront of transforming government operations. Their leadership and expertise are critical to the success of any organization.

There is no statutory limitation on the total number of SES positions. However, the law (5 U.S.C. 3133) requires OPM to allocate “spaces” to agency heads on a biennial cycle. Agencies can establish positions within their allocations without further OPM approval. Flexibility has been built into the process to allow for limited adjustments outside the biennial cycle. However, agencies are expected to manage their executive resource needs within the levels set during the biennial allocation process to the extent possible.

The law requires that the executive qualifications of each new career appointee to the Senior Executive Service (SES) be certified by an independent Qualifications Review Board based on criteria established by the Office of Personnel Management (OPM). The Executive Core Qualifications (ECQs) describe the leadership skills needed to succeed in the SES; they also reinforce the concept of an “SES corporate culture.” This concept holds that the Government needs executives who can provide strategic leadership and whose commitment to public policy and administration transcends their commitment to a specific agency mission or an individual profession.

Executives with a “corporate” view of Government share values that are grounded in the fundamental Government ideals of the Constitution: they embrace the dynamics of American Democracy, an approach to governance that provides a continuing vehicle for change within the Federal Government.

OPM has identified five executive core qualifications. The ECQs were designed to assess executive experience and potential--not technical expertise. They measure whether an individual has the broad executive skills needed to succeed in a variety of SES positions--not whether they are the most superior candidate for a particular position. (The latter determination is made by the employing agency.) Successful performance in the SES requires competence in each ECQ. The ECQs are interdependent; successful executives bring all five to bear when providing service to the Nation.

The five ECQs are Leading Change, Leading People, Results Driven, Business Acumen, and Building Coalitions. Each ECQ is defined by a set of important competencies that each senior executive must possess to be successful.

Within VHA, the Corporate Senior Executive Management Office (CSEMO) is responsible for the daily operation of the Senior Executive Service. Senior executive positions in VHA are unique in that they need to possess the technical skills necessary to manage a health care organization in addition to fundamental leadership competencies.

Title 38 SES Equivalent Positions

VHA delegated authority under 5 U.S.C Title 38 to hire qualified and skilled candidates with a strong background in clinical and health care delivery services. These senior executives are in Title 38 SES Equivalent (EQV) positions. Appointments to SES EQV positions do not count against VA's SES allocations. Appointments under Title 38, 7306 are in the excepted service and are initially appointed for a period of up to four years with reappointments permissible. There are two types of SES EQV positions: 1) Title 38 Physicians and Dentists and 2) Title 38 Hybrids (non-physicians/dentists). Candidates selected for Medical Center Director or Network Director positions may be appointed under either an SES or SES EQV appointment. SES EQV candidates are not required to submit ECQs or obtain certification through OPM's QRB process.

The Succession Planning Crisis

While the overall analysis of executive positions in Chapter 3, Total Workforce Analysis, demonstrates the challenges in VHA with regard to succession planning for all leadership positions, none is more challenging than SES positions. According to OPM, the retirement pattern in recent years projects that more than half of the SES could leave the government within the next five years. Analysis of VHA's SES positions predicts that approximately 84% of senior leaders will be eligible for retirement by FY 2018, and 56% of this population will retire, taking with them significant knowledge and expertise. In addition, the FY 2011 vacancy rate for VHA SES positions was 15.5%. VHA needs to hire approximately 30 SES per year to maintain staffing levels as projected through FY 2018.

In VHA, the critical expertise needed at the SES level includes the specialized knowledge and skills to run a hospital or a network of hospitals and a system of health care providers. The FY 2011 vacancy rate for Medical Center Directors was 21%, much higher than that of Network Directors (4.8%) and Chief Officers (2.5%). Furthermore, because the higher complexity levels of some VHA facilities necessitate skills specific to managing a VHA facility, vacancies are often filled from within the existing SES talent. The seven-year projections of retirement eligibility for Medical Center Directors increased from 82% as reported in the 2012 Workforce Succession Strategic Plan to 86% through FY 2018. This requires VHA to build a deep and diverse pipeline of talent.

Not all SES and SES EQV members eligible to retire will retire, however, a sizable percentage likely will retire. Assuming the departing members are replaced and the current staffing level of 180 is maintained through the end of FY 2018, an average of 8% will likely retire each year between fiscal years 2012 and 2018. Actual regular retirement rates for SES members and SES EQV were higher than retirement rates for the overall employee workforce during fiscal years 2010 through 2011. In addition, 58.2% of the pipeline to the SES Corps, just below SES level in health system administration, will be eligible to retire by FY 2018. These trends highlight the importance of SES succession planning because

the SES retirements will result in a loss in leadership continuity, institutional knowledge, and expertise among the SES corps with the degree of loss varying among administrations. VHA's formal SES succession planning efforts place appropriate emphasis and attention to ensure a well prepared, qualified, and diverse group of people are available to fill SES positions.

The SES retirement trends projected for the first few years of this decade illustrate that the SES is an aging workforce. Because individuals normally do not enter the SES until well into their careers, SES retirement eligibility generally is much higher than for the overall workforce. Such emphasis and attention on executive succession planning is a good management practice that addresses the continuity in leadership.

For a more detailed examination of SES projections, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession/va.gov/2013supplemental>.

Recruitment, Selection, and Development

The Under Secretary for Health has indicated that senior executive positions are one of the most significant resource issues VHA faces. Additionally, VHA executives will establish and implement a succession-planning framework to maintain skilled and ample bench strength. This framework will incorporate strategies to ensure the most critical positions are filled immediately via VHA's leadership pipeline for continuity of health care operations.

VHA is pursuing multiple approaches to recruitment that includes active recruitment of talent pools within and outside VHA and the Federal government.

These activities include:

- Developing a repository for candidates within and outside government linking to existing efforts to increase diversity and reach out to Veterans utilizing VHA's Executive Recruiter;
- Working in partnership with the CSEMO to make the process easier for candidates to apply using the resume-based hiring model;
- Creating a diverse pool of GS 14/15 candidates with strong leadership and management skills as described in Chapter 7, *Developing Leaders At All Levels*; and
- Utilizing executive search firms to obtain a diverse group of qualified applicants with executive leadership and health care experience.

SES Recruitment and Incentives

- **Resume Only Process** – is a streamlined, applicant-friendly process, introduced in 2010, that reduces the burden of applying for an SES position by requiring only a resume. This process has been shown to produce a broader, more diverse applicant pool, simplify the initial assessment, reserve more detailed requirements for top candidates, and target candidates based on experience and specific job competencies.
- **CSEMO Connect** – is a collaborative website exclusively for the Senior Executive designed to promote information-sharing, implement executive management initiatives, enhance communication activities between VA Senior Leadership and Senior Executives, and assist as a recruitment and informational tool for SES members. It includes an updated roster of Senior Executive biographies within VA, information about the latest CSEMO services and projects, and a Senior Executive Gateway to increase knowledge sharing and collaboration. The recruitment portal

houses information on vacancies, and provides quick access to the documents necessary to speed up the hiring process.

- **VHA’s Web-based Executive Recruitment Tool** – is used to automate steps in the executive recruitment process, and provides a position history for current senior executives as well as an interactive map to track leadership positions, vacancies, geographic preferences, and position status across VHA. Current executives can access the recruitment tool to provide their top three geographic preferences to aid in succession planning. Mobility is an important element in the replacement of outgoing executives; it enables the Secretary to reassign senior executives to best accomplish the agency mission.
- **Recruitment and Relocation Incentives** – are designed to attract the best qualified candidate for a position. A recruitment incentive may be offered to a newly appointed career executive; a relocation incentive may be offered to a current executive who must relocate to accept a position in a different geographic area. Both incentives can be used when the position is difficult to fill.
- **Retention Incentives** – used to retain employees with high or unique qualifications in positions that are likely difficult to fill or whose services are essential to a special VA need and are likely to leave Federal service without an incentive. A retention incentive may be paid only when the executive’s rating of record is at least “Fully Successful” or higher.

Support Programs for Senior Executive Development

Support programs maximize executives’ effectiveness and potential while growing skill sets to ready the corps for future challenges and agency needs. These programs emphasize executive development.

VA and VHA have established a number of programs and initiatives designed to assist and support senior executive development and retention. This includes support throughout their career.

The programs include:

- **VA Executive Onboarding** – Designed to accommodate and assimilate new leaders into VA’s organization. The concept is to make new employees feel welcome and comfortable in their new environment. For newly placed executives, the onboarding program will establish networks and relationships, help them gain knowledge and insight of VA structure, and will provide awareness of the overall environment.
- **VA Senior Executive Strategic Leadership Course at UNC/Chapel Hill** – This VA program is a partnership with UNC’s Kenan-Flagler Business School at Chapel Hill to help all VA executives excel at the strategic level. Executives learn key content and insight, and participate in simulations and group activities such as Executive Decision Making, Managing High Performance, Strategy and Execution, Negotiation and Partnerships, Financial Resource Management and Driving Strategic Change. The overall goal of this course is to further develop an executive’s enterprise and business skills in an increasingly complex, volatile, and dynamic world.
- **VA Senior Executive Service Candidate Development Program (SESCDP)** – Designed to train, develop, and certify employees who exhibit outstanding executive potential for SES positions within VA. This program is geared toward high performing GS-15 and Title 38 equivalent employees. Administrations and Program Offices are responsible for cultivating talent and encouraging senior personnel to apply. The VA SESC DP is certified by OPM. The primary emphasis of the program is on mastery of the five OPM ECQs.

- **VA Executive Coaching Program** – This program provides executives with the skills needed to succeed, excel, and render excellent performance. The Executive Coaching Program is a personalized leadership development experience where coach, leader, and key stakeholders collaborate over time to accelerate the leader’s development, achieving results that positively impact the executive, team, and organization. From the beginning, the coaching process is tailored to the individual executive. Working collaboratively with the coach, the executive will: complete a 360 degree assessment and other measures to get a snapshot of the executive’s leadership style; target key areas and behaviors that will positively impact the Department; enhance the Executive Development Plan, and make progress toward meeting individual goals. All of this is in the context of being shadowed by the coach to receive direct, immediate, situational and developmental feedback.
- **VHA Healthcare Senior Executive Coaching Network Program** – This knowledge transfer program is designed to help senior executives transition into positions of greater complexity and responsibility within a health care environment. The Coaching Network is comprised of current and recently retired senior executives who provide coaching and guidance to executives moving into similar roles. The SES Coaching Network allows newly appointed VHA SES the opportunity to meet regularly with groups of their peers and assigned coach to:
 - discuss shared or unique experiences, challenges, and successes;
 - identify skills or competencies in their leadership portfolio that need further development;
 - enhance their knowledge of current and rising national challenges within the VHA health care system;
 - gain additional knowledge transfer from monthly coaching calls; and
 - participate in interactive Webinars that focus on VHA health care oriented topics and case studies facilitated by VHA or external subject matter experts.
- **VHA Senior Executive Orientation** – A quarterly two-day seminar on the topics of Leading in the New Environment, Building Effective Relationships with Stakeholders, Leading for Results through Crucial Conversations, and Executive Decision-Making. This orientation is designed for newly appointed SES and SES Equivalents. The facilitators for these seminars are experienced VHA Senior Executives.
- **VHA Executive Team Assessment** – Designed to assess executive teams’ effectiveness to illustrate the importance of relationship and function elements in building effective, engaged teams. VHA National Center for Organization Development (NCOD) administers the assessment and offers assistance in its interpretation and action planning for improvement. In addition, NCOD trains staff in the field as transition facilitators for Leadership Transition Briefings to assist incoming leaders in gathering essential information quickly while gaining an overview of the organization.
- **Education and Development Activities** – A variety of VA, VHA and Federal-wide education and development activities are made available to SES and SES equivalents to assure they continue to develop skills and competencies to assume the highest functioning leadership with VHA.



Chapter 5: VHA Program Office Analysis

Program Office Overview & Strategic Direction

VHA Program Offices provide mission critical infrastructure to support initiatives and operations. Primarily working at the national level, they foster standardization, develop national policy, provide oversight, as well as functional guidance and direction and provide health professions training programs for VHA. Program offices have a significant role in interfacing with external stakeholders such as the media, U.S. Government Accountability Office, Veterans Service Organizations, Congress, and the White House.

The strategic direction for VHA Program Offices is aligned to support the VHA Strategic Goals defined by the National Leadership Council, chaired by the Under Secretary for Health.

- Provide Veterans personalized, proactive, patient-driven health care
- Achieve measurable improvements in health outcomes
- Align resources to deliver sustained value to Veterans

These three goals provide a foundation and a framework for Program Offices to build their strategic plans. VHA Program Offices have responded to this vision by aggressively realigning services and product lines to support health care transformation initiatives, aligning additional staffing needs to further improve quality of care, access to care, and Veteran outreach with specific focus on mental health, rural health, and services to women Veterans.

To support the Secretary’s vision of transforming the Department of Veterans Affairs into a high-performing 21st century organization—one that adapts to new realities, leverages new technologies, and serves a changing population of Veterans with renewed commitment—VHA has taken the lead in a collaborative and supporting role for major initiatives and sub initiatives:

- Establishment of the Office of the ADUSH for Quality, Safety, and Value, whose mission is to enhance the quality, safety, reliability and value of VHA’s clinical and business systems by enabling enterprise wide approaches to compliance, risk awareness, and continuous improvement;
- Continued staffing and expansion of health care access for Veterans, including women and rural populations, through the Chief Business Office’s Veterans’ Travel Service and Kiosk and Veterans’ Point of Service Program, and continued deployment of Consolidated Patient Account Centers (CPACs);
- Formulation of the Office of the ADUSH for Administrative Operations to support VHA and monitor and ensure the integrity, quality, and value of administrative services to include Emergency Preparedness and Operations; Contracting Operations and Logistics; Network Liaison Services; Health Care Energy and Engineering Oversight; Medical Center and State Veterans Home Capital Investments; Veterans Canteen Service; Environmental Programs Oversight; Occupational Safety and Compliance; Biomedical Engineering and Health Care Technology Oversight; coordination of Hospital Activations; improving Telephone Service and Performance through the “Fix the Phones” sub initiatives.

- Focus on meeting the industry standards outlined in the eight recommendations from the 2010 Institute of Medicine’s (IOM) Future of Nursing report by the Office of Nursing Service.
- Increased emphasis on continual performance improvement and standardization of services, metrics, and quality standards by numerous offices, such as Office of Finance, Office of the ADUSH for Informatics & Analytics, Workforce Services, etc.

VHA Program Offices have aligned their workforce succession planning activities in order to recruit, develop, and retain a competent, committed, and diverse workforce to meet the growing and changing needs of today’s Veterans and the health care delivery systems of the future. Program Offices are frequently the first line of response for changing priorities and courses of action, which adds a unique complexity to their mission. Communication of strategic succession plans to all employees within the organization, including both Program Office staff and field-based discipline-specific staff, will enable successful matching of strengths, capabilities, and resources to the strategic initiatives of VHA.

Realignment

A realignment of the VHA Central Office (VHACO) national Program Offices began in FY 2010 and continued through FY 2011. The realignment organized offices into functions that fall under the Under Secretary for Health, the Principal Deputy Under Secretary for Health, the Chief of Staff, the Deputy Under Secretary for Health for Operations and Management and the Deputy Under Secretary for Health for Policy and Services. Offices vary in structure, size and geography, with some staffed by no more than a dozen individuals while others range from 100 to slightly over 5,000 employees. While many offices have at least some employees located in Washington, DC, the majority are geographically dispersed outside of the VHACO/DC area.

The new alignment for Program Offices separated and synchronized policy, operations, and oversight. Clinical operations moved from policy organizations in Patient Care Services to the Deputy Under Secretary for Operations and Management. Policy offices are grouped together under a new Deputy Under Secretary for Policy and Services. Quality and oversight functions are aligned under the direct control of the Principal Deputy Under Secretary. The new alignment is organized to provide effective VHACO support for the VISNs, create a functional leadership design that fosters collaboration over ownership, integrate strategic and capital planning, achieve efficiencies by combining similar functions, and leverage data and analysis to ensure the highest quality in health care.

Smaller adjustments and refinements of the initial realignment phase begun in FY 2011 will occur in FY 2012:

- Creation of the Office of Health Equity, which will champion efforts to address health disparities through education, training, communications, and clinical interventions;
- Realignment of Healthcare Transformation from the Deputy Under Secretary for Health Operations and Management to the Principal Deputy Under Secretary for Health to more closely align the work of the major initiatives with the executive sponsor;
- Realignment of the Chief Business Office under the Assistant Deputy Under Secretary for Health for Administrative Operations;

- Internal reorganization of workstreams under the Office of the ADUSH for Quality, Safety and Value in the following areas: Compliance and Business Integrity, Quality Standards and Programs, Safety and Risk Awareness, High Reliability Systems and Consultation, and Healthcare Value;

Mental Health

As part of the realignment, the Office of Mental Health Operations (OMHO) was created and aligned under the office of the Deputy Under Secretary for Health for Operations and Management. A number of staff from the Mental Health Services (MHS) transferred to OMHO to establish the new office. In addition, several VHACO positions were created and filled by subject matter experts (SME) to develop and lead the transformation of VHA mental health programs in response to one of the VA Transformation Initiatives: Improving Veterans Mental Health. The revised and expanded scope and complexity of VHA mental health will require the continued SME leadership from these two organizations.

Historical Workforce Analysis for VHA Program Offices

Significant workforce changes occurred in VHA Program Offices from the consolidation of services and reorganization of existing programs. An increase in onboard personnel was necessary to meet emerging mission requirements and workload directly related to the VA Transformation Initiatives: Expand Health Care Access for Veterans, Including Women & Rural Populations (Veteran Travel Service); New Models of Care (Handbook & Kiosk/Veterans' Point of Service program) as well as one of VHA's six operating specific initiatives, "Deploy Best Business Practices in Financial and Business Processes." All of these initiatives support the health care transformation of VHA, with an emphasis on patient-centered care and standardization of services.

The most significant changes in structure and services came from the Chief Business Office (CBO).

- Consolidated Patient Account Centers (CPACs) completed construction and facility activation at the North Central, North East and West CPACs.
- Four new organizational units were established in Member Services:
 - Veterans Transportation Service (VTS)
 - Veterans Point of Service (VPS)
 - Business Engineering System Team (BEST)
 - CBO Systems Management (CSM).
- The Health Eligibility Center (HEC) and the Health Resource Center (HRC) increased their staff to meet the needs of the number of military personnel transitioning from active duty military to Veteran status.
- The Office of Health Information grew to support VA/DoD initiatives, clinical informatics, congressional mandates, and the national electronic health record.

As a result of these newly realigned offices and mission requirements, the VHA Program Office onboard workforce grew by 23.4% in FY 2011. Overall, the total loss rate for VHA Program Offices decreased from 8.8% in FY 2010 to 8.2% in FY 2011. Regrettable losses decreased from 4.7% to 4.3% in the same period. Retirement rates have remained at approximately 2% since FY 2008.

VHA Program Office – Historical Data

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Program Office Employees Onboard	5,206	6,049	7,469	9,124	11,258
% Change from Previous Year Onboard ¹	-12.97%	16.19%	23.47%	22.16%	23.39%
Average Onboard	5,381.67	5,599.33	6,730.83	8,258.50	10,237.92
FTE at End of FY	5,119.61	5,946.99	7,346.96	8,997.93	11,139.84
Voluntary Retirements (CSRS & FERS)	140	112	138	171	202
Disability Retirements	17	18	13	14	21
Special (Early Out) Retirements	12	0	1	1	0
Resignations	195	213	230	302	341
Transfers to Other Govt. Agencies (352G)	51	49	58	86	99
Terminations, Removals, & Separations	91	104	117	146	161
Deaths	11	15	11	8	18
Total Losses	517	511	568	728	842
Total Gains (Computed)	-259	1,354	1,988	2,383	2,976
Voluntary Retirement Rate	2.60%	2.00%	2.05%	2.07%	1.97%
Regrettable Loss Rate*	4.57%	4.68%	4.28%	4.70%	4.30%
Total Loss Rate	9.61%	9.13%	8.44%	8.82%	8.22%

Data exclude medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data includes permanent & temporary, full-time & part-time employees in a Pay status. Loss data are based on the date the loss was effective. "Total Gains" are computed as current year losses plus growth over the previous year. ¹**Regrettable Loss Rate includes 317 resignations and 352G transfers; it no longer includes 901 transfers to other VA administrations.**

VHA Program Office Diversity Analysis

The VHA Program Office workforce is less diverse than the VHA workforce overall, with 32.1% in minority race/gender groups compared to 39.3% for VHA overall. As illustrated in Figure 15, while

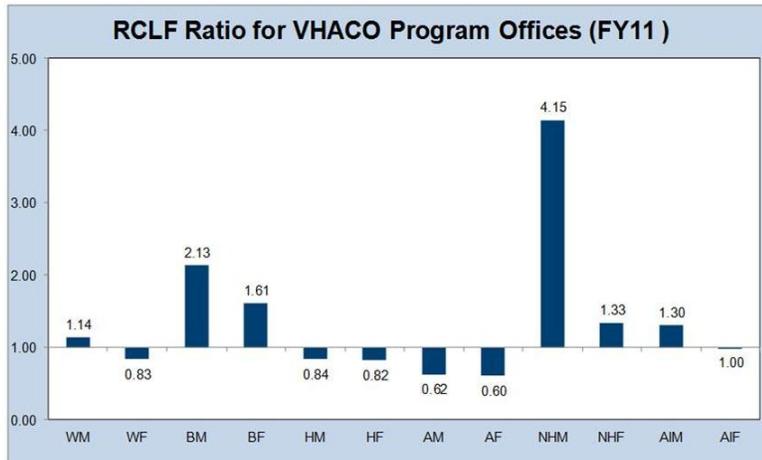


Figure 15

Hispanic males were equal to the RCLF in FY 2010, their representation is now below the RCLF at 84% in FY 2011. Hispanic female representation increased from 67% of the RCLF in FY 2010 to 82% in FY 2011. Asian male and female participation was 62% and 60% of the RCLF, respectively.

Because the RCLF demonstrates extremely small numbers in the population comparisons, Native Hawaiian/Pacific Islander, American Indian, and Other/multiple race/gender groups are all higher than the RCLF.

VHA Program Offices exceed VHA overall levels for targeted and non-targeted disabilities. There was a 0.2 percentage point increase in FY 2011 in employees with targeted disabilities and a disability rate of 12.9%, compared to the VHA rate of 10.4%.

EEO Category	VHACO FY 2011	VHA Overall FY 2011
Non-Targeted Disability	11.13%	8.73%
Targeted Disability	1.75%	1.64%
Veteran	36.16%	30.78%

In addition, VHA Program Offices continued to exceed the Department’s interim goal of 35% Veteran employee

representation rate in FY 2011. Veteran representation may be higher in part because most VHACO positions (81%) are in non-clinical occupations, which tend to be filled by Veterans—70% of Veterans employed in VHA hold non-clinical Title 5 positions.

Age of VHACO Employees

The average age of VHA Program Office employees, illustrated in Figure 16, has steadily decreased every year since the FY 2006 high of 47.9 to the FY 2011 average of 46.5. Additionally, VHACO employees are somewhat younger on average than the VHA workforce overall (48.2 years.)

In FY 2011, the percentage of the workforce under 30 decreased to 8.3% from the FY 2010 rate of 9.8%. The percentage in the 60+ age group decreased from 14.9% in FY 2010 to 12.4% in FY 2011 (Figure 17).

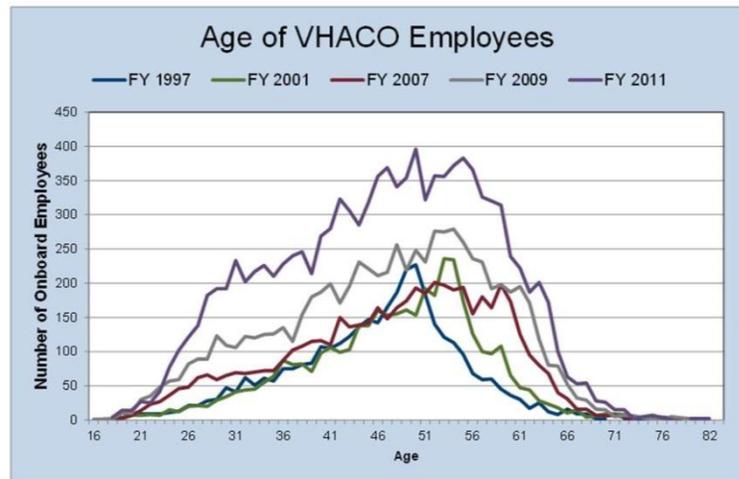


Figure 16

Recruitment and Retention Challenges

VHACO Program Offices face unique challenges such as delays in the recruitment process and high turnover/internal transfer among Central Office Human Resources (COHR) staff, difficulty recruiting to the Washington DC area, “recycling” of applicant pools, and competition between Program

Offices, all other federal government agencies, and

Of the over 11,000 Program Office employees, only 10% (approximately 1,200) are physically located in Washington, D.C.

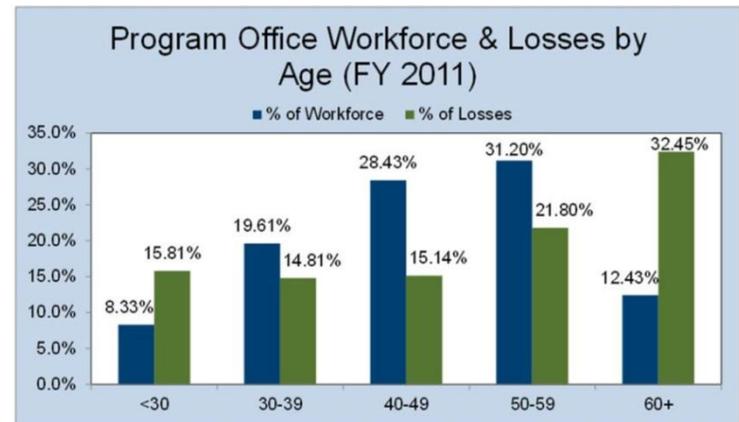


Figure 17

the private sector for the same workers. While internal transfers benefit the organization at large by keeping workforce resources that might otherwise leave VHA, they still require the same or similar recruitment

workload in terms of announcing the position, determining best qualified, and interviewing and training selected employees on the specifics of their new position.

VHA Servicing Human Resources Office (VSHO)

In 2011, VHA launched an initiative to establish the VHA Servicing Human Resources Office (VSHO). The VSHO is a network of HR professionals providing a full range of HR and consultative services to the VHA Central Office nationwide community. VSHO experts in the field of HR will ensure VHA's Headquarters top management receives exceptional customer service.

VSHO has achieved operational capability while simultaneously implementing the phased transition of Headquarters personnel. VSHO successfully transitioned a segment of Workforce Management and Consulting and the Federal Recovery Coordination Program Office, and operates as a geographically dispersed virtual organization with the hub of operations located in North Little Rock, Arkansas.

In June 2012, the Under Secretary for Health announced that VSHO had assumed responsibility for providing human resource support for designated VHA offices, and had received the transfer of responsibility from Central Office Human Resources Service (COHRS). The new organization is aligned under Workforce Management and Consulting and is a fully functional HR service supporting the Program Offices of the Under Secretary for Health, Principal Deputy Under Secretary for Health, Chief of Staff, Research Oversight and Medical Inspector.

Projected Workforce Data

Following the 23% increase in onboard strength that occurred in FY 2011, another increase of 18.8% occurred in FY 2012 as the realignment and restructuring of Program Offices continued. More modest growth is projected between FY 2013 and FY 2018. Between FY 2012 and FY 2018, 34.1% of the Program Office workforce will be eligible for or will take retirement.

VHA Program Office – Projected Workforce Data

	FY 2011 (Actual)	FY 2012 (Actual)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Onboard End of FY	11,258	13,379	13,820	14,000	14,100	14,200	14,300	14,400
% Change from Previous Year	23.39%	18.84%	3.30%	1.30%	0.71%	0.71%	0.70%	0.70%
Eligible for Regular Retirement			1,596	1,725	1,829	1,974	2,051	2,071
Voluntary Retirements	202	250	264	286	299	324	343	347
Regrettable Losses	440	597	624	638	645	649	654	658
Other Losses	200	201	254	260	262	264	266	268
Total Losses	842	1,048	1,142	1,184	1,206	1,237	1,263	1,273
Total Gains/Gains Needed	2,976	3,169	1,583	1,364	1,306	1,337	1,363	1,373

See page 28 for a full description of inclusion/exclusion criteria. FY 2012 data represent actual numbers through September 30, 2012.

Program Offices with a Discipline-Specific Component

The mission of many Program Offices includes a focus on a specific occupation, a group of occupations, and/or programs that cross disciplines throughout the VHA system. Without line or staffing authority, these Program Offices provide professional and functional guidance to field staff that fosters a standardized approach to both clinical and business operations that supports recruitment, development, and retention of the VHA workforce. These Program Offices include elements in their

Workforce Succession Strategic Plans that go beyond their own staff, reaching out to influence the disciplines, occupations, and functional areas that they support.

Several Program Offices oversee and coordinate various Technical Career Field (TCF) Training Programs for the occupations they support. However, the extent of Program Office support to the field is far greater. Program Offices independently, collectively, and through collaboration and partnership with Network and facility field experts, provide support to the workforce through many other, non-traditional means.

The ADUSH for Health for Clinical Operations supports strategies for hiring Central Dental Laboratory (CDL) positions and implements contracts to facilitate selective outsourcing where necessary. The Office plans to collaborate with the Military through professional conferences to make contact with retirees.

The ADUSH for Informatics and Analytics is identifying requirements for programs that facilitate certification of privacy specialists. New mandates and laws are requiring privacy specialists to achieve the Certified Information Privacy for Professional/Government (CIPP/G) certification via the International Association of Privacy Professionals (IAPP). To increase availability of a diverse pool of Health Informatics candidates, the Office is establishing partnerships with academic institutions that provide health informatics curriculum, promoting use of the student Pathways program, internships, preceptorships, mentorships and work-study opportunities for individuals in health informatics educational programs. The ADUSH for Informatics and Analytics is also increasing strategic focus of Health Informatics Initiative (Hi²) staff and creating an environment that promotes collaborative interaction between workstreams.

The ADUSH for Quality, Safety, and Value (QSV) recognizes a high turnover rate of Patient Safety Managers within VHA. While the Office does not have direct staffing authority, it provides support to the facility and VISN-level patient safety program staff and is developing Root Cause Analysis/Patient Safety training in 2012. To facilitate relationship building and strong practice building, a Systems Redesign community of practice is being created. The community of practice will assist Systems Redesign professionals in learning about new techniques, collaborating on projects, and creating new knowledge in the practice of systems redesign. QSV struggles with high loss rates of credentialing staff. In 2012, the Credentialing and Privileging Team will facilitate the increased knowledge, awareness, and strength and efficiency of existing programs within the field. Projects will proceed with the goal of promoting the growth and development of new and existing medical staff professionals, credentialing staff, and medical staff leaders. A minimum of two “Boot Camps” for new medical staff professionals and credentialing staff will be held at the Durham, NC office location.

The Office of Nursing Service (ONS) has created the VHA RN Residency (Transition-to-Practice) Program. After developing a business case, ONS launched a 12-month pilot of a Nurse Residency Program at eight VHA facilities of various complexity of care levels. The program’s curriculum focused on refinement of graduate nurse clinical competencies, and development of professional nursing roles and leadership characteristics. The program utilized a variety of educational strategies including classroom education; preceptor led clinical experiences, monthly meetings, group clinical debriefings, one-on-one mentoring, and an evidence-based practice project. All findings indicate the program was successful and ultimately proved beneficial to every facility in the pilot, resulting in a 100% RN retention rate of the pilot participants to date.

The Readjustment Counseling Program Office has conducted a needs assessment for Marriage and Family Therapists. The office is recruiting an additional 58 Marriage and Family Therapists to ensure that family members of returning combat Veterans and/or deceased combat Veteran family members are not left behind. In FY 2011 Readjustment Counseling was authorized 20 new Mobile Vet Center Units (MVC) in addition to the already existing 50. The Office anticipates a steady increase in onboard staff through FY 2014 to reach their approved staffing level of 1,917, an increase of 11% over FY 2011.

Summary

VHA Program Offices suspended formal succession planning during the FY 2011 planning cycle to allow for implementation of the realignment and update of relevant data sources. Succession planning for the Program Offices began again in FY 2012, using the field workforce planning structure whereby secondary offices produce workforce plans and submit their plans to their primary office for consolidation into a single comprehensive plan for the Program Office. This process strengthens the sound workforce planning practice of maintaining open lines of communication and close contact with every level. In addition to succession planning for the employees within each individual office, Program Offices are frequently the first line of response for changing priorities and courses of action that can have dramatic impacts on the larger VHA workforce. This adds a unique complexity to their mission and highlights the importance of effective communication about their strategic direction and succession planning efforts, which may affect the entire organization.



Chapter 6: Occupational Priorities, Challenges and Initiatives

This chapter provides an analysis of all top occupations as well as a narrative summary of issues regarding recruitment and retention challenges. In addition, physician and nurse specialties are addressed within each of those occupation summaries, and narrative assessments of the Other Targeted Occupational Workforce Priorities are also presented. For more detailed information and data specific to each occupation, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

2013 Top 10 Occupations

Rank	Top Ten Occupations	Losses FY 2012 Through FY 2018	Hires FY 2012 Through FY 2018
1	0602 Medical Officer (Physician)	14,318	16,722
2	0610 Nurse	29,304	38,164
3	0201 Human Resource Mgmt	1,567	2,042
4	0633 Physical Therapist	794	1,015
5	0644 Medical Technologist	2,251	2,539
6	0660 Pharmacist	2,754	3,262
7	0180 Psychology	2,305	3,405
8	0631 Occupational Therapist	571	656
9	0603 Physician Assistant	1,203	1,265
10	0605 Nurse Anesthetist	432	497
Total		55,499	69,567

Consolidated data from the VISN Workforce Succession Strategic Plans submitted in the spring of 2012 identified the occupations that are most challenging to recruit and retain. VISN plans projected staffing replacement needs based on regrettable losses, retirements, other separations and future mission needs. Facilities continued their participation in the succession planning process by providing their input on the top ten

occupations to their Network planners. The occupations aggregated through this process are listed in rank order in the 2013 Top Occupations table. A total of 55,499 losses are anticipated between FY 2012 and FY 2018. A total of 69,567 new hires will be needed to maintain staffing levels and grow these occupations as projected through FY 2018.

Top 6 Physician & Nurse Specialties	
Physician	Nurse
31 Psychiatry	87 RN, Mgr/Head Nurse
25 Gastroenterology	88 Staff Nurse
07 Orthopedic Surgery	75 Nurse Practitioner
P1 Primary Care	N4 NP Mental Health SUD
38 Radiology - Diagnostic	Q1 RN/Staff-Outpatient
1 Anesthesiology	S2 RN Informatics

In addition to the top ten occupations for recruitment and retention, the six physician and nurse specialties are also identified and aggregated through the VISN and facility planning process. These specialties are discussed in the physician and nurse occupation narratives in this chapter.

Other Targeted Occupations (Ranked 11-16)
0647 Diagnostic Radiologic Technologist
0620 Practical Nurse
0801 General Engineering
0649 Medical Instrument Technician
0651 Respiratory Therapist
0640 Health Aid & Technician

Finally, occupational priorities that ranked 11 to 16 are identified as other targeted occupational priorities, and these are discussed briefly at the end of the chapter. Typically, these occupations have either recently been on the top ten list or are making their way toward the top ten list.

Onboard Growth

While the number of employees onboard in the top occupations group (illustrated in Figure 18 below) continued to grow since FY 2009, the rate of that growth has slowed considerably. However, at 2.9%, the FY 2011 top occupations group average rate is still slightly higher than the VHA total workforce growth rate of 2.7%. Psychology (6.8%) had the highest growth rate. Nurse anesthetist (6.5%), human resources management (4.6%), physical therapist (3.6%), medical officer (3.2%), and nurse (2.8%) also had rates higher than the FY 2011 VHA average. Medical technologist was the only occupation in the top occupations group that did not grow in FY 2011.

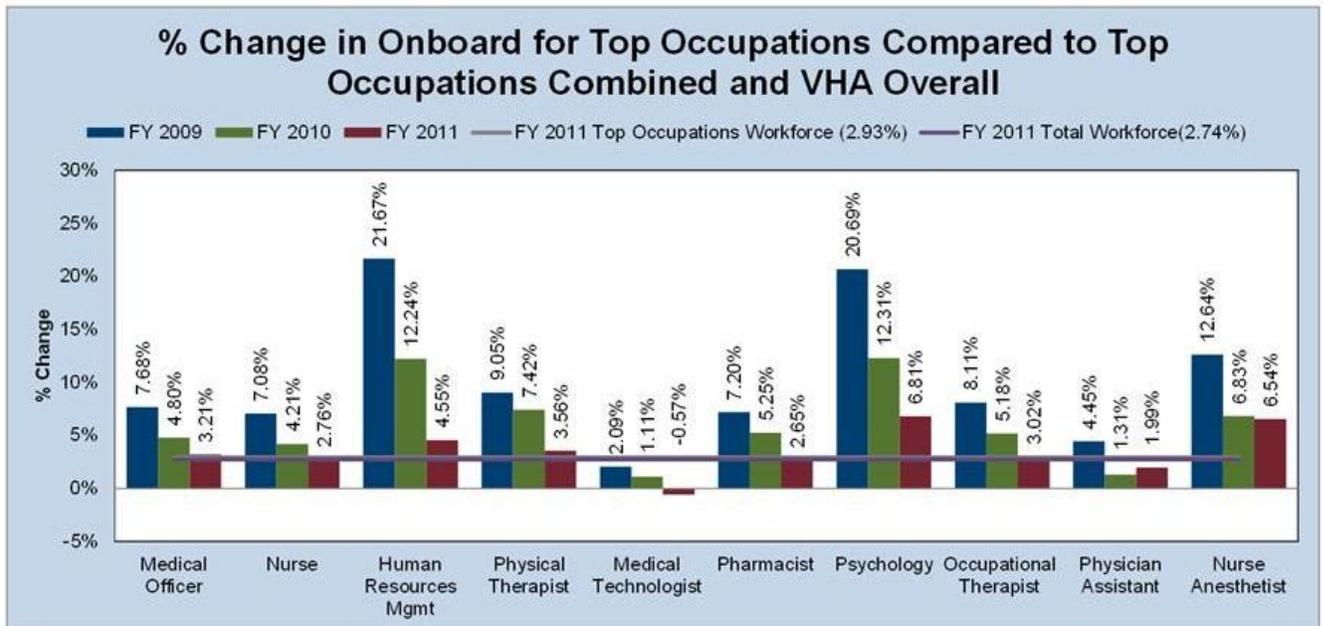


Figure 18

Loss Rates

The rebound in losses that began in FY 2010 continued in FY 2011, with a resulting increase in loss rates for nearly all of the top occupations. However, the total loss rate average for the top occupations group (7.2%) was lower than the VHA total workforce average (8.2%) for FY 2011.

The voluntary retirement rate increased in FY 2011 by 0.3 percentage points (pp) for the top occupations group average. As illustrated in Figure 19, the only exception was physician assistant, which experienced a 0.4 percentage point reduction in retirement rates. The largest increases in retirements were seen in physical therapist and occupational therapist (+1.2 percentage points).

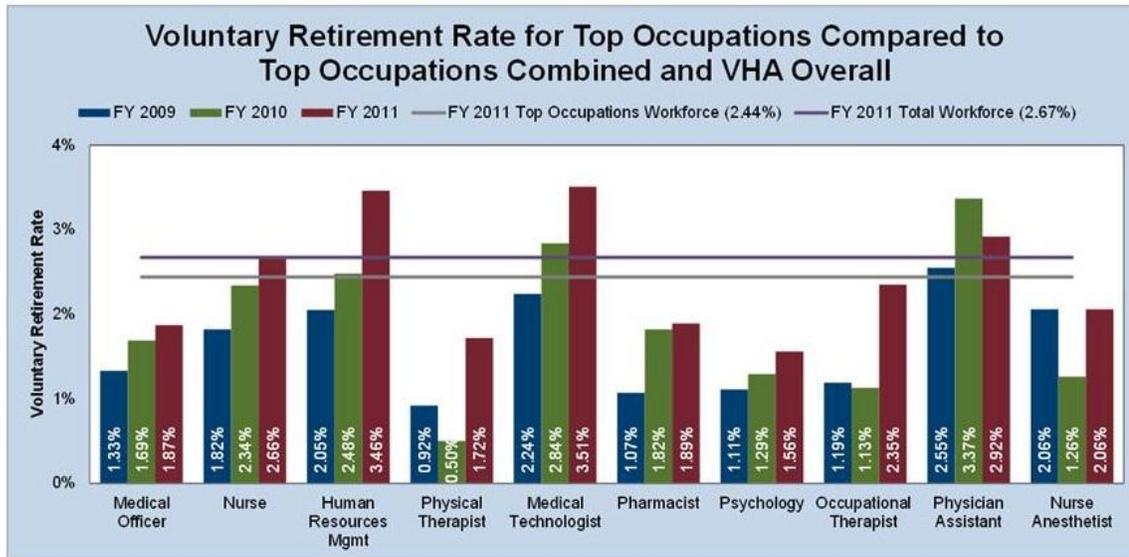


Figure 19

The quit rate for the top occupations group increased slightly (+0.3 percentage points) in FY 2011, as did most of the individual occupations’ quit rates (Figure 20). Occupational therapist had the only decrease in quit rate (-1.4 percentage points), while physician assistant (+1.6 percentage points) had the largest increase.

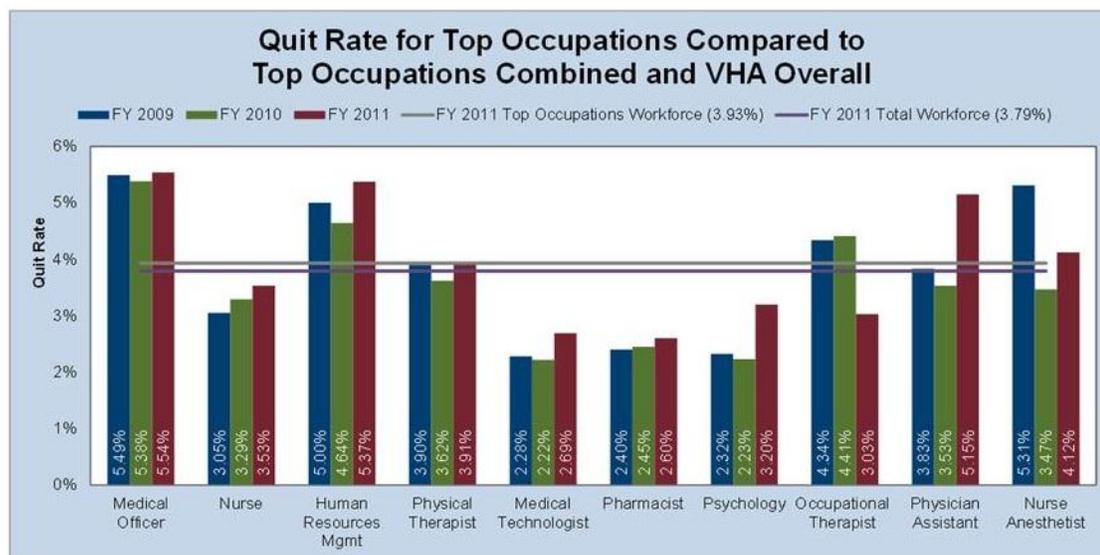
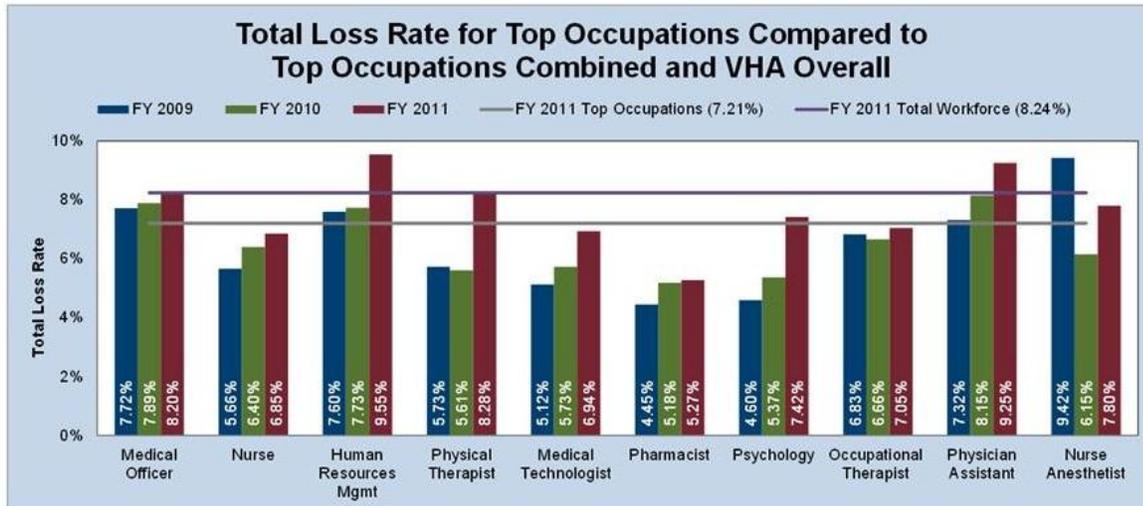


Figure 20

The total loss rate for the top occupations group increased by 0.6 percentage points in FY 2011. Physical therapist (+2.7 percentage points), psychology (+2.1 percentage points), human resources management (+1.8 percentage points), and nurse anesthetist (+1.7 percentage points) had the largest increases (Figure 21).



Data Source: VSSC HR Employee and HR NOA cubes. **Voluntary Retirement Rate:** All voluntary retirement actions divided by average onboard. **Quit Rate:** All resignations and 352G terminations (transfers) divided by average onboard. **Total Loss Rate:** Any loss, retirement, death, termination, or voluntary separation divided by average onboard. Loss calculations exclude transfers (NOA codes 900 and 901).

Figure 21

Average Age

The top occupations group average age in FY 2011 was 48.8 years, as compared to the total workforce average age of 48.2 years (Figure 22). Medical officer, nurse, medical technologist, physician assistant, and nurse anesthetist all had higher average ages than the total workforce. Physical therapist (42.7 years) had the lowest average age.

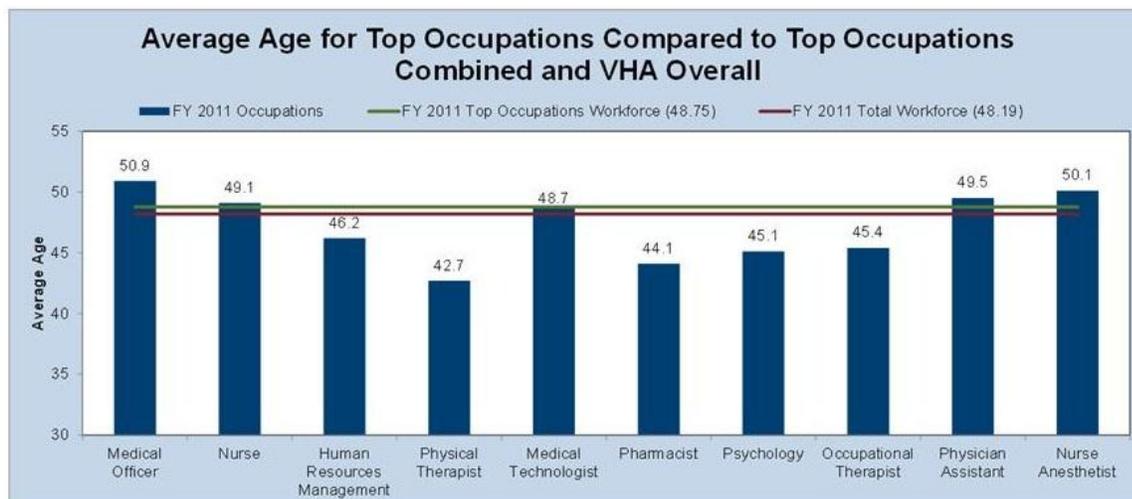


Figure 22

Quits by Year of Employment for All Top Occupations

See page 29 for a full list of inclusion/exclusion criteria.

Gain Year	1st	2nd	3rd	4th	5th
FY 2004	15.78%	9.60%	4.98%	3.75%	2.04%
FY 2005	15.96%	8.93%	4.72%	3.82%	1.91%
FY 2006	15.37%	7.85%	3.53%	2.57%	1.86%
FY 2007	13.17%	6.33%	3.42%	2.74%	
FY 2008	10.20%	6.14%	4.01%		
FY 2009	9.98%	7.24%			
FY 2010	10.50%				

- On average, 34.2% of new hires in the top occupations quit in the first five years of employment; three percentage points more than for the workforce overall.
- 21% of top occupation new hires quit in the first two years of employment, which represents more than two-thirds of their total losses in the first five years. However, the rate

of quits in the first two years has decreased from 19.5% in FY 2007 to 17.2% in FY 2009.

- 10% to 16% of top occupation new hires typically quit within their first year of employment.

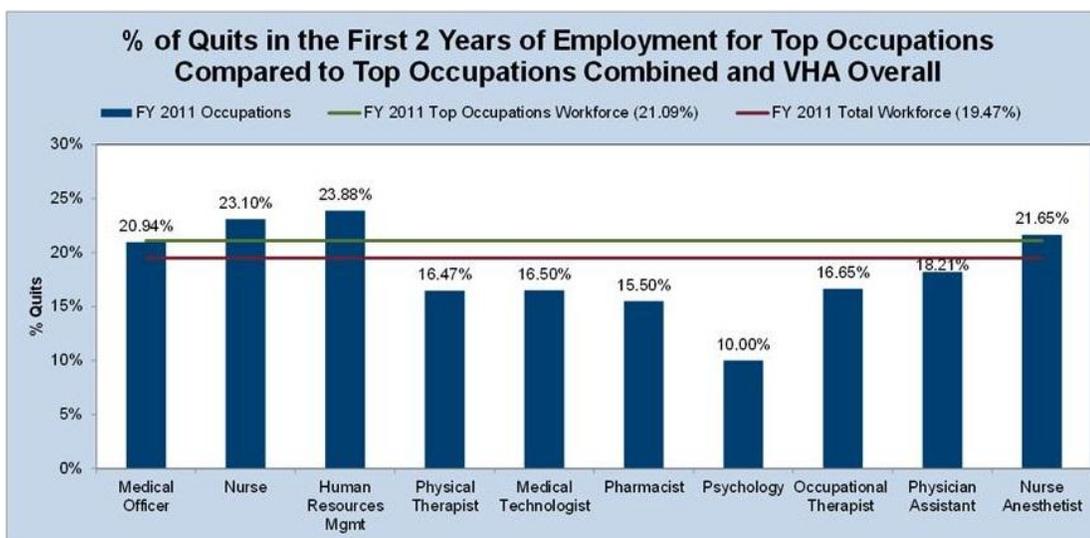


Figure 23

An examination of individual occupations' quit rates within the first two years of employment (for those hired between FY 2004 and FY 2009) reveals that the occupations with the highest loss rates within the first two years are medical officer, nurse, human resources management, and nurse anesthetist.

Psychology, pharmacist, physical therapist, medical technologist, occupational therapist, and physician assistant had the lowest quit rates within the first two years (Figure 23).

Entrance Survey Results

As illustrated in Figure 24, the FY 2011 VA Entrance Survey indicated that those in the top ten occupations chose to work for VHA for the following reasons:

- 21% career opportunity/advancement
- 21% benefits
- 12% job stability/security

Those in top occupations chose “I am a Veteran” at a lower rate than those in other occupations. This could be because the majority of occupations in the top ten list are Title 38 and are not typically Veterans.

Job Opportunity Sources

The VA Entrance Survey collects information from new employees to give insight into how applicants learn about job opportunities. Figure 25 below summarizes the findings. Specific information about each occupation is further described later in this chapter. Understanding how candidates learn about job opportunities helps the HR community develop better outreach strategies by capitalizing on proven sources.

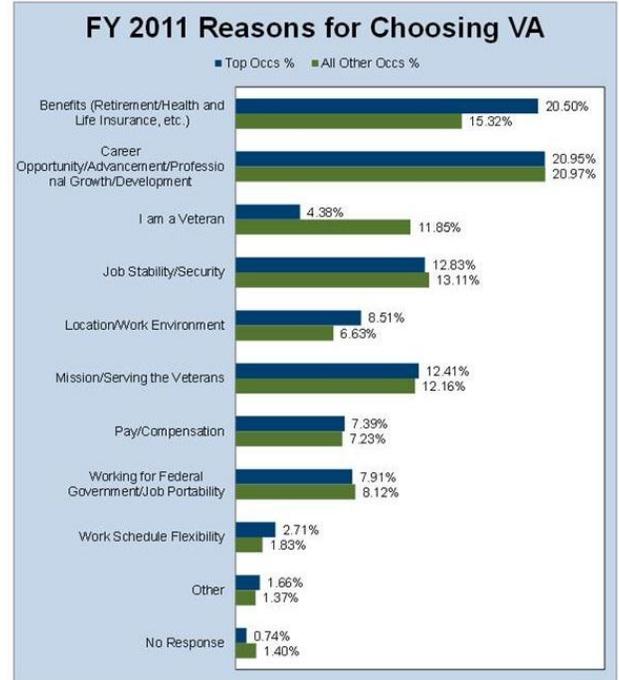


Figure 24

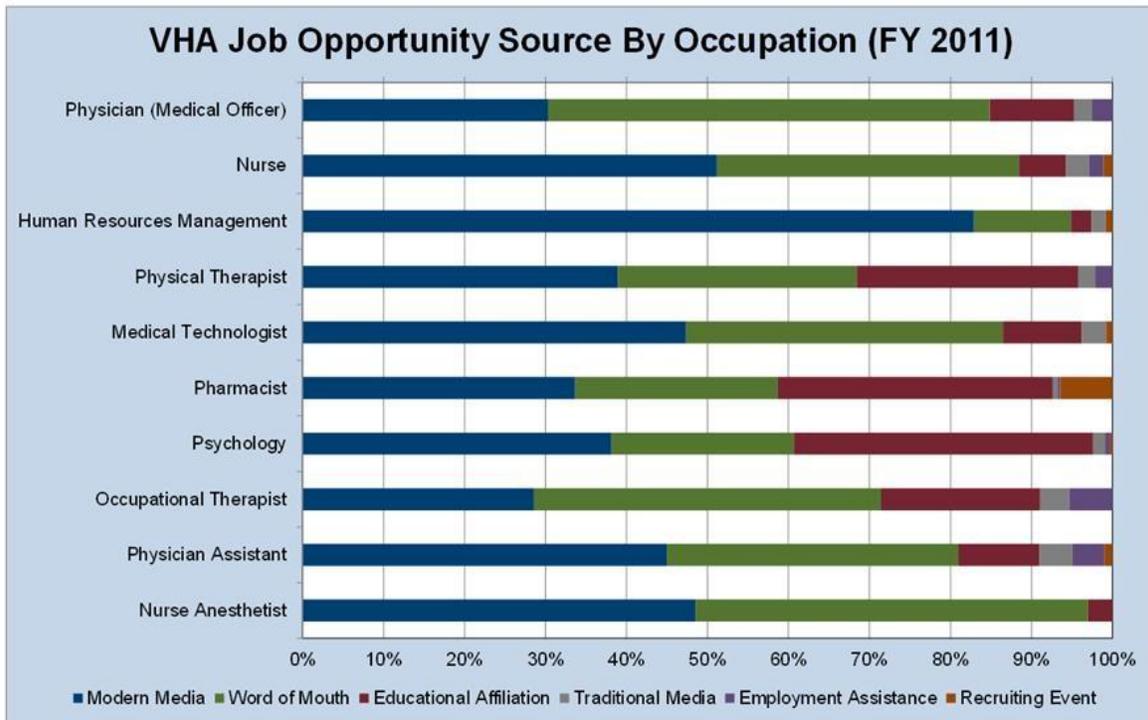


Figure 25

Exit Survey Results

As illustrated in Figure 26, the FY 2011 VA Exit Survey indicated that those in the top ten occupations left VHA for the following reasons:

- 21% normal retirement
- 16% advancement
- 10% relocation with spouse

Those in top occupations selected “family matters,” “relocation with spouse,” and “advancement (unique opportunity elsewhere)” somewhat more frequently than those in all other occupations. Those in the top occupations chose “attend school,” and “advancement (lack of opportunity),” less frequently than those in all other occupations. Many of the top occupations require education as a prerequisite for hiring.

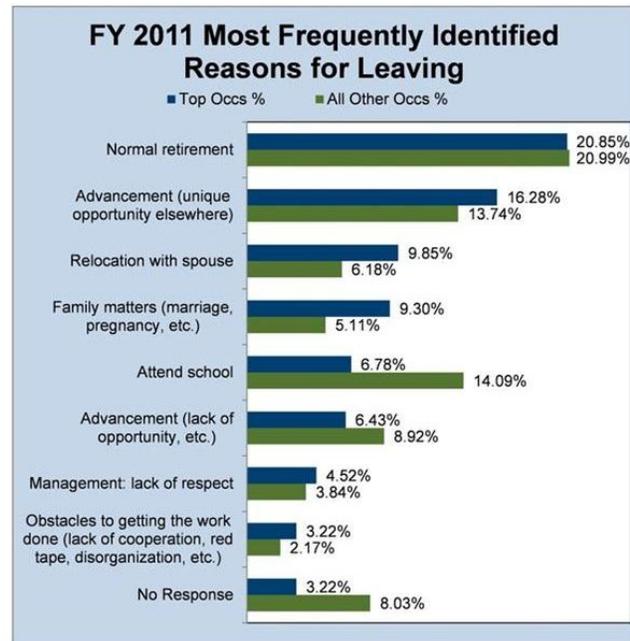


Figure 26

2012 All Employee Survey (AES) Results

Like VHA overall, Job Satisfaction Index (JSI) scores indicated that the top occupations were most satisfied with work quality, work type, co-workers, and customer satisfaction, and least satisfied with promotion opportunity, satisfaction compared to two years ago, senior management, praise, and pay. Pay satisfaction was of more concern than praise among clinical laboratory employees, physicians, physical medicine therapists (such as OT and PT), physician assistants, and certified registered nurse anesthetists (CRNAs). In addition, all top occupations rated the culture of the organization as bureaucratic followed by rational, with the exception of clinical laboratory employees, who rated enabling second. All occupations rated the organization as less likely to be entrepreneurial. The Organization Assessment Inventory (OAI) of the AES, however, did not provide scores that were as similar across the top occupations. While resources, work/family balance, and diversity acceptance were rated as the top satisfiers for the top occupations, no element was an across the board stand-out as the top satisfier, indicating that the OAI may provide more detail about the specific concerns for each occupation. However, job control and psychological safety were the least satisfying elements for the top occupations group.

Minority Representation

As illustrated in Figure 27, the percentage of minorities among the top occupations is generally lower than the total workforce. The top occupation’s group average in FY 2011 was 33%, compared to the total workforce rate of 39.3%. The occupations with the highest percentage of minorities were human resources management, medical technologist, and medical officer (38.3%, 36.4%, and 35.8% respectively.) The occupations with the lowest percentage were psychology, nurse anesthetist, and physician assistant (13.7%, 17%, and 19.7% respectively).

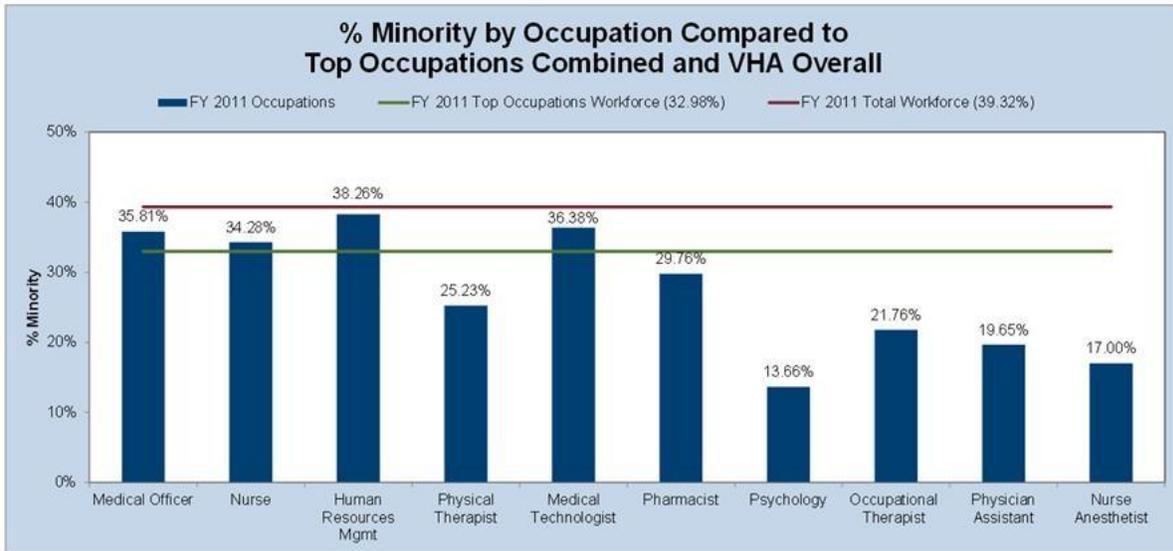


Figure 27

Figure 28 illustrates that the top occupation’s group average percentage of females was 68.7% as compared to the total workforce average of 61%. With the exception of medical officer (34.8%), psychology (58.5%), physician assistant (50.9%), and nurse anesthetist (52.7%), the rate of females is higher for most of the top occupations.

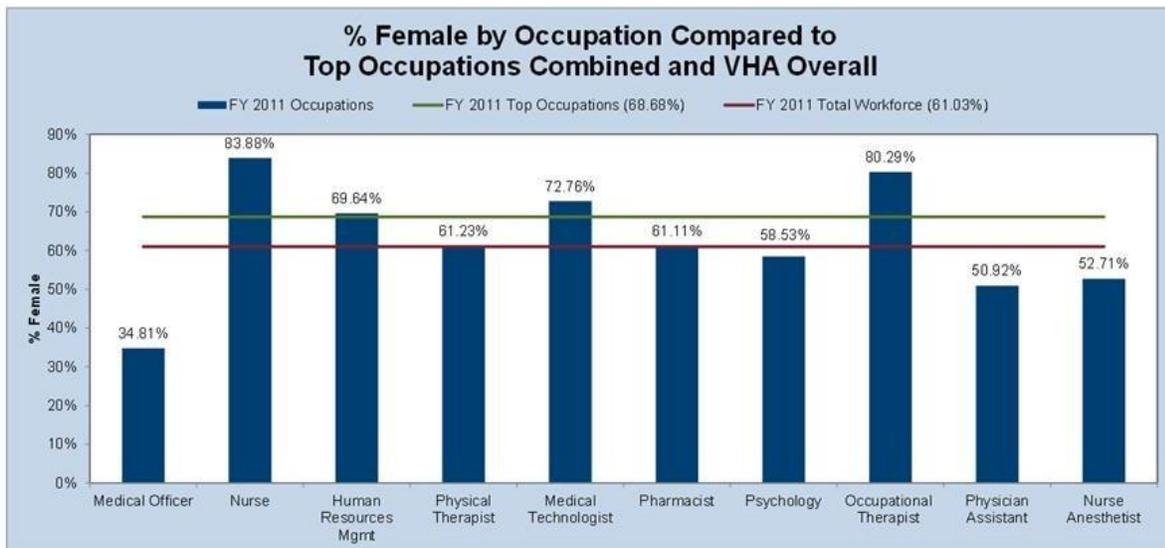


Figure 28

Veteran and Disability Representation

The percentage of Veterans among the top occupations group, illustrated in Figure 29, was 13.4% as compared to the total workforce rate of 30.8%. Human resources management (38.2%), nurse anesthetist (34%), and physician assistant (32.9%) had Veteran percentages higher than the total workforce. VHA's goal for Veteran representation has been set to 40% by FY 2014.

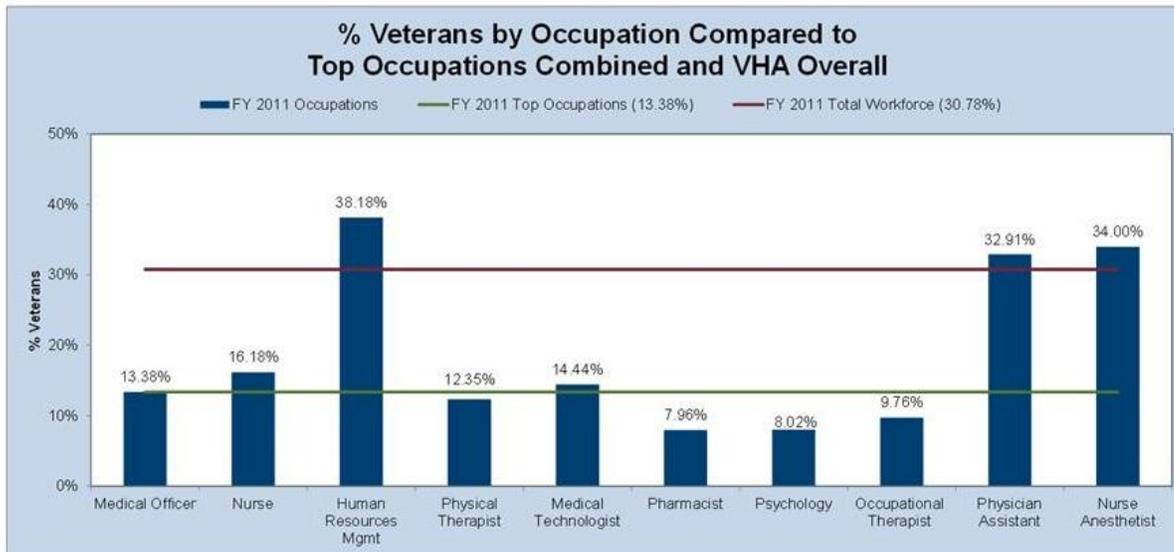


Figure 29

VHA's goal for targeted disability participation is 2%. The top occupations' group average, illustrated in Figure 30, is 0.6%, as compared to the total workforce average of 1.6%. Human resources management (1.7%) was the only occupation with a targeted disability participation rate that is higher than the VHA average.

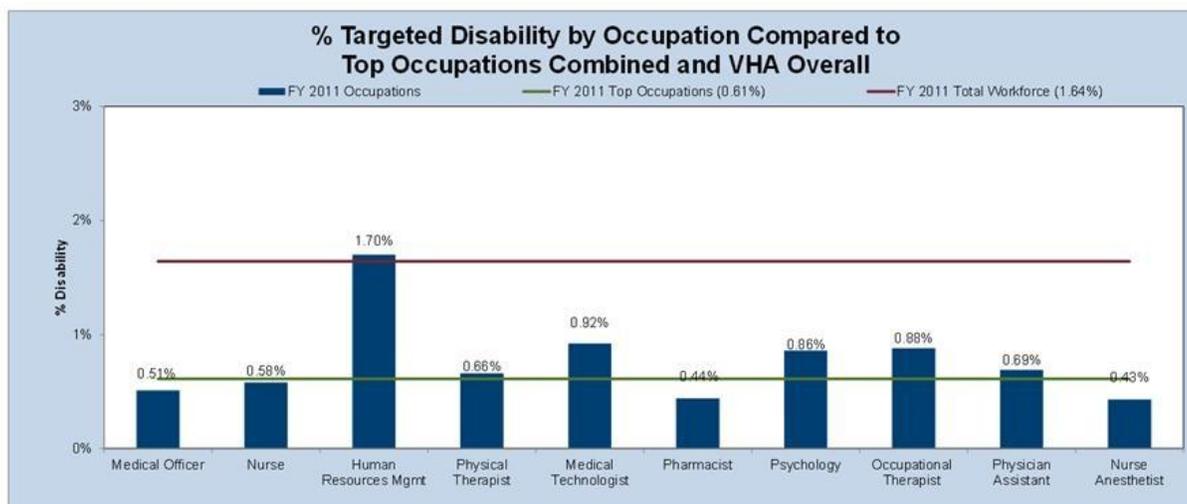


Figure 30

Veteran New Hires

In FY 2011, the rate of Veteran representation among new hires in the top occupations group, illustrated in Figure 31, was 14.6%, compared to the total workforce at 32.7%. Veteran representation among clinical occupations is typically lower than that of administrative occupations due to the fact that the pool of candidates for clinical occupations is largely represented by non-Veterans. While human resources management had the highest percentage (53.7%), physician assistant and nurse anesthetist, at 18.9% and 15.8% respectively, had representation rates higher than the top occupations average, yet still lower than the VHA average and well below the VHA goal of 40%. The occupations with the lowest percentage of Veteran representation were psychology (3.7%), occupational therapist (5%), and pharmacist (7.7%).

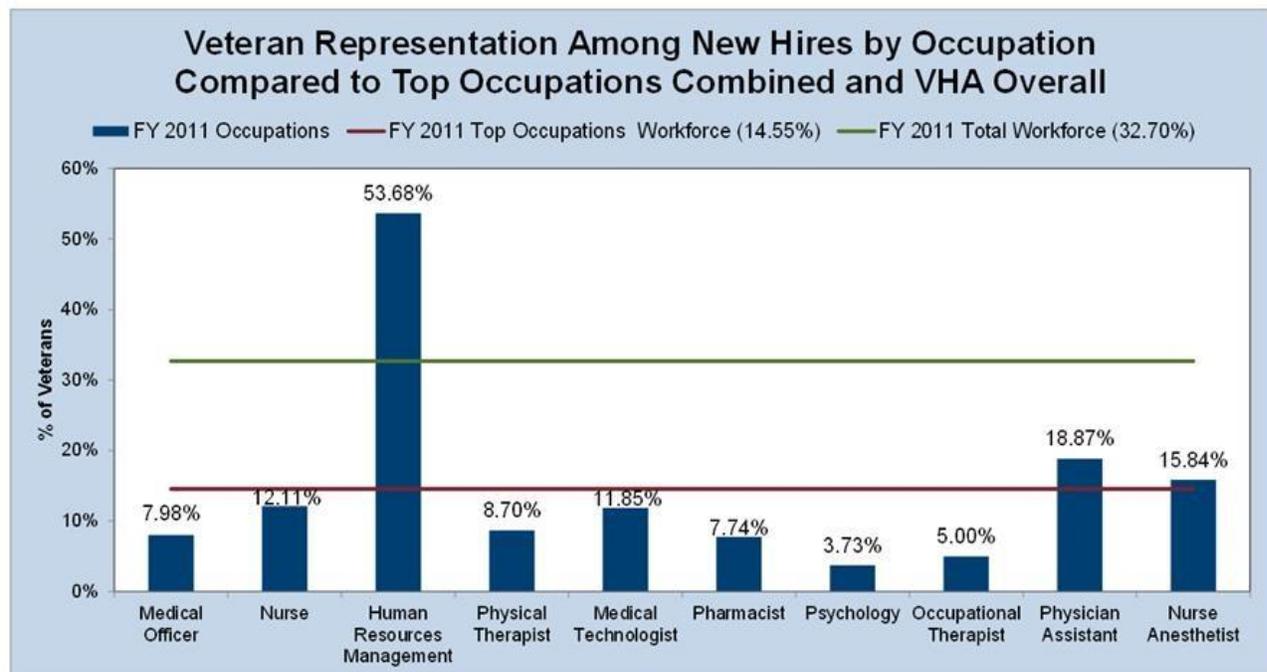


Figure 31

Significant Occupation-Specific Initiatives and Issues

Hybrid T-38 Conversions

The Title 38 personnel system was created in 1946 to simplify and expedite the employment process and provide compensation policies and practices necessary for VA to effectively recruit and retain health care providers, allied health care and support staff. Since then, 27 occupations have been designated as Hybrid Title 38 occupations, affording VA with the flexibilities needed to effectively recruit and retain employees in those occupations.

Under PL 111-163, dated May 5, 2010, the Secretary of the Department of Veterans Affairs was delegated the authority to extend Hybrid status to additional occupations so that it no longer requires legislative action. This delegation to the Secretary provides the agency a more efficient and expedient method to convert occupations that are directly related to patient care to the Title 38 personnel system. Since this delegation, VA has approved the conversion of nursing assistant, medical support assistant, and additional sub specialties for medical instrument technician (GI and eye technician).

Currently there are 40 occupations scheduled to either have the qualification standard revised or to be converted to Hybrid. VHA foresees that it will continually work with the Program Offices to update and revise the qualification standards to incorporate new requirements within the field or education.

Impact of Affordable Care Act on VHA Occupations

According to a report conducted by The Lewin Group (2012), “The Patient Protection and Affordable Care Act (ACA) is the most far reaching reform of the U.S. health care system since the creation of Medicare and Medicaid in 1965.” Further, ACA “...affects the market for health professionals, both on the demand and on the supply side.” While it remains to be seen what effect the ACA will have on the VHA workforce, the VHA Office of Policy Analysis under the ADUSH for Policy and Planning has sponsored a series of studies and analyses to determine the most likely scenarios and the implications of health care reform under ACA on VHA’s workforce.

The studies estimate that the market-wide demand for health professionals will increase by three to five percent as a result of ACA. In addition, they predict an overall increase in demand for mental health professionals due to new insurance coverage mandates for mental health conditions that previously did not exist. Finally, the national market for health care professionals is expected to become increasingly challenging for recruitment and retention, due to factors such as the aging physician workforce, and an aging general population.

The study estimates the push and pull effects of ACA on the health care workforce. The analysis reports the workforce effects for two scenarios:

1. The “Base Case” scenario represents a case in which all states participate in the Medicaid expansion, and results in no significant change in enrollment.
2. Scenario 2 assumes that the 29 states that filed lawsuits against Medicaid expansion will not implement the expansion due to the recent Supreme Court ruling. Under this scenario, VHA would experience net gains in enrollment by 2016 of about 190,000 Veterans, an increase of 4.2%. Based upon current ratios of enrollees to health workforce, and assuming no changes in case mix, patterns of care deliver, or staffing ratios, this would translate into a requirement for additional medical officers, nurses, and practical nurses in VHA by 2016 in order to meet the demand from new enrollment under this scenario.

The study suggests that the implications for occupations in the health care workforce at large may have residual effects on VHA’s ability to recruit and retain health care workers. Registered nurses will continue to be the largest component of the health care workforce at large. Employment in all health professions, except laboratory technology and nurse anesthetist positions, is expected to grow by more than 20% between 2014 and 2016. The number of job openings for social workers who provide mental health and substance abuse treatment will increase by approximately one-third. For physician providers, the studies estimate increased demand across all provider types, but slightly more so for mental health care and specialist care compared to primary care and inpatient care.

This increased demand for health care workers overall may drive up the salaries requested by workers, especially in occupations facing a current shortage. Medical doctors and advanced practice nurses, with long education and training pipelines and somewhat fixed training capacity may experience the largest

increases in salary. Other occupations with shorter training pipelines or current excess capacity could potentially experience little or no wage increase. VA workers facing static salaries may be induced to seek jobs with other employers who are able to adjust salaries more easily. For this reason, the studies estimate that ACA-induced wage effects may increase quits for the health care workforce across the VHA system by as many as 291 by 2016.

To prepare for these anticipated changes, the Office of Policy and Planning has prepared a set of briefings for key executives to discuss the outcome of these studies and determine next steps.

Military Medic/Corpsman VA Employment Initiative

The active recruitment of recently separated Servicemembers is a key priority for VA to ensure a seamless transition for Veterans into employment. A particular focus has emerged on the value of the operational experience that these recently separated Servicemembers can provide in health care settings. Army and Air Force medics as well as Navy Corpsmen receive extensive and valuable health care training while on active duty. However, transitioning Servicemembers' clinical experience does not translate easily into civilian clinical roles. Secretary Shinseki asked VHA to explore how it could hire well-trained medics and corpsmen transitioning out of active service. As a result, a taskforce/workgroup was assembled in January 2012, to explore how VHA may be able to employ transitioning medics and corpsmen, provide them with career opportunities, and simultaneously meet VHA workforce needs.

The workgroup goal is to establish a position and progressive career track that attracts separating military health personnel to VA and to address issues related to preparation, licensing, and credentialing of Veterans who have served in the military in clinical and allied health positions, but who may not have the education or certification required for licensure in a civilian setting.

The workgroup developed a one-year pilot, which began in the fourth quarter of FY 2012, to identify needs that medics and corpsmen can fill within VHA. This involves creation of a new Title 5 health technician role (Intermediate Care Technicians, GS-0640 series)

which is being piloted in the emergency department at 15 unique VA Medical Centers with a known need for skilled technicians. As of October, 2012, 45 of the vacancies at the pilot sites have been filled.

Competencies: A standardized system will be developed to ensure the medics and corpsmen are competent to perform their duties. Their military transcript can be used to verify their skills and experience while on active duty. An annual competency checklist will be completed to ensure they are still able to perform the listed skills.

Potential Pilot Program Benefits:

- *Adds new skilled workforce for VHA*
- *Creates a pipeline for future licensed professionals*
- *Increases VHA Veteran hiring*
- *May increase Veteran patient satisfaction*

Health Informaticist Career Development

A predicted national Health Information Technology (HIT) worker shortage has arisen, in part, from two pieces of federal legislation: Patient Protection and



Affordable Care Act of 2010 and the American Recovery and Reinvestment Act (ARRA) of 2009. These federal programs with their related financial incentives for adoption and certification of electronic health records will impact the supply and demand for skilled workers that are capable of innovating, implementing and using health information technology. The Bureau of Labor Statistics estimates the shortfall at 35,000 HIT workers by 2018 (Zywiak, 2010). Competition for skilled HIT workers will impact VA's ability to recruit and retain the informatics staff necessary for health care operations.

The VA Major Initiative "Transforming Health Care Delivery through Health Informatics" (Hi²) is working to address this challenge by increasing the capacity of the VA informatics workforce through competency, career and community development efforts and a number of interrelated deliverables.

Health informatics is an emerging discipline without a consistently defined professional identity (Hersh, W., 2009) An early task undertaken by the Hi² Workforce Development Team (also known as Workstream C Career Subgroup) was to define health informatics in VA:

"Health informatics is a discipline at the intersection of information science, computer science, and health care that designs and delivers information to improve clinical care, individual and public health and biomedical research. Health informatics optimizes health-related information acquisition, processing, and use using resources and tools that include people and processes; hardware and software; algorithms and data; and information and knowledge."

The health informatics workforce is heterogeneous and multidisciplinary, with various points of entry and career paths, levels of educational preparation, professional certifications and credentials, position descriptions and communities of practice. There are many roles in VHA today that perform health informatics functions such as Chief Health Informatics Officers, Nursing Informatics Specialists and Clinical Application Coordinators (CACs) to name a few. The CACs have played a key role in the design, construction, configuration and support of the largest electronic health record system in the world. They have been and continue to be a true VHA HIT asset.

Based on the results of staffing level studies, a CAC Staffing Workgroup in VISN 8 determined that the current CAC staffing levels in the VISN could not support the demands of the various clinical applications being used. In addition to lack of staffing, additional key concerns such as inability to recruit and fill critical CAC vacancies at the full performance level and the impending retirement of the CAC community spurred the workgroup to create the first formalized, VISN funded, three-year CAC Trainee Program in VHA. The Program incorporates competency checklists, mentoring, oversight by the Lead CAC at each site, an annual evaluation process, and education credits through TMS. At the end of the program, the trainees complete and present a project that demonstrates their skills and knowledge of the CAC role. The Program allows for one trainee per VISN and facility to be hired.

On the national front, the Career Subgroup of Workstream C addressed the need to develop an informatics career path. The first step in this process was to align all of the major duties and responsibilities of the Title 5 CAC workforce into a single title, series, and grade. Historically in VA, the CAC role has been assigned to different job classifications as well as different titles, series and grades. Consequently, different qualifications requirements are applied to essentially the same body of work. In order to facilitate the alignment, Workstream C partnered with the Office of Human Resources Management, Classification and Compensation Service to develop and classify a standardized position description for Title 5 Clinical Application Coordinators. This work resulted in a new, more descriptive

and recognizable job title of Health Informatics Specialist (HIS), under which Title 5 employees in the current CAC position will be realigned. In addition, a new national position description that includes career ladder developmental position descriptions for Health Informatics Specialists was developed and will be available for mandatory facility use in 2012. This standardized position description will ensure the consistent application of qualifications requirements to recruit and select the best applicants among all VHA facilities in which the HIS position is operating.

In addition to the implementation and realignment of Title 5 CACs into the new HIS PD, the Workstream C Career Subgroup is focused on the following recruitment and retention goals and strategies for the HIS career field:

- Ensure that VHA has a diverse and talented HIS workforce that is prepared to support health care modernization and improved care delivery through health informatics.
- Create a diverse pool of HIS candidates by promoting and using various student training and mentorship programs.
- Support the retention of HIS employees in order to facilitate the delivery of high-quality care to Veterans and meet the transformational goals of the organization.
- Foster a flexible and inclusive work environment that enables employees to achieve their highest potential.
- Once the HIS position is established, identify, assess, and develop staff to ensure they are ready to assume key HIS roles and tackle future challenges.

Other Workstream C Career Subgroup activities planned for FY 13 include: development of a standardized position description for a Health Informatics Application Coordinator (HIAC) (formerly known as ADPAC); development of recommendations for HIS and HIAC staffing models; implementation of HIS Recruitment and Retention Plans; development of sample functional statements for Nursing Informatics Specialists; development and delivery of large scale educational programs that will build the informatics literacy of VA staff.

For questions regarding the health informatics career field in VHA, contact the [VHA hi² WSC CAREER](mailto:VHA_hi2_WSC_CAREER) mail group or visit <http://hi2.med.va.gov/>.

Growing Demand for Geriatrics Expertise

The Under Secretary for Health charged the Executive Taskforce on the Healthcare Workforce for Aging Veterans with making recommendations to ensure VHA is suitably prepared to address the health care challenges posed by the increasing age of Veterans, the growth in number and proportion of aging Veterans, and the increasing medical and functional complexity that characterizes individuals of advanced age. The Taskforce found growing demand for geriatrics expertise in VHA, diminishing access to that skill and knowledge in VHA, and serious implications of the present and projected situations.

Evidence of Growing Demand: Over 44% of Veterans seeking VHA services are age 65 and over. VHA expended \$16B on the care of Veterans age 65 and older in 2010 and is projecting those expenditures to increase to over \$20B by 2015.

Diminishing Access to Expertise: The proportion of clinicians with advanced training in geriatrics in every discipline is shrinking. While the patient population and clinical challenges are significant, advanced training and certification in geriatrics is not compensated due to the fact that additional

training is not factored into the determination of salary tiers. For example, in VHA, primary care providers and geriatricians are in the same salary tier.

In addition, most health care providers in and out of VHA have received little to no training in the care of the elderly, due to the fact that it is afforded limited curriculum time, there is limited and diminishing expertise among faculty, and there is limited focus in licensure criteria.

VHA has historically been a leader in geriatrics but the expertise is not consistently available through the outpatient, inpatient, or extended care areas. Inpatient geriatric consultation is offered at fewer than 40 sites. Sixty percent of VA Medical centers and nearly 100% of CBOCs lack Geriatric Primary Care for older Veterans. Furthermore, there is no established model for care of seriously mentally ill Veterans aging into dependency.

Implications: There is extensive and multidisciplinary literature that convincingly demonstrates clinical care of older Veterans that is not informed by geriatrics expertise results in poorer outcomes, such as:

- Greater morbidity, resulting in reduced function, greater subsequent dependency, higher cost;
- Lower patient, family, and staff satisfaction;
- Greater costs from avoidable hospital and nursing home utilization, longer lengths of stay, greater readmission rate after discharge, greater demand for extended care, and utilization of more costly care options when less costly ones may be preferred by patients;
- Placement in more restrictive settings that promote further decline in function.

Recommendations: The taskforce completed its recommendations for addressing the situation in October 2010, organizing them around three themes:

- Existing recruitment and retention strategies need to be focused on enhancing the size and expertise of the geriatrics VHA workforce;
- Existing geriatric educational activity should be increased and directed to the existing workforce in addition to enhancing pre-professional, multidisciplinary geriatric training content and opportunities; and
- Models of inpatient and outpatient care that are known to optimally leverage geriatrics expertise should be generally available in VHA.

The Healthcare Workforce for Aging Veterans Executive taskforce full report and the business case can be found at the following link.

<http://vaww.infoshare.va.gov/sites/geriatrics/geriprograms/hwave/report/default.aspx>

Mental Health Hiring Initiative

The goal of the Mental Health Hiring initiative, begun in FY 2012, is to increase access to mental health services. To assist in meeting this goal, the agency has placed a focused effort on hiring 1,900 psychiatrists, psychologists, mental health nurses, social workers, marriage and family therapists, licensed professional mental health counselors, and clerical/administrative staff necessary to support clinical staff. The roles of the new clinical staff include: general outpatient mental health access; PTSD, Substance Use Disorder, and other specialty access; delivery of evidence-based psychotherapies; primary care-mental health integration; Veterans Crisis Line staff; and mental health compensation and pension examiners.

In the past, facilities have had the flexibility to determine staffing mix based on local resources and needs. However, in the past year, it became clear that sites could benefit from additional guidance on best practices in determining needed mental health staff. To help accomplish this, VA developed a staffing model based on the process used by VHA Primary Care to develop population-based guidance. VA Central Office is providing technical assistance to VISNs and additional funding to aid recruitment and hiring of mental health staff. For more information regarding recruitment and retention efforts please refer to Chapter 8, Recruitment and Retention.

Due to the timing of the hiring initiative (April 2012), there was little input on the recruitment and retention challenges from VISN Workforce Succession Strategic Plans submitted on March 31, 2012, regarding the occupations included in this initiative. However, psychology, nurse mental health (substance use disorder), and medical officer –psychiatry were listed as the top mission critical specialty priorities for recruitment and retention in the plans that were submitted, indicating the level of importance and focus that had already been placed on these positions across the organization.

Increases in Mental Health Staffing

In order to meet the current need, approximately 1,600 mental health clinicians will be added to the existing VHA workforce of 2,490 mental health staff. The goal for reaching 1,900 hires also includes 300 additional support staff. There were 2,815 existing vacancies as of May, 2012.

Mental Health Occupation-Specific Issues

To augment existing VHA mental health services, two new occupations were added to the list of core mental health professionals in VHA in September, 2010.

- Marriage and family therapists (MFTs) must have a Master's degree in marriage and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education. Entry level for this position is at the GS-9 with a full performance level of GS-11. MFTs have knowledge of human development throughout the lifespan, and an ability to independently assess the psychosocial functioning and needs of patients and their family members. They provide counseling and/or psychotherapy services to individuals, groups, couples and families. VHA is partnering with the American Association of Marriage and Family Therapists on recruitment and hiring of MFTs.
- Licensed Professional Mental Health Counselors (LPMHCs) have a master's degree in mental health counseling and must have graduated from a program accredited by the Council on Accreditation of Counseling and Related Educational Programs. The entry level is at the GS-9 with full performance at the GS-11 level. LPMHCs provide mental health services within the knowledge, theory, and training foundations of professional counseling and may be involved in program evaluation and/or research activities.

Nursing. Through collaboration with the Office of Nursing Services, several focused efforts related to mental health nurses have been developed:

- Appointed a field based Clinical Nurse Advisor for Mental Health;
- Chartered a Mental Health Nursing Field Advisory Committee responsible for developing (1) a staff nurse guide on leading mental health groups, (2) mental health systems redesign collaborative guidance, (3) mental health nursing fact sheets for medical centers and (4) toolkits for psychiatric patients with diabetes;

- Contacted key nursing organizations, such as the Academy of Advanced Practice Nurses and the American Psychiatric Nurses Association, to assist with current recruitment, retention and education of future mental health nurses;
- Chartered a VA/American Association of Colleges of Nursing workgroup to develop a toolkit for preparing future nurses with a focus on Veteran specific clinical needs;
- Sought collaboration with VHA mental health leadership to engage in staffing methodology for nursing personnel in mental health programs.

Psychology. VA has been training psychologists since 1946. Approximately 50% of psychologists in the U.S. have had some VA training. Furthermore, approximately 70% of current VA psychologists have had some VA training prior to being hired. Between 2008 and 2009, Mental Health Services, in collaboration with the VHA Office of Academic Affiliations added 167 new trainee positions for psychologists in four new internship programs, and 26 new postdoctoral fellowship programs. In addition, VHA has expanded mental health training opportunities by 30% over the last five years, and has performed a targeted expansion for psychology with a 60% increase in training in rural and highly rural facilities.

Peer Specialists. Mental Health Services provided immediate funding to hire permanent peer specialists, a new and emerging occupation in VA, in FY 2012. Peer specialists perform a variety of therapeutic and supportive tasks that include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services. To be hired as a peer specialist, the applicant must be a Veteran, must be or have been in recovery from a mental illness, and must be certified to provide peer support services. There is also a position description for a GS-5 peer support apprentice. This is an entry-level grade that does not require the applicant to be certified to provide peer support services. Peer support apprentices will be able to access certification in VHA and must become certified before they can move into the peer specialist position.

0602 Medical Officer (Physician)

For the last three years, physicians were ranked as the top occupation for recruitment and retention priorities in VHA. The following factors have contributed to persistent physician recruitment demand. Physician workforce expansion, while slower than past years, is still at 3.2% in FY 2011. Total losses continue to climb annually because of an increased number of retirements and resignations. Programmatic expansions and re-designs in Mental Health, as well as implementation of the Primary Care PACT model, has contributed to continued physician demand. This year, VHA's Healthcare Assessment and Information Group has begun an analysis of physician specialists as a start of VHA Transformation of Specialty Care, an area neglected in recent physician expansion initiatives. Increases in the number of enrolled Veterans and in the scope of services offered have additionally increased demand for physicians. Aggregate data from the 21 Veteran's Integrated Service Networks (VISNs) identified the top six physician specialty recruitment challenges to be Psychiatry, Gastroenterology, Orthopedic Surgery, Primary Care, Diagnostic Radiology, and Anesthesiology.

Top Physician Specialties

31-Psychiatry

25-Gastroenterology

07-Orthopedic Surgery

P1-Primary Care

38-Radiology – Diagnostic

1-Anesthesiology

The Patient Protection and Affordable Care Act (PPACA, H.R. 3590 as amended by H.R. 4872) contains provisions that impact physician workforce planning. With regard to demand for physicians, the PPACA provides new insurance coverage for an estimated 32 million Americans and will likely increase demand for physician services for both primary and specialty care. Besides more people being insured, the largest growth in the U.S. population will be in those greater than 65 years of age, the people that consume the greatest health care resources.

With regard to physician supply, it remains uncertain how physicians who are currently practicing will respond to changes brought by health care reform. In 2010, 25.2% of U.S. physicians were 60 years or age or older, and by 2020 it is projected that one third of all active physicians will be over 55 years of age. The American Association of Medical Colleges predicts there will be a massive physician deficit of 62,900 by 2015 and 130,600 physicians by 2025. National problems with maldistribution of physicians relative to demand are likely to continue. The variance across the U.S. is significant ranging from 176.4 to 415.5 active physicians for every 100,000 persons. The lowest ratios are in the South and Mountain West while the highest are in the Northeast. This pattern of physician supply is largely the opposite of Veteran demand.

In order to address issues with supply and demand of physicians, VHA must establish aggressive recruitment and retention strategies. First, the organization must utilize all its current authorities (salary, recruitment, relocation and retention), adapting them to the individual market demand and interests of the applicant. Second, capitalize more on educational and training programs. The AAMC has reported that 67.4% of MDs that receive their Under-Graduate Medical Education (UME) and Post-Graduate Medical Education (GME) stay in that state to practice. Further, 47.8% of physicians who only get their GME will stay or return to that state for practice. This supports VHA's continued investment and participation in these training programs and makes the case for targeting recruitment to graduates. Third, adapt positions to accommodate those applicants wishing alternate work schedules or part-time employment consistent with generational data of those entering the workforce and

transitioning to future retirement. The need to attract and retain excellent physicians is expected to continue as a key workforce issue for VHA into the foreseeable future.

Recruitment and Retention Challenges

Data from the VHA New Employee Entrance Survey (FY 2010 & FY 2011) shows that physicians who responded to the survey in FY 2011, indicate that their primary source of learning about job opportunities in VHA was from a VA employee, a friend or family member. These data are consistent with physician recruitment research that indicates physicians typically find new employment opportunities by networking with colleagues. Additionally, physicians ranked the VACareers job site (www.vacareers.va.gov) as the third highest source of information about VA job opportunities. More than twice as many physicians report finding their career opportunities on VACareers than on the USAJobs site. USAJobs was the fourth most frequently cited employment information source, followed by colleges and universities.

A study of 2011 Residents and Fellows, by CEJKA Search, revealed that 74.7% of new physicians report using networking as a key job search method. The CEJKA Search Survey also indicates that 67.5% of Residents and Fellows report responding to job opportunities that were received by e-mail. While that sourcing strategy was not in the top five for VA, it has increased as a selected response on the new employee survey because national recruiters and others have begun to use e-mail blasts to reach potential job candidates. Physicians also rely rather heavily on Physician Recruiters for information about job placement opportunities with 61.4% of new physicians reporting reliance on that group for employment opportunities and online job boards reported as a fourth source.

The two largest groups of physicians seeking part-time employment are young female physicians, who tend to seek flexible schedules to accommodate family matters, and baby-boomer and mature physicians, who are seeking part-time employment in advance of retirement. Because physicians tend to retire later than the general employee population, working part-time is a win-win for VHA and for the talented physicians seeking work-life balance prior to retirement.

Physician Recruitment Strategies

- Create a formal system of physician recruitment ambassadors within each VHA facility. Identify key managers/physicians/nurses/other employees who are well networked within the physician academic and private practice communities and provide them with current lists of physician vacancies & ideal candidate profiles. These ambassadors can actively use their networks to help identify great candidates for current and future vacancies.
- Post vacant positions to VACareers through USAJobs with a clearly defined candidate profile included. Instruct interested candidates to submit or mail a CV directly to a designated recruiter. Use the Recruiters' Toolkit Internet Posting Planner to then link the open job posting to multiple occupationally specific/professional association and niche job boards to more broadly communicate the job posting. As CVs are received, the designated recruiter/HR specialist can then qualify candidates within 48 hours; perform a pre-credentialing screening and forward qualified candidates directly to hiring managers and schedule an initial interview.
- Establish strong productive relationships with medical affiliates and their residency training program managers. Provide recruitment briefings to all medical residents and fellows rotating through the VHA facility.

- For the most complex, hard-to-fill physician positions contact the national recruiter assigned to your VISN and request assistance in recruitment.
- Design creative incentive packages to help recruit strong candidates. Remember, not all incentives are monetary. Use a combination of salary realistically based on local markets, performance incentives, educational debt relief, relocation incentive and recruitment incentives (hiring bonuses) combined with flexible work and call schedules. Develop compensation strategies that evolve with the physicians' career stages; early, mid and late career practitioners will have different compensation needs and motivators. Early career candidates look for guaranteed compensation and advanced technology. Mid career candidates seek productivity based compensation and leadership opportunities. Late career candidates seek flexibility, flexible hours and quality of life.
- Redesign the staffing mix and medical practice setting to allow for greater employment of part-time physicians to capitalize on the growing number of practitioners seeking less than full-time employment.

For more detailed information about the VHA medical officer (physician) workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at

<http://vaww.sucession.va.gov/2013supplemental>.

0610 Nurse (Registered Nurse)

VHA directly employs almost 54,000 registered nurses at more than 1,609 sites of care, including hospitals, community and facility-based clinics, nursing homes, domiciliaries, readjustment counseling centers, and various other facilities.

As VHA continues to grow to meet the needs of Veterans, the demand for registered nurses (RNs) continues to increase as well. It is estimated that by 2020, VHA will be serving close to 8.8 million Veterans and meeting their mental health, chronic disease management, preventative care, and care coordination needs. VHA is currently experiencing difficulty recruiting and retaining RNs who possess the advanced professional skills, knowledge and experience to deliver the care necessary for these cohorts of Veterans and increase access to critical services for underserved populations and rural areas. By FY 2018, approximately 42% of VHA nurses will be eligible for retirement. While retirements have increased for the general population of RNs, the number is nearly double for nursing administrators and advance practice nurses.

Indicators of a National Nursing Shortage

A fact sheet authored by the American Association of Colleges of Nursing (AACN; 2012) consolidates information on a number of indicators of current and projected shortages for Nursing. According to the site:

- The Bureau of Labor Statistics (BLS, 2012) estimates an increase in the number of employed nurses to 3.45 million in 2020, an increase of 26%. Further, BLS estimates 1.2 million job openings for nurses will exist by 2020 due to growth and losses.
- A report in the American Journal of Medical Quality (Juraschek, Zhang, Ranganathan, and Lin, 2012) states that although a nationwide shortage of nurses is predicted between 2009 and 2013, it is expected to be most intense in the South and the West.
- A May 2001 report by the University of Illinois College of Nursing (Stone and Wiener, 2001) states that growth in the elderly population between 2010 and 2030 will result in a 40% decrease in the ratio of caregivers to elderly unless the number of nurses and other caregivers grows in proportion.
- The AACN (2012) also reported a 5.1% increase in enrollment in baccalaureate nursing programs in 2011; however, this increase will not be sufficient to meet the projected demands for nurses that are expected as a result of implementation of the Patient Protection and Affordable Care Act. Furthermore, AACN reported that U.S. nursing schools turned away 75,587 qualified applicants due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints.

VHA Top Nurse Specialties

Consolidated data from VISN Workforce Succession Strategic Plans identified the following RN specialties as priorities for recruitment and retention:

RN Manager/Head Nurse –Nurse Managers function as front-line supervisors, and handle the needs of patients, staff, and hospital administration. They are often stretched over multiple units, and have a large workload. In June 2010, the Office of Nursing Services (ONS) initiated a national, standardized training program for new and existing nurse managers to increase skills in budget

management, microsystems, retention strategies, and leadership in an effort to blend and balance both the clinical and business management skills, that are essential to retention.

Staff Nurse – VHA staff nurses serve not only in medical and surgical care units, but also intensive care units and outpatient clinics. Because Med/Surg is typically an entry point for new RN staff who then seek specialization to transition into Intensive Care Unit (ICU) and clinic settings, retention of Med/Surg nurses is difficult. This results in a disproportionate staffing mix of novice nurses to experienced nurses, especially during off tours. Additionally, more and more sophisticated procedures, once performed only in hospitals, are being performed in outpatient care centers. As a result, the need for nursing personnel at the staff nurse level with this skill set is expected to grow quickly, adding to an already significant need for qualified and experienced nursing staff.

Nurse Practitioner (NP) – NPs are RNs who are prepared, through advanced education and clinical training, to provide preventive and acute health care services to individuals of all ages. They have completed a master's or doctoral degree in the diagnosis and management of medical conditions, hold an advanced practice registered nursing license and a national board certification through the American Nurses Credentialing Center or American Academy of Nurse Practitioners, and provide a broad range of acute and chronic health care services. ONS is pursuing a policy to ensure all VHA Advanced Practice Registered Nurses (APRNs) are Licensed Independent Practitioners (LIP).

Nurse Practitioner (NP) for Mental Health Substance Use Disorder – NPs for mental health substance use disorders (SUD) provide a holistic, integrated approach to needed health care services. They are trained in physical diagnosis, health promotion, pharmacology, pathophysiology and chronic disease management (Puskar, 1996). Psychiatric NPs address high costs, limited access to care, and quality improvement. They perform physical assessments to treat the chronic health conditions that may be caused or exacerbated by the SUD, and provide screenings, short term treatment and referrals to specialists when needed, identify social factors and problem solve with patients to deliver care.

RN/Staff-Outpatient – The increase in outpatient and ambulatory care in the health care industry has been driven by advances in technology that allow for more care to be delivered in the outpatient setting. Additionally, changes in care delivery models within VA have created increased demand for skilled nursing personnel in the outpatient setting. The outpatient RN role has become critical with the implementation of such national initiatives as Patient Aligned Care Teams (PACT), Specialty Care, and Specialty Care Access Network and Extension for Community Healthcare Outcomes (SCAN-ECHO) projects. Furthermore, the increase in VA Women's Health clinics, both as stand-alone clinics and embedded into PACT, and "mini" residencies have contributed to the demand.

RN/ Informatics Nurse – According to the American Nurses Association, "Nursing Informatics (NI) is a specialty that integrates nursing science, computer science, and information science to manage and communicate data, information, knowledge, and wisdom in nursing practice. NI supports consumers, patients, nurses, and other providers in their decision-making in all roles and settings. This support is accomplished through the use of information structures, information processes, and information technology." The Chief Nursing Informatics Officer plays a key role and represents the bridge between clinical practice and informatics that transforms patient care delivery for the entire organization. Recent federal health care reform legislation promoting the adoption and use of electronic health records has greatly increased the demand for highly skilled health informatics employees. The Bureau of Labor statistics estimates a national shortfall of 35,000 health information technology

workers by 2018. This shortfall will impact VHA's ability to recruit and retain qualified informatics staff necessary for health care operations. As of April 2012, 43% of Informatics Nurses in VHA are eligible to retire (American Nurses Association, 2008).

The Clinical Nurse Leader

A CNL is a master's prepared advanced generalist nurse who uses evidence-based practices to facilitate and coordinate care for groups of patients and provides direct patient care in complex situations, engaging other nurses and members of the care delivery team to affect positive patient outcomes. The CNL works at the microsystem point of care as an advanced "generalist" to promote excellence in nursing practice, and to coordinate and optimize quality patient care delivery.

The Office of Nursing Services (ONS) continues to promote and support CNL implementation as part of its Clinical Nurse Leader Spread Plan. The objectives of this plan are to overcome barriers to implement and sustain the CNL role, to employ and fully integrate the CNL role into the patient care delivery model, to objectively embed quality, safety, and efficiency into patient care delivery, and to enhance collaborative partnerships with affiliating schools of nursing and inter-professional teams. The activities of the CNL Spread Plan, which are described below, include focus on developing the VHA nursing workforce and providing opportunity for expert nurses who desire to remain in direct care roles to provide practice leadership and microsystem influence.

Clinical Nurse Leader Implementation and Evaluation Service. ONS has partnered with the Central Texas Veterans Healthcare System and Portland VA to support a team of two consultants and two administrative staff to provide consultative assistance to VA Medical Centers, academic affiliates offering a CNL curriculum, individual CNL students and preceptors, and practicing CNLs regarding clinical practice, clinical immersion training, and CNL role implementation, sustainment, and evaluation. Services provided by the team include consultative site visits, virtual training, strategic planning and consultative support, increased access to resources and practice networks, and development of core metrics for evaluating the impact of the CNL role on patient and system outcomes.

Academy for the Improvement of Microsystems (AIM) is a collaborative partnership between ONS and the Midwest Mountain Veterans Engineering Resource Center (VERC) to foster development of CNLs using an inter-professional approach that emphasizes systems redesign and performance improvement. AIM serves as a foundation to guide medical center leaders toward implementation and sustainment of the CNL, and to evaluate practice outcomes. Cohorts of VA medical centers, coming together in a combination of face-to-face and virtual collaborative learning sessions, are engaged in quality and safety practice improvements utilizing the CNL role at the microsystem level.

Clinical Nurse Leader Transition to Practice Curriculum was developed by seasoned practicing CNLs and education program subject matter experts. It is a self-paced program to guide novice CNLs and CNLs new to the VA system as they transition from academic training to establishing CNL practice. The curriculum includes preceptor-guided activities designed to facilitate CNL practice integration into microsystem care delivery. The learning domains include role differentiation, care outcomes management, clinical environment management, data management, and using evidence to guide practice.

Recruitment and Retention Solutions

VHA continues to coordinate system-wide, comprehensive programs for recruiting qualified and talented RNs, including internships for nursing students, such as the VA Learning Opportunities Residency (VALOR), attending health career job fairs, participating in speaking engagements, and developing and enhancing relationships with schools of nursing. In addition, VHA offers incentives such as scholarships and loan repayment programs, including VA National Employee Education Program (VANEED), National Nurse Education Initiative (NNEI), Employee Incentive Scholarship Program (EISP), and Education Debt Reduction Program (EDRP), which continue to be viable recruitment and retention strategies. In addition, the National Recruitment Program works to change the paradigm of how VA sources and recruits nursing staff and other highly qualified clinical professionals.

The Office of Nursing Services (ONS) continues to work closely with stakeholders, while upholding the VA Core Principles and Characteristics, to implement not only the national mission on VA Nursing recommendations, but also the carefully integrated [VHA National Nursing Strategic Plan: 2012-2016](http://vaww.va.gov/NURSING/About_ONS.asp) (http://vaww.va.gov/NURSING/About_ONS.asp). Recruitment and development efforts within ONS involve a wide range of initiatives and strategies to attract, hire, and retain RNs into the organization, many of which are described in the supplemental report (see link below). For additional information please visit the ONS Internet site (<http://www.va.gov/nursing/>) or intranet site (<http://vaww.va.gov/NURSING>).

For more detailed information about the VHA nurse (registered nurse) workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.



0201 Human Resources Management

HR practitioners provide the connection between the front line supervisor and top level executive management officials to attract and retain quality employees with the appropriate competencies in mission critical occupations. In the past, HR Practitioners assisted with administrative functions such as handling employee benefits, recruiting and placing employees, managing employee relations and processing personnel transactions. Today's HR practitioners continue to manage these functions; however their role has evolved into that of a consultant to employees, managers, and top executives both inside and outside their facility regarding the strategic planning process for human capital. As a result, they suggest and change policies and link HR functions with the mission and vision of the organization. As strategic planners, they routinely adapt services to meet the client's recruitment and retention needs. They design and carry out HR services that incorporate business systems, and use HR principles to change HR business practices to improve efficiency and effectiveness. They strive to enhance morale and productivity, limit job turnover, and help organizations identify areas to increase performance and improve business results by recommending methods to increase employee satisfaction and identifying ways to improve working conditions.

The Bureau of Labor Statistics (BLS) projects a growth rate of 21% between 2010 and 2020 for all HR practitioners and a 13% increase for HR managers. This continued growth is due, in part, to complex employment laws, health care coverage options, increased emphasis on the importance of finding and keeping quality, high performing employees, as well as legislation and court rulings that have set standards in various areas such as occupational safety and health, EEO, wage determinations, retirement planning, family leave and work-life programs. There is also an increased demand for HR practitioners who have expertise in training and labor relations. Furthermore, many job opportunities will continue to arise from the need to replace workers due to turnover.

The extensive and complex knowledge required by VHA's HR practitioners is unique in the federal sector. In addition to maintaining knowledge of basic federal personnel management principles, VHA HR professionals maintain knowledge of both Title 38 and Title 5 pay systems, and operate in an environment that continues to experience significant change. They have been tasked with identifying improvements in the timeliness and efficiency of HR product delivery and services, and assisting managers in recruiting and retaining employees in more than 300 occupations.

The current cadre of seasoned HR professionals is decreasing with losses attributed to transfers to other federal agencies and retirements. Retirements are expected to continue to create additional losses of valued technical HR expertise. To address these issues, VHA offers two extensive training programs, the ***Technical Career Field (TCF) Program for HR Interns***, and the ***Master's Program for HR Assistant Chiefs***. Additional information on the Master's program can be found in Chapter 7, Developing Leaders At All Levels.

Staffing levels for HR professionals within VHA continue to be far below those of other federal agencies. At the end of FY 2008, VHA mandated an ***HR Hiring Initiative***, reinforced by the 2010 HR Delivery Model, which required VISNs to hire a specified number of HR professionals each year for four years. The goal was to bring the staffing ratio to 1 GS-201 HR practitioner for every 85 VHA employees by the end of 2012, a ratio that is closer to that of other federal agencies which, according to OPM's most recent *Human Resources Line of Business Agency HR Benchmarking Report* (September, 2010), is 1 to 60.7 employees. As a result of this initiative, the VHA ratio went from 1:142 in August 2008, to 1:106 in

July 2012. For VHA to have continued success and approach the targeted HR staffing ratio, executive management support is critical.

To meet the strategic needs of the organization VHA must continue provide HR supervisors with vital training on subjects such as mentoring and coaching, refresher training for technical HR knowledge and competency based models to follow when supervising employees. The following strategies and initiatives will improve the ability to hire and retain competent and highly skilled HR Practitioners:

- Continue implementation of the VHA HR Delivery Model. The HR Delivery Model provides a comprehensive solution for improving the delivery of HR services in VHA through efficient business practices and redesign efforts that are cost effective, leverage current resources, and utilize consistent, accurate, timely and measurable HR services to meet mission goals for management, supervisors and employees. The Model includes a comprehensive staffing plan with ratios for HR Practitioners, specific IT and automation initiatives (WebHR), expanded HR development and competency-based training and HR performance and accountability metrics. In 2011 VHA implemented the HR CARDS (Consult/Assist/Review/Develop/Sustain) team to provide each field HR office with an annual consultation/assessment performed by a cadre of highly trained technical HR Consultants. The implementation of the HR Dashboard (performance metrics) and the HR QuickCard customer service satisfaction survey has placed additional emphasis on critical HR functional areas.
- Continue automation efforts and continue to provide tools to fully integrate and implement the WebHR components developed by the Healthcare Talent Management (HTM) office. WebHR is the sole source for automated SF-52's and continues to become a comprehensive tool for automating many HR processes and providing data and numerous reports regarding the effectiveness and timeliness of local HR offices.
- Continue information technology efforts to integrate HR automated systems, reports, including USA Staffing, Vet Pro, WebHR and e-QIP.
- Continue to focus on new strategies and systems redesign elements to improve timeliness of all transactional HR functions and to foster the sharing of strong practices among the HR community.
- Expand the current HR Development (HRD) model to include a virtual Learning Program for HR professionals and traveling training corps to train HR staff in the VISN on beginner, intermediate, and advanced HR subjects.
- Continue to enhance the HR Cluster Café Series and other HR competency based training. The HR Cluster Café series has continued to provide essential training for both new and experienced HR professionals and will continue to increase their technical skills and develop core HR competencies.
- Consolidate services and establish consolidated units to provide services such as Classification and Retirement either locally or through virtual methods in accordance with the HR Delivery Model.
- Continue to focus on utilization of tools to enhance the employee's work experience such as telework, compressed work schedules, and virtual work assignments.

For more detailed information about the VHA human resources management workforce, refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at

<http://vaww.succession.va.gov/2013supplemental>

0633 Physical Therapist

The Bureau of Labor Statistics predicts that employment of physical therapists (PT) will grow 39% from 2010 to 2020, much faster than the average for all occupations. The impact of proposed federal legislation imposing limits on reimbursement for therapy services may adversely affect the short-term job outlook for physical therapists. However, the long-term demand for physical therapists should continue to increase as new treatments and techniques expand the scope of physical therapy practices. BLS indicates job opportunities for PTs should be especially good in acute hospital settings, skilled nursing, and orthopedic settings where the elderly are most often treated. Moreover, the increasing elderly population, which is typically more vulnerable to chronic and debilitating conditions, is expected to drive growth in the demand for physical therapy services, including cardiac and physical rehabilitation. Advancement in medical technology will permit a greater percentage of trauma victims to survive, creating additional demand for rehabilitative care.

VHA anticipates growth in the need for rehabilitation therapies because of the greater therapeutic needs of returning OIF/OEF Veterans due to traumatic injuries and the comorbidities of orthopedic, sensory, PTSD, and other injuries sustained in combat. The influx of new Veterans, combined with the increasing age of VHA's traditional Veteran population and increased emphasis on non-institutional care, telerehabilitation, and rural health coverage, will contribute to growth in this occupation within VHA. Strategies for efficiently utilizing non-VA care for PT services will be critical for meeting the increasing rehabilitation demand of our Veterans. National Pain Management Strategies for alternative forms of therapies will require improved collaboration between PTs and primary care providers. As the focus on alternative pain strategies and therapies are highlighted, PTs will have to expand the types of services provided and modify scopes of practice and clinical practice guidelines to meet the increasing complexity and volume of rehab services. VHA's mandate to have a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited pain management program by 2014 will be a driving force behind the need for increased collaboration.

A variable that may affect demand for therapists is the role played by Physical Therapy Assistants (PTA) in the delivery of services. PTAs working closely with clients under the guidance of a physical therapist should help meet demand, and may help reduce the magnitude of any shortages of therapists that may arise. Utilization of PTAs for provision of therapy services needs to be considered wherever possible.

The challenge of many of our VHA health care systems is establishing and maintaining competitive salary rates for PTs, many of which are now entering the work force as doctoral prepared professionals. "Credential Creep" is becoming more prevalent as universities combine masters and doctoral PT degrees into one program. In 2009, VHA revised the PT qualification standard to help address some credential creep issues; however, VHA will have to make a concerted effort to retain new PTs entering VHA at the top of their occupation. VHA will need to provide other avenues of career growth for PTs such as leadership development opportunities or increased scopes of practice.

A national PT Supervisory Forum has been established in order to assist new and experienced supervisors in their leadership roles. The forum provides networking opportunity for sharing best practices within the PT community. In order to mitigate recruitment difficulties, many VISN's within VHA have focused on improving and monitoring affiliation agreements with local colleges and universities in hopes of attracting new graduates to VHA. Pay freezes and other budget constraints will contribute to the difficulty many facilities are experiencing in the recruitment and retention of higher level PT graduates.

Increases in trainee positions through VA's Office of Academic Affiliations (OAA) could mitigate the risk associated with competition from the private sector. In addition, local physical therapist VA Learning Opportunities Residency (VALOR) programs may be considered for those networks with high losses for physical therapists who return to school along with other recruitment and retention incentives, such as Education Debt Reduction Program (EDRP), Employee Incentive Scholarship Program (EISP), and the Student Loan Repayment Program (SLRP).

Additional information about the physical therapy field can be found at the American Physical Therapy Association (APTA) website: <http://www.apta.org>.

Recruitment Strategies

- Establish a PT Recruitment Ambassador program to share job opportunities with current PTs so they can help share employment information with their non-VA PT colleagues.
- Search the USAJobs database for previously posted PT positions and contact qualified candidates to determine interest in current vacancies. Refer interested candidates directly to hiring managers.
- Retain resumes of qualified candidates and upload them in the VHA Applicant Tracking System.
- Expand recruitment outreach at each affiliated Schools of Physical Therapy. Develop a standard recruitment presentation and have Rehabilitation Service Managers schedule employment briefings at each school. Collect resumes/CVs from students and enter them into the VHA Applicant Tracking System (ATS).
- If there are no candidates in ATS, post vacant positions on www.vacareers.va.gov and have interested candidates submit or mail their CV directly to the Recruiter /HR Specialist for immediate qualification and pre-screening of credentials. Within 48 hours of CV submission, forward qualified candidates directly to hiring managers for review.

For more detailed information about the VHA physical therapist workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

0644 Medical Technologist

The Occupational Supply Demand System for the U.S. Department of Labor reports a national average annual demand of 5,330 medical technologists and with an average annual supply of only 3,014. A survey conducted in 2011 by the American Society for Clinical Pathology indicates that vacancies in laboratory occupations are highest in blood banking (11.6%), chemistry (8.6%), hematology (7.0%), and microbiology (6.8%). The Bureau of Labor Statistics (BLS) reports the number of medical technologist job openings is expected to continue to exceed the number of job applicants, projecting an 11% growth in employment from 2010 to 2020. BLS estimates that 19,200 new medical technologists will be needed by 2020 as the volume of laboratory tests continues to increase with both population growth and the development of new types of tests.

The increasing age of the Veteran population, along with more emphasis on personalized medicine, intensifies the demand for laboratory services within VHA. Technological advances continue to have opposing effects on employment since new, more powerful diagnostic tests and accelerated advances in genomics will increase testing volume and spur employment; however, research and development aimed at simplifying and automating routine testing procedures may enhance the ability of non-laboratory personnel, such as physicians and patients, to perform tests currently conducted in laboratories. While these simplified procedures will make routine tests more available to patients, more qualified medical technologists will be required to oversee minimally-trained, non-laboratory personnel performing these tests to ensure quality results are provided.

The VHA qualification standard for medical technologists requires the passing of an appropriate certification exam within one year of employment – a requirement not yet standard in the private sector – that may exacerbate recruitment challenges and competition with private sector employers. Several VA facilities have partnered with local academic institutions to offer medical technologist training programs, thereby creating a direct recruitment pipeline. Alternative education options and academic affiliations should be explored in VISNs that have difficulty recruiting medical technologists.

Recruitment and Retention Strategies

- Offer tuition support through the EISP and career counseling to medical technicians to help them transition to technologist positions.
- Utilize the Pathways Internship Program and VA Learning Opportunities Residency (VALOR) appointments to create a pipeline of qualified candidates.
- Utilize recruitment resources available through the VHA Healthcare Recruiters' Toolkit, especially EasyPost. This tool provides free postings to a variety of national job boards, including Monster, CareerBuilder, and HealthCareers.
- Expand marketing efforts to national job boards beyond VA Careers and USA Jobs.
- Publicize job opportunities to internal staff and promote local referral incentive programs to the fullest extent.
- Establish a Recruitment Ambassador for internal medical technologists to share information about VHA employment opportunities with their non-VA colleagues.
- Review Hay Group or local salary survey data regularly and adjust pay schedules adjusted in accordance with guidelines in Human Resources Management Letter (HRML) 05-11-06, in order to remain competitive with local private sector salaries.

- When budgets allow, consider the use of recruitment, retention, and relocation incentives as well as the EDRP and the SLRP for hard-to-fill medical technologist positions.
- Search the USAJobs database for previously posted positions and contact qualified candidates to determine interest in current vacancies. Refer interested candidates directly to hiring managers.
- Retain resumes of qualified candidates and upload them to the VHA Applicant Tracking System.
- Expand recruitment outreach to affiliated Schools of Medical Technology. Develop a standard recruitment presentation and have Laboratory Service Managers schedule employment briefings at each school. Collect resumes/CVs from students and enter them into the VHA Applicant Tracking System (ATS).
- If there are no candidates in ATS, post vacant positions on www.vacareers.va.gov and have interested candidates submit or mail their CV directly to the Recruiter /HR Specialist for immediate qualification and pre-screening of credentials. Within 48 hours of CV submission, forward qualified candidates directly to hiring managers for review.

For more detailed information about the VHA medical technologist workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at

<http://vaww.succession.va.gov/2013supplemental>.

0660 Pharmacist

The Bureau of Labor Statistics (BLS) projects a 25% growth in employment of pharmacists from 2010 through 2020, requiring 69,700 new pharmacists in the United States. The Occupational Supply and Demand System for the U.S. Department of Labor reports an average annual demand of 10,580 and an average annual supply of 11,873 Doctor of Pharmacy graduates, which signifies more balance between supply and demand.

One significant contributor to the shift from demand to supply is the increasing number of pharmacy schools opening across the country. As of March 2012, there were 102 accredited and 8 pre-candidate schools of pharmacy in the United States with an additional 17 schools being explored. In December 2011, the American Society of Health-System Pharmacists (ASHP) published a job market perceptions survey of ASHP student and new practitioner members to assess their attitudes and experiences with the current pharmacist job market. Key findings of the survey are that pharmacy school graduates started their job searches earlier in 2011 and applied for more positions and residencies than peers who graduated in previous years. Moreover, 95% of 2010 pharmacy school graduates, and 84% of those expecting to graduate in 2014, agreed or strongly agreed with the statement, “I am concerned that the supply of pharmacists is outpacing the demand for pharmacists and will impact my future.”

The surge of Doctor of Pharmacy graduates is causing an increase in the number of candidates pursuing residency training in order to be more competitive for a position in pharmacy practice, a phenomenon also referred to as “degree” or “credential creep.” The ASHP and the American College of Clinical Pharmacy (ACCP) are advocating for residency training to be a prerequisite by the year 2020 for new pharmacy graduates who will provide direct patient care. The ASHP utilizes National Matching Services, Inc. (NMS) to match pharmacy residency applicants with a residency program. Nationally, the number of pharmacy residency applicants exceeds the number of positions available. The 2012 “match” was no exception with only 2,408 postgraduate year one (PGY1) positions offered to 3,706 match participants, resulting in an excess of 1,298 applicants.

Academic affiliations, the pharmacy residency program, the Pathways Internship Program, and the VA Learning Opportunities Residency (VALOR) Program continue to function as effective recruitment pipelines for pharmacists. In fact, the number one job opportunity source identified by newly hired pharmacists in VA was an educational affiliation. VHA trained more than 400 PGY1 and PGY2 pharmacy residents during the 2011-2012 academic year. Not every facility that is capable of supporting residency training has a program established, so there is room for growth. Student and resident positions should be utilized to the fullest extent possible, especially in rural areas that traditionally have greater difficulty recruiting quality candidates. The special hiring authorities available for these candidates provide another recruitment advantage and allow for a smooth transition from student/resident to full-time VA pharmacist.

As more pharmacists pursue first-year postgraduate training, second-year pharmacy residencies will become increasingly popular (and necessary), as will earning national board certification. As of January 2011, the Board of Pharmacy Specialties (BPS) reported VA has 1,313 board certified pharmacists, which represents approximately 19.9% of all VA pharmacists (6528), and 10.2% of all board certified pharmacists globally (12,900). In October 2011, BPS administered the Ambulatory Care specialty certification exam for the first time, and 117 VA pharmacists successfully passed the exam, which represents 22.5% of all Ambulatory Care certified pharmacists globally (518). The breakdown of board certified VA pharmacists by specialty is as follows: Pharmacotherapy, 1,017; Psychiatry, 123;

Ambulatory Care, 117; Oncology, 29; Nutrition Support, 20; and Nuclear, 7. The 59% increase this year over last year in the number of board certified VA pharmacists is consistent with the ongoing expansion of VA clinical pharmacy services.

Due to the increased training that new practitioners receive, graduates of PharmD and residency programs have a desire for more clinical functions. They want more patient interaction and a challenging work environment resulting in an increased demand for “clinical pharmacist” positions; however, the increased competition in the job market is making it more difficult for new graduates without residency training to obtain clinical pharmacist positions in hospitals. Several VA facilities are requiring at least one year of residency training (or equivalent experience) for pharmacist positions and two years for clinical pharmacy specialist positions.

The issues described above have led to the ASHP Pharmacy Practice Model Initiative and the development of integrated staffing models for pharmacy services, a combination of clinical and distributive work for each pharmacist. The proceedings and recommendations from the November, 2010, ASHP Pharmacy Practice Model Summit were published in the June 15, 2011, issue of the *American Journal of Health-System Pharmacy*. The following issues were among those commonly addressed in the design of contemporary pharmacy practice models: “definition of core clinical services, unit-based pharmacist collaboration with patient care teams, specially trained pharmacists for high-risk medication use, integration of pharmacy generalists and specialists, competency assurance of pharmacists, use of residents and students as pharmacist extenders, and use of technicians and technology in drug distribution.” One of the key recommendations made during the summit was that “in optimal pharmacy practice models, individual pharmacists must accept responsibility for both the clinical and the distributive activities of the pharmacy department.” The 2009 ASHP national survey on monitoring and patient education reported that 24.4% of hospitals have a drug-distribution-centered model; 64.7% of hospitals have a patient-centered integrated model with clinical generalists who have distributive and clinical responsibilities; and 10.9% of hospitals have a clinical specialist model with separate roles for clinical staff and distributive staff (note: data does not include VA facilities). Considering the recommendations of the Summit, it is expected that utilization of an integrated staffing model will increase, while the percentage of hospitals using a drug-distribution-centered model will decrease. In order to continue to recruit and retain highly qualified pharmacists, VA facilities will need to be actively engaged in the practice model transformation that is occurring nationally.

Nationally, the Healthcare Retention and Recruitment Office (HRRO) and the Pharmacy Recruitment and Retention Office (PRRO) within Pharmacy Benefits Management Services (PBM) have put forth extensive efforts towards recruitment and retention. In conjunction with HRRO, PRRO coordinates representation at national, regional, and state pharmacy recruitment events. PRRO also coordinates the pharmacy field recruiters representing every Veterans Integrated Service Network. PRRO provides recruitment and retention information for the field through a monthly newsletter, *Pharmacy News*, published in collaboration with the PBM Clinical Pharmacy Program Office. PRRO also maintains a SharePoint site that includes leads obtained from recruitment events. PRRO also collaborated with HRRO and a third party marketing firm to develop two email blasts: one targeting pharmacy students and another focused on pharmacy manager recruitment. Both campaigns achieved results higher than industry averages.

The 2011 ASHP Pharmacy Staffing Survey showed national pharmacist vacancy and turnover rates to be stable at 2.4% and 6.1%, respectively. In the survey, pharmacy directors indicated that the biggest

perceived shortage is in the area of pharmacy management. This is consistent with input from VISN workforce succession plans and statistics on supervisor retirement eligibility. To ensure a smooth transition and continuation of services in the face of these projected retirements, facilities must continue proactive efforts to identify and develop future pharmacy managers and to recruit for replacements at least six months prior to a known potential vacancy. In support of these efforts, PRRO is sponsoring up to four VA pharmacists to attend the 2013 ASHP Foundation Pharmacy Leadership Academy. Additionally, Pharmacist Executive Pay (a special pay incentive up to \$40,000) was approved in 2011 (VA Handbook 5007/38, Part VIII, Chapter 17) to help alleviate salary disparities for PBM Consultants, CMOP Directors, and VISN Pharmacist Executives.

The Pharmacy Hay Group salary survey data, released each fall by the Office of Human Resources Management (OHRM) and VHA's Workforce Management and Consulting (WMC) office, provides national, regional, and some limited local market-based salary data. These data allow for more accurate and timely salary adjustments that will help facilities compete with their local labor market. Special salary rates, recruitment, retention, and relocation incentives as well as the EDRP and SLRP can and should be utilized for difficult-to-fill positions when funding is available. In these times of economic austerity, focus should be placed on non-financial incentives for pharmacists (e.g., job stability, developmental opportunities, stable federal benefits, time off awards, flexible work schedules, telework, and leave negotiation for experienced pharmacists).

Recruitment and Retention Strategies

- Expand recruitment outreach at each affiliated School of Pharmacy. Develop a standard recruitment presentation and have hiring managers schedule employment/fellowship briefings at each school. Collect resumes/CVs from students and enter them into the VHA Applicant Tracking System (ATS).
- Utilize the ATS as a source for job candidates, after first considering internal candidates. Send best qualified candidates to the hiring manager for review/interview.
- If there are no candidates in ATS, post vacant positions on www.vacareers.va.gov and have interested candidates submit or mail their CV directly to the assigned recruiter for immediate qualification and pre-screening of credentials. Within 48 hours of CV submission, forward qualified candidates directly to hiring managers for review.
- Search the USAJobs database for previously posted pharmacy positions and contact previously qualified candidates to determine interest in current vacancies. Refer interested candidates directly to the hiring manager.
- Retain resumes of qualified candidates either in an applicant supply file or upload them into the ATS.

For more detailed information about the VHA pharmacist workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

0180 Psychology

Psychology is an essential mental health profession in VHA that has undergone and continues to undergo significant growth as part of the expansion and transformation of the VA mental health care system to an evidence-based and recovery-oriented system of care. This expansion and transformation process is guided by VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and clinics, which specifies the range of evidence-based and recovery-oriented services that must be available to all Veterans throughout the system, as well as by the VHA Mental Health Initiative Operating Plan, which implements the VA Transformation Initiative: Improving Veterans Mental Health (IVMH).

To further implement these overarching plans and promote mental health care access and care continuity, VHA plans to add an additional 1,600 mental health clinicians by early FY 2013. These new staff positions will include Psychology, as well as other core mental health professions in VHA.

The Bureau of Labor Statistics (BLS) predicts a 22% growth in the Psychologist occupation between 2010 and 2020, which is faster than the average for all occupations. Further, BLS estimates that 37,700 psychologists will be needed by 2020 to meet growth and replacement needs.

As part of its overall strategic plan for expanding and transforming mental health care, VHA is working to:

- Close gaps in and increase capacity of VA mental health care, with the guiding principle that mental health care should be treated with the same urgency as physical health care.
- Transform VA's culture of care to one of psychosocial rehabilitation with a recovery orientation, moving beyond an emphasis only on symptom reduction.
- Transform the delivery system to integrate primary care and mental health services in VHA.
- Provide care that integrates science and practice, resulting in delivery of evidence-based mental health care responsive to emerging research findings.
- Enhance suicide prevention activities.
- Provide accessible, timely services to meet the mental health needs of newly returning Veterans from Afghanistan and Iraq.

Psychologists, including many working in specialty areas, such as neuropsychology and geropsychology, are an integral part of team-based care both in Mental Health clinics and as part of the Patient Aligned Care Teams (PACT). Psychologists provide a range of psychological and cognitive assessment and intervention services for a wide variety of mental and behavioral health conditions. The delivery of evidence-based psychotherapies represents an important area of focus and expansion for VHA psychologists.

Psychologists, along with other mental health professionals, are essential to the delivery of integrated, evidence-based, and recovery-oriented services. Accordingly, with the remarkable expansion of mental health services in VHA, the number of psychologists employed has increased dramatically since 2006. Additional growth in the number of psychologists in VHA is anticipated in FY 2013 as a result of the mental health staff hires noted above.

Clinical psychologists usually require five years to earn a doctoral degree, followed by postdoctoral training. To help increase the supply of these highly trained professionals, VHA has expanded the number of psychology internship and post doctoral fellowship positions. This commitment has been

very valuable, as approximately 70% of staff psychologists in VHA have received some part of their clinical training in VHA prior to their employment. VA provides Internships, Postdoctoral Fellowships, and Practicum Training in many sites across the U.S. With about 480 internship positions at 106 locations, and 260 postdoctoral fellowship positions at 58 sites funded each year, VA is the largest provider of training in Psychology in the nation. Compensation within VHA compares favorably with the BLS national mean.

VA has continued to expand training opportunities and added 70 additional positions for the 2011 - 2012 academic year. These positions included additional internship and post doctoral positions within existing training programs and the development of new internship programs in Boise, ID; Canandaigua, NY; Columbia, SC; Huntington, WV; Indianapolis, IN; Madison, WI; Philadelphia, PA; Tuscaloosa, AL; and West Palm Beach, FL. For the 2012 - 2013 academic year, VA will start nine new internship programs with a focus on the needs of rural Veterans. These programs will be located in Chillicothe, OH; Fargo, ND; Harlingen, TX; Iron Mountain, MI; Nebraska-Western Iowa (based in Omaha, NE); Prescott, AZ; Sheridan, WY; Sioux Falls, SD; and Spokane-Walla Walla, WA. Because these programs have just been created, they are not yet accredited. However, the lack of accreditation will not affect the participants' eligibility for VHA employment. All existing VA Internship and many post doctoral psychology training programs hold American Psychological Association (APA) accreditation status.

For more detailed information about the VHA psychologist workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

0631 Occupational Therapist

According to the Bureau of Labor Statistics (BLS), the occupational therapy (OT) program prepares individuals to assist patients limited by physical, cognitive, psychosocial, mental, developmental, and learning disabilities, as well as adverse environmental conditions, to maximize their independence and maintain optimum health. BLS industry projections estimate that between 2010 and 2020 the demand for OTs will grow by nearly 33%, which is faster than average for all occupations. National BLS statistics indicate the supply of OTs is adequate to meet the demand. Job opportunities for licensed occupational therapists will be excellent in all health care settings; particularly in acute hospital, rehabilitation, and orthopedic settings because of the elderly population that receive their care in these settings. Newly emerging areas of practice for OT's include low-vision rehabilitation; treatment of various types of dementia; mental health care; assisted living; and home modification.

The influx of OEF/OIF/OND Veterans seeking rehabilitation care for traumatic injuries and co-morbidities of orthopedic, sensory, mental health, and other injuries sustained in combat will increase VHA's demand for OTs. Increased Veteran therapy demands will continue to affect Non-VA Care costs. Strategies for efficiently utilizing Non-VA Care for OT services will be critical for meeting those demands. In addition to this increased demand, the complexity of the role of OTs will also increase. For example, they will play a larger role in caregiver training and educational services for Veterans requiring home health services. In addition, national pain management strategies for alternative forms of therapies will require improved collaboration between OTs and primary care providers. As a result, OTs will have to expand the types of services provided and modify scopes of practice and clinical practice guidelines to meet the increasing complexity and volume of rehabilitation services.

Establishing and maintaining competitive salary rates for OTs is a challenge for many VHA health care systems due to "Credential Creep." This phenomenon is becoming more prevalent in regions of the country where doctoral OT degree programs are offered by colleges and universities, and results in more OTs entering the work force as masters or doctoral prepared professionals. In order to retain new graduates, VHA will need to provide other avenues for career growth such as leadership development opportunities or modified scopes of practice. A national OT Supervisory Forum has been established to assist new and experienced supervisors in their leadership roles. The forum provides networking opportunity for sharing best practices within the OT community.

In order to mitigate recruitment difficulties, many VISN's within VHA have focused on improving and monitoring affiliation agreements with local colleges and universities in hopes of attracting new graduates to VHA. Pay freezes and other budget constraints will contribute to the difficulty many facilities are experiencing with recruiting and retaining higher level OT graduates. As a result, the use of Certified Occupational Therapy Assistants (COTA) for provision of therapy services, along with expansion of OT functions may be necessary in order to meet the increased demand for OT services. Utilization of COTAs may help to mitigate the risks associated with shortages of OTs and should be considered when appropriate.

It is recommended that VHA Program Offices and facility Directors survey and analyze the recruitment and retention strategies for OTs to identify strong practices, recruit aggressively to ensure an adequate pool of competitive applicants, and encourage the use of the Education Debt Reduction Program (EDRP), Employee Incentive Scholarship Program (EISP), Student Loan Repayment Program (SLRP), and other leadership and career development opportunities.



Recruitment and Retention Strategies

- Establish an Occupational Therapy Recruitment Ambassador program to help internal OTs share information about job opportunities in VHA with their external OT colleagues.
- Search the USAJobs database for previously posted OT positions and contact qualified candidates to determine interest in current vacancies. Refer interested candidates directly to hiring managers.
- Expand recruitment outreach at each affiliated OT training program. Develop a standard recruitment presentation and have Rehabilitation Medicine Managers schedule employment briefings at each school. Collect resumes/CVs from students and enter them into the VHA Applicant Tracking System (ATS).
- Check the ATS for potential qualified candidates. If there are no candidates in ATS, post positions on www.vacareers.va.gov and have interested candidates submit online or mail their CV directly to the Recruiter for immediate qualification and pre-screening of credentials. Within 48 hours of resume submission, forward qualified candidates directly to hiring managers for review.

For more detailed information about the VHA occupational therapist workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at

<http://vaww.succession.va.gov/2013supplemental>.

0603 Physician Assistant

Physician assistants (PAs) are health care professionals trained at the master's level and credentialed to provide medical services to patients traditionally provided by physicians. PAs provide patient centered medical care to assigned patients in collaboration with a physician. They practice with a significant degree of autonomy and exercise independent medical decision making within their scope of practice. VHA has utilized physician assistants since the occupation was established in the late 1960s and is the largest single employer of PAs in the United States.

PAs receive intensive training using the medical educational model with an average program length of 27 months. The graduate level curriculum includes all major areas of medicine and over 2,000 hours of supervised clinical instruction. PAs often have prior experience in other health care occupations such as military medics and corpsmen, paramedics, nurses, respiratory therapists, and medical technicians. Most PA training programs are affiliated with college or university school of medicine and are nationally accredited by the Accreditation Review Commission on Education of the Physician Assistant (ARC-PA). Initial and maintenance of board certification by the National Commission on Certification of Physician Assistants (NCCPA) is required for state licensure and to meet VHA employment qualifications. The ARC-PA and NCCPA's rigorous standards ensure consistency in the training and competency of PAs.

Post-graduate residency programs are available for PAs in disciplines such as surgery, dermatology, emergency medicine, mental health. These programs provide advanced clinical and procedural skills in specific disciplines. VHA Office of Academic Affiliation implemented a post-graduate residency pilot program in PACT Primary Care in 2012 to address the need for more highly skill PA in the VHA PACT model of primary care.

While several sources project a worsening physician shortage, the extent of the shortage continues to be debated. Medical schools are attempting to respond to the projected increase in need of physicians by increasing capacity. However, health care workforce researchers are concerned that this action alone will still not meet the projected need. The training cycle to produce functioning physicians is far too long to even address immediate or short term needs. Physician assistants, with a typical training cycle of 24 – 27 months, will play a critical role in providing solutions to addressing patient care delivery needs.

Due to the generalist nature of PA training, there is great flexibility in utilization of PAs to address changing patient care needs. PAs can be reassigned to a different medical or surgical discipline with a minimum of orientation and quickly acquire additional knowledge and clinical skills necessary to function as a patient care provider in that area of need.

PAs are in high demand in the general health care work force. The Department of Labor, Bureau of Labor Statistics report in May 2012 projected that the occupation will expand by 30% by 2020. The PA education community has responded to a projected PA workforce shortage by increasing class sizes of current programs and 47 new training programs are scheduled to undergo evaluation by ARC-PA for formal accreditation before 2015. The current number of annual graduates from PA training programs is estimated at 7,000. With additional existing programs expanding class sizes and the projected number of new programs, that number is estimated to grow to 9,000 annually. However, despite this increase in supply, a corresponding increase in demand will continue to make competition for recruitment more robust and retention efforts challenging.

The VHA PA workforce grew at a robust average rate of 5.7% between FY 1999 and FY 2006. Similar to the overall VHA workforce, the growth rate for PAs peaked in FY 2008 (8.74%), and has since declined rapidly. Onboard strength in FY 2011 was 1,893, but dropped to 1,885 in FY 2012, a 0.4% decrease, and is projected to increase by only 3.7% over the next seven years. This decline in growth rate corresponds to the trends in increased losses due to retirements, regrettable losses, and lower gains. Current recruitment of new hires has been insufficient to compensate for losses. With the increasing percentage of the PA workforce reaching retirement eligibility (approximately 39.5% by FY 2018), this trend is likely to continue.

Recruitment Challenges

VHA has a long history of participating in the clinical education of PA students. Many VA medical centers have affiliation agreements with PA training programs and provide clinical rotation sites for trainees. In addition, funding is available through the VHA Office of Academic Affiliations in the form of PA trainee stipends. Participation in PA student training and education has been a successful recruitment tool in the past. However, with the expansion of PA training program class sizes and the significant increase in the number of new programs, adequate numbers of clinical rotations are not available. This trend limits the number of trainees that have an opportunity for exposure to the VHA system reducing recruitment opportunities.

The May 2010 Bureau of Labor Statistics report and the American Academy of Physician Assistants 2010 Annual Census Report places the national median salary for PAs at \$86,410 with a range from \$60,000 (10th percentile) to \$135,000 (90th percentile). While VHA salaries for PAs varies with geographic location, they are significantly less than private market pay for entry level positions, especially in rural or highly rural areas.

An analysis of trends in grades of appointment reveal that 10.6% of new hires are placed in the entry level grade for the occupation while 75.6% are placed in the top two grades. The phenomenon is in part due to the fact that the salary range for the top grades more closely approximates private market pay for equivalent experience and the significant pay disparity for PAs entering the profession. The average age of a VHA physician assistant hired in FY 2011 was 42 years. The age of the VHA PA workforce was a mean of 48 years. This compares with a mean age of 28 for new PA graduates and 38 for the national PA workforce. The focus by VHA on recruiting older, more experienced PAs and the expense of younger new graduates may have an impact in future recruitment and retention efforts. As the demand for PAs increases, greater recruitment efforts and more focus on retaining experienced PAs by non-VA health care institutions is expected to increase competition for the same pool of applicants.

The cost of training in health care occupations has increased dramatically in recent years. The PA occupation is not immune. Job selection for graduates is often based on a student loan repayment assistance plan as part of the benefits packages. In most cases, PAs have not been eligible for the Education Debt Reduction Program as the occupation was not included in the Top Critical Occupations in the past or were not considered difficult to recruit.

Retention Challenges

Although the salary ranges in the higher PA grades is somewhat close to private market pay, a significant disparity still exists in some locations. A typical non-federal employer offers a compensation package that includes payment of licensure and certification fees and funding for Continuing Medical

Education (CME). VHA is prohibited from paying for licensing or certification fees and is generally unable to provide CME funding.

Exit interviews with PAs resigning from VHA employment often cite the lack of advancement opportunity or professional development as a reason for leaving. Tuition support through the Employee Incentive Scholarship Program has not been available in the past due to the fact that the PA occupation has not been included in the VHA list of Top Critical Occupations in the past.

Recruitment and Retention Strategies

- Disseminate vacancy announcements more widely by using PA professional job posting sites, PA training program job referral offices, and virtual networks.
- Develop strategies to target separating military service physician assistants for recruitment.
- Increase VHA's visibility and recruitment efforts at national and regional PA professional conferences.
- Incorporate eligibility for the Employee Debt Reduction Program in vacancy announcements and offers of employment.
- Increase the use of Special Pay Rate authority for areas with significant salary disparities.
- Increase the use of Recruitment and Retention Incentives when justified where salary disparities cannot be sufficiently addressed with Special Pay Rates.
- Increase the use of the Employee Incentive Scholarship Program for PAs inclined to obtain advanced degrees in the physician assistant profession
- Participate as a rotation site for a local PA program. Many newly graduated PAs go to work in the practices in which they train. This also provides an excellent opportunity to screen and evaluate individuals in the clinical setting.
- Utilize word of mouth. Establish an Ambassador Program and start with all PA colleagues working at VA and enlist them in the recruitment process. Put the word out to those networks. Emphasize sharing of job opportunities within their local community and professional association contacts.
- Contact your state's PA organization or American Academy of Physician Assistants (AAPA). State professional organization can assist with the job search and are good places to post job vacancies.
- Contact local PA programs. Contact local PA training programs and request assistance with recruitment. Develop a presentation on VA practice opportunities and share job/recruitment information.

For more detailed information about the VHA physician assistant workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at

<http://vaww.succession.va.gov/2013supplemental>.

0605 Nurse Anesthetist (CRNA)

Although surgical workload within the operating rooms has remained relatively consistent since FY 2007, anesthesia workload outside of the operating room has increased. Despite recruiting challenges in specific markets, VHA has had recent success recruiting certified registered nurse anesthetists (CRNAs) by using recruitment and retention allowances. This success is reflected by the fact that onboard strength for non-trainee employees has increased 43.4% since FY 2006.

Ongoing issues for CRNA recruitment and retention in VHA include the basic salary cap, the Congressionally mandated pay freeze (PL 111-322), and an increasing number of retirement aged individuals. In April 2012, 40.8% of CRNAs had retention allowances (n=298 of 731). The average allowance is \$20,261 with a range of \$153 to \$41,997. The median amount is \$16,995. In May 2010, the President signed Public Law 111-163 which will allow local facilities to exceed the basic RN salary cap for CRNAs. In March 2012, the implementation of Public Law 111-163 increased the basic salary maximum for CRNAs from EL-V (\$155,500) to EL-I (\$199,700). Prior to the salary cap adjustment there were 265 of 728 CRNAs at the \$155,500 salary cap. After implementation of new salary tables, 270 CRNAs received a salary increase, with an average increase of 4.6%.

We are unable to predict retention allowance changes (if any) based on the new salary tables. Facilities seeking to revise their pay tables in order to decrease the reliance upon such allowances have been limited by PL 111-322.

CRNA recruitment efforts include a successful ongoing partnership with the U.S. Army Medical Department Center and School at Fort Sam Houston, Texas (AMEDDC&S) to educate interested and qualified VA critical care nurses in the field of nurse anesthesia. Through the Employee Incentive Scholarship Program (EISP), the Healthcare Retention and Recruitment Office (HRRO) funds scholarships including tuition and books for employees participating in the Army/VHA CRNA program. EISP funding requires a three year employment commitment within VHA after completion of the program. There have been three or four students per year in the Army/VHA collaborative program. Thirty-one VA employees have participated in the program since its inception. Twenty VA employees have graduated as CRNAs and filled hard-to-recruit positions in VHA facilities. Eleven students are currently in the program. Additionally, HRRO has provided educational support to 31 CRNA students enrolled in educational programs other than the Army/VHA program.

The EDRP has also been used to provide funding for student loan reimbursement. Since 2002 there have been 117 individuals that have received EDRP funds to support education as a CRNA.

For more detailed information about the VHA nurse anesthetist (CRNA) workforce, please refer to the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

Other Targeted Occupational Workforce Priorities

Through the workforce and succession planning process, VISN and facility workforce planners have identified additional occupations to monitor carefully.

Although these occupations have not been elevated to the top of the list, they may have recruitment and retention concerns or may have dropped from the top ten list because the issues have been effectively addressed. Strategic planning for the future allows us to observe potential shortfalls in services due to industry trends and a maturing workforce.

Other occupations to observe and track:

- *0647 Diagnostic Radiologic Technologist*
- *0620 Practical Nurse*
- *0801 General Engineering*
- *0649 Medical Instrument Technician*
- *0640 Health Aid & Technician*
- *0651 Respiratory Therapist*

Diagnostic Radiologic Technologist (0647)

Advancements in radiologic technology require today’s diagnostic radiologic technologists (DRTs) to specialize in more sophisticated modalities such as MRI, CT, ultrasound, nuclear medicine, and mammography. By January 1, 2015, all new technologists are required to have an associate, baccalaureate, or graduate degree from an accrediting agency recognized by the American Registry of Radiologic Technologists (ARRT) in order to be eligible for certification in radiography, nuclear medicine technology, and radiation therapy and for the primary pathway to MRI and sonography. Candidates graduating from an educational program beginning January 1, 2013, will have three years to establish eligibility for ARRT certification, as opposed to the five years that is available to those who complete their program by December 31, 2012.

Because of the rapid rate of technological advancement, ARRT believes there is a “shelf life” to knowledge and therefore, as of January 1, 2011, graduating technologists are required to demonstrate continued qualifications (CQ) every 10 years in order to maintain certification. As part of their education, candidates must also demonstrate competency in didactic coursework and an ARRT-specified list of clinical procedures by completing competency requirements established for the discipline in which they are seeking certification.

In addition to the increased demand and the shortage of applicants for specialized modalities, VISNs have expressed increased difficulty filling positions with qualified candidates due to salary disparities between private sector and VA, and difficulty recruiting DRTs due to limited pools of trained applicants in rural areas. It is not possible to fill all vacancies with new graduates who lack certification in these specialties, so experienced DRTs must be attracted to VA. It is important for hiring managers and human resources to collaborate and review Hay Group and/or local salary survey data regularly and adjust pay scales in accordance with Human Resources Management Letter (HRML) 05-11-06. In this climate of fiscal austerity, some VISNs have limited the use of the Education Debt Reduction Program (EDRP) to fund only difficult-to-recruit specialized DRT positions (i.e. CT, MRI, ultrasound) rather than offering EDRP for all DRT vacancies.

Although teleradiology has addressed some issues in rural areas, not all radiological studies can be performed without the presence and/or supervision of a radiologist. Recognizing the need for radiologist extenders, the ARRT, ASRT (American Society of Radiologic Technologists), and ACR (American College of Radiology) have agreed to a new profession within the diagnostic radiologist arena, known as the “radiologist assistant.” An R.R.A., or Registered Radiologist Assistant, is an advanced-level radiographer who enhances patient care by extending the capacity of the radiologist.

Their role falls between the traditional roles of the radiologist and the radiographer. There are twelve ARRT-recognized Registered Radiologist Assistant education programs in the United States. In 2011, The Office of Patient Care Services was given the approval to write classification requirements for this new profession.

Some VISNs are leveraging their academic affiliations by offering their medical centers as clinical training sites and using VHA clinical staff as adjunct faculty. This practice allows the staff to informally evaluate the students as potential employees and gives the students the opportunity to experience the VA work environment and culture. This recruitment strategy has been so successful in VISN 12 that they have eliminated the need for recruitment bonuses, are phasing out retention bonuses over the next three years, and have removed DRTs from their VISN top ten list.

Although VHA offers a variety of employee leadership development programs for management personnel at the GS-13 level, those programs do not address the need to prepare mid-managers, such as Chief Technologists, who typically fall between the GS-11 and GS-12 grade levels. In addition to technical knowledge, Chief Technologists must understand various complex management duties such as hiring and payroll, equipment selection and installations, and how to create business plans for the current and future radiology program. With a growing number of these managers becoming retirement eligible, it is necessary to focus on preparing a pipeline of candidates with adequate knowledge of the complexities of radiology departments and the VHA system in order to replace future retirees.

Practical Nurse (0620)

The licensed practical nurse and licensed vocational nurse (LPN/LVN) occupations are faced with increasing demand and shortage issues. According to projections from the U.S. Bureau of Labor Statistics (BLS) employment of LPNs is expected to grow by 21% between 2008 and 2018 in response to a general increase in demand for health care services.

Strategies similar to the ones identified for recruiting and retaining registered nurses are available for networks to use in addressing potential LPN/LVN shortages. Options include: establishing or expanding upward mobility programs, increasing the use of VA scholarships and recognition authorities (cash and step advancements for achievement and performance), attending job fairs, participating in speaking engagements and developing or enhancing relationships with schools that offer this program of study. Since many facilities serve as clinical training sites for LPN programs, emphasis is being placed on expanding marketing of recruitment opportunities to new graduates.

Changes to the boarding process for LPNs that were made in 2007 continue to be disseminated. The LPN Professional Standards Boards (PSB), or peer review board, is now comprised of all LPN members. The time in grade requirement has been removed so that boarding is based upon years of experience. Promotion up to the journeyman level (GS-6) is performed by the supervisor and second line supervisor rather than the PSB. Special Advancements for Performance (SAP) nominations no longer require PSB review, but rather are completed by the supervisor and second line supervisor for all grades. Opportunities exist for LPN/LVNs to be promoted to a GS-7, based upon the complexity of the position. This change existed prior to 2007, but education and strategic planning continue in order to evaluate VA facilities and models of care delivery (e.g., Patient Aligned Care Teams) for opportunities to best leverage the skills and abilities of our most accomplished licensed practical/vocational nurses.

The national LPN/LVN PSB infrastructure has been enhanced this year with biannual membership appointments to regional/national boards. Monthly conference calls continue to offer national venues

for presenting didactic and question and answer learning formats, in addition to professional development topics. ONS anticipates the creation of several online resource areas for LPN/LVN communities by late 2012 – one to support PSB virtual secure access reviews, one for learning communities/exchanges, and one as a toolkit and resource area to include content such as: sample functional statements, employee self evaluations, nurse manager and LPN/LVN peer presentations.

General Engineering (0801)

VHA health care engineering’s mission is to effectively manage owned and leased capital assets, both infrastructure and equipment, comprising the total environment that facilitates the delivery of health care to patients throughout the nation’s largest network of hospitals and clinics. Health care engineers nationally operate, maintain, and renovate over 6,500 buildings that support 259,000 VHA staff members. According to the Capital Asset Inventory, the average age of VHA’s facilities is well beyond 50 years. This alone creates significant challenges inherent to meeting the demands of a 21st century health care delivery model while relying on antiquated mid-20th century infrastructure. This portfolio of aging buildings and associated systems and equipment will continue to exert enormous pressure on VHA engineers. As VHA strives to move its 20th century infrastructure into the 21st century, having a cadre of professional engineering staff within the system is critical.

In FY 2010, VHA’s health care engineers were responsible for spending \$6.8 billion to operate and maintain VHA’s infrastructure and equipment while concurrently managing the activities of 11,000 employees in professional, trade, and administrative functions. In addition, another \$2.2B of project funds was spent to renovate, construct, and modernize facilities. The workload associated with construction has increased as more construction projects (minor and major) are approved to renovate and modernize VHA facilities. In addition, the size and complexity of construction projects designed and administrated at the facility level have grown significantly in response to changes in construction program definitions, expanded clinical program needs, and the latest accreditation and design requirements. The number of general engineers in VHA rose by 12% between FY 2009 and FY 2011. Even though the occupational numbers increased in the general engineering profession in VHA the demand for engineers is still high within the federal government and VHA.

Approximately 17% of the current (FY 2012) workforce will be eligible to retire by FY 2013, and the retirement eligibility is expected to increase to 38.5% by FY 2018. Retirements made up nearly 43% of the total losses in FY 2011, but only 34% of the losses in FY 2012. Continued focus on succession planning, retention and workforce development for engineering occupations is critical. Overall employment for this occupation in the federal government is expected to grow; however, due to economic issues, the private sector outlook for employment in this career field is only between 6-9% growth during the next decade.

Biomedical engineers are a critical specialty to the VHA mission. Nationally, the field of biomedical engineering is expected to have an employment growth of 62% in the next decade. The driving force behind this growing demand is the national focus on health care, more sophisticated medical equipment and procedures, and increased concern with cost containment. To meet specific general engineering succession planning requirements, the TCF Intern program is being utilized. Twenty general engineering TCF slots were allocated for FY 2012. An additional 21 slots were allocated for Biomedical Engineering specialties. In addition to TCF Intern positions, VHA utilizes the Student Loan Repayment Program (SLRP) to enhance recruitment and retention efforts for these mission critical

occupations. Many VA Medical Centers are utilizing other programs, such as student employment programs, and some have enlisted the assistance of VHA National Recruiters. It is critical for VHA to continue to place emphasis on this group of highly technical trained professional engineers who perform building operations, maintenance, design, and safety and sustainment functions.

Medical Instrument Technicians (0649)

Medical instrument technicians operate and maintain the medical equipment used for therapeutic treatments, imaging bodily structures, or monitoring organs such as electrocardiographs, Holter monitoring scanners, ultrasonic scanners, and pulmonary function apparatuses. Most positions require basic knowledge of anatomy and physiology as well as a thorough understanding of a particular piece of equipment or medical procedure. The level of education required depends on the area of specialization; however, most medical instrument technicians are required to have passed an accredited training program. Other positions may require an associate's or bachelor's degree in a field such as surgical technology or cardiovascular technology. Occupational supply and demand data is difficult to obtain because the Bureau of Labor Statistics combines this occupation into a broad class of other medical assisting occupations.

Historically, medical instrument technician positions have been difficult to fill in VA due to a limited number of qualified candidates for vacancies. In addition, private sector salaries far exceed the pay scale for the federal government, and remain uncompetitive even after applying retention, recruitment, and relocation incentives, or special salary rates. It has been especially difficult to recruit for cardiology and ultrasound due to rapidly changing technology in these fields. Other challenges cited by VHA facilities and VISNs are high turnover rates, recruitment lag time, a lack of qualified candidates for positions, and the limited availability of experienced medical instrument technicians in rural areas.

To overcome the challenges in this occupation, continued use of recruitment incentives and student debt reduction programs such as EDRP and SLRP is necessary. In addition, the use of student training programs, such as the Pathways Internship Program, Hispanic Association of Colleges & Universities (HACU), VA Learning Opportunities Residency (VALOR) Program, and Workforce Recruitment Program for College Students with Disabilities (WRP) and conversion of students to VHA appointments at the conclusion of their program is highly recommended.

Respiratory Therapist (0651)

The BLS indicates 28% growth in employment of respiratory therapists (RTs) by 2020, much faster than the average for all occupations. Factors spurring this increasing demand include growth in the middle-aged and elderly population, who typically have a heightened incidence of cardiopulmonary disease, and the expanding role of respiratory therapists in case management, disease prevention, emergency care, and the early detection of pulmonary disorders. As a result, job opportunities should be especially good for those with cardiopulmonary skill sets, and those working in hospital settings and home health services.

Within VHA, increased emphasis on non-institutional care, telehealth, and rural health coverage, will contribute to RT's growth. VHA employs both certified RTs (CRT) and registered RTs (RRT). Both occupations must be licensed by the National Board for Respiratory Care (NBRC) or certified by another body which the NBRC recognizes as its credentialing equivalent. Although not all states require RTs to be licensed, VHA qualification standards require RTs to be certified as a CRT or RRT to be

eligible for employment. This discrepancy makes it difficult to recruit minimally qualified RTs in states where certification/licensure is not required.

Pay freezes and increasing private sector salaries add to VHA's difficulty in recruiting and retaining RTs. It may be necessary for facilities to evaluate and review RT responsibilities to focus on higher acuity responsibilities rather than routine interventions, which could be absorbed by ancillary health care staff. Strong academic affiliations mitigate the risk associated with private sector competition by providing additional trainee positions. Increases in trainee positions through VA's Office of Academic Affiliations (OAA) could assist VHA in stabilizing the retention rates for RT's. VA Learning Opportunities Residency (VALOR) program and the Education Debt Reduction Program (EDRP), Employee Incentive Scholarship Program (EISP), and the Student Loan Repayment Program (SLRP) may also improve recruitment and retention.

Health Aid and Technician (0640)

The 0640 series, which encompasses both Health Aid and Health Technician, is designed as a "catch-all" category for nonprofessional positions in health and medical work for which no other adequate series coverage exists. Health Aid is the suggested title for GS-1 through GS-3, and Health Technician is the suggested title for positions at grades GS-4 and above. Minimum educational requirements are a high school diploma or GED, but some employers prefer an Associate's degree in a health care-related field. Tasks performed by health aids and technicians include taking patients' vital signs, phlebotomy, assisting medical staff with minor procedures, etc.

Because this occupation is not well-defined, and has duties that overlap with other occupations, national supply statistics are limited, as the Bureau of Labor and Statistics (BLS) combines data on health aids and technicians with other similar occupations. However, BLS projects that demand for the broad category of occupations is expected to grow 18.7% between 2008 and 2018.

VHA faces several challenges related to the health aid and technician occupation. One issue inherent to the occupation is that it is generally a temporary career step on the way to other careers, such as dentistry, medicine, nursing, or pharmacy. Consequently, many VA facilities indicate that there is high turnover and a lack of quality candidates in the labor market to fill available positions. In addition, implementation of the VA telehealth initiative has caused an increase in the demand for these types of workers. The VA Military Medic/Corpsman Hiring Initiative Pilot Program may help manage these challenges. For more information about the Initiative, see page 65 at the beginning of this chapter.

Chapter 7: Developing Leaders At All Levels

The VHA is undergoing unprecedented changes on all fronts, from its business operations to the nature of its patient populations. Dealing with these changes while enhancing the quality of care provided to Veterans and their families, is no easy task. It takes a culture where VHA's leaders are devoted to serving the needs of those they lead and empowering each person to reach his or her fullest potential. The VHA Servant Leader culture is one that promotes continuous learning and growth of all employees at every level in the organization. This chapter describes some of VHA's ongoing efforts to develop a learning organization to meet its current and future challenges. It highlights the numerous opportunities for employees to develop their skills and abilities through formal and informal means. Employees at all levels can use this information to support their career development endeavors. Leaders will find the information extremely useful in guiding the learning activities of their employees and in advising them on their career development options.

“Leadership is lifting a person's vision to higher sights, the raising of a person's performance to a higher standard, and the building of a personality beyond its normal limitations.”

Peter F. Drucker

The Foundations of Employee Development in VHA

The VHA High Performance Development Model (HPDM)

In 1996, VHA adopted a framework for capturing and describing the key attributes that made VHA a high performing organization. Emerging out of an extensive succession planning and benchmarking effort, the VHA High Performance Development Model (HPDM), illustrated in Figure 32, soon permeated all of VHA's personnel-related functions. The graphical representation of the HPDM placed “veterans” in the center to focus attention on the primary mission of the VHA. Six radiating arms or spokes represented the primary tools or means through which VHA achieved maximum effectiveness as an organization. They included a sound performance management system; active coaching and mentoring; using performance-based interviews to identify candidates with the highest probability of success; continually assessing and improving processes; developing the competencies underlying successful performance; and providing continuous

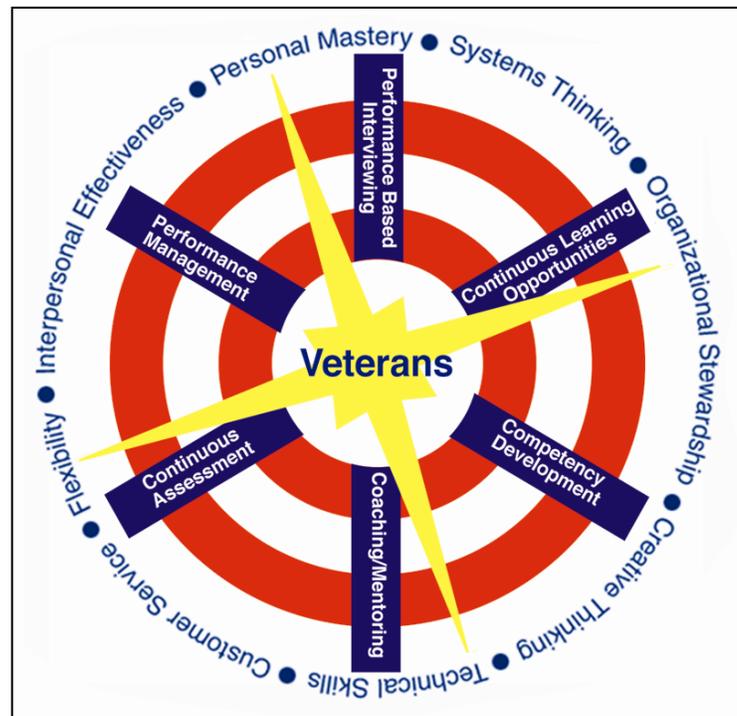


Figure 32

learning opportunities for the workforce. Concentric rings in the model reflected four tiers, or levels, into which employees could be categorized, from frontline staff in Level-I to senior executives in Level-IV. Eight core competencies encircled the model and captured the fundamental domains of employee behavior that supported high performance. Detailed behavioral descriptions for each competency were used as guides in creating VHA’s employee development programs and ensuring that learning objectives were always consistent with the target audience’s competency level.

The HPDM has stood the test of time. However, as the Department embarks in new strategic directions and sets new expectations for its workforce, some of the elements in the HPDM may need to be revisited and updated. One of the drivers for the changes will be the Department’s effort to design and implement an enterprise-wide framework for employee development programs. As a first step, VA has outlined a common set of values and competencies that are intended to supplant the current competencies that comprise the VHA HPDM.

An Emerging Department-Wide Framework for Employee Development

Successful organizations define themselves by a set of guiding principles and shared values that identify who they are and how they conduct business. Within the VA, these guiding principles are the VA Core Values. In announcing the Core Values in June 2011, Secretary Shinseki said, *“We are privileged to fulfill a sacred trust, and upholding that trust is a moral obligation. Fulfilling moral obligations is inextricably linked to moral values.”*

“If there are no common values, there can be no image of the future.”

Robert Bundy

VA’s Core Values follow a simple acronym – I-CARE. The initials stand for Integrity, Commitment, Advocacy, Respect and Excellence. The few words capture the essence of VA culture and serve as the foundation on which VA builds its workforce and conducts its daily operations.

The design of VA’s workforce development efforts revolves around complimentary sets of competencies that can be categorized into three broad groups, as illustrated in Figure 33:

- Competencies common to all employees regardless of occupation or level in the organization.
- Competencies that reflect the technical aspects of an occupation or job.
- Competencies meant to capture the behaviors of persons in leadership positions.

VA’s six *All Employee Competencies* and six *Leadership Competencies* are listed in the table below. Each one has two to four sub-competencies to further define its meaning and attributes.

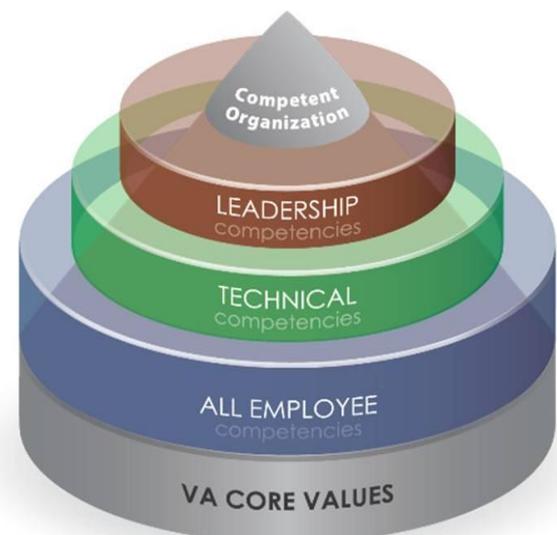


Figure 33

VA Competencies

All Employee Competencies	Leadership Competencies
<p>Communication</p> <ul style="list-style-type: none"> Demonstrates effective written communication Demonstrated effective oral communication <p>Interpersonal Effectiveness</p> <ul style="list-style-type: none"> Demonstrates empathy Fosters diversity and inclusion Contributes to high-performing teams <p>Critical Thinking</p> <ul style="list-style-type: none"> Demonstrates creative problem solving skills Demonstrates good judgment <p>Organizational Stewardship</p> <ul style="list-style-type: none"> Exemplifies integrity Demonstrates accountability Organizes and prioritizes work Makes effective use of resources <p>Veteran and Customer Focus</p> <ul style="list-style-type: none"> Advocates for Veterans Meets customers' needs <p>Personal Mastery</p> <ul style="list-style-type: none"> Exhibits self-awareness and commitment to self development Demonstrates resilience, agility, and a sense of urgency 	<p>Leading people</p> <ul style="list-style-type: none"> Promotes leadership at all levels Inspires continual learning and development Builds high-performing, diverse teams <p>Building Coalitions</p> <ul style="list-style-type: none"> Drives integration Builds and maintains partnerships Demonstrates political savvy Effectively manages conflict <p>Leading Change</p> <ul style="list-style-type: none"> Champions innovation Communicates vision and drives change <p>Results Driven</p> <ul style="list-style-type: none"> Fosters reasonable risk taking and drives execution Fosters accountability to Veterans <p>Global Perspective</p> <ul style="list-style-type: none"> Ensures strategic alignment Enhances outcomes for Veterans <p>Business Acumen</p> <ul style="list-style-type: none"> Applies forward-looking human capital management principles Applies sound financial and resource management Employs technology effectively

Each VA competency can be described by the behaviors expected of persons at various grade or experience levels. HPDM described the behaviors using four different levels of employees. In the VA model, the behaviors are stratified on a 1 to 5 scale from Novice (1) to Expert (5). As with HPDM, each level has its own set of unique behaviors. A Novice is expected to demonstrate awareness of the basic concepts and processes of the competency, possess little or no experience, and require a highly structured work environment and close supervision. On the other end of the spectrum, an Expert is expected to demonstrate comprehensive mastery of the concepts and processes associated with the competency, have many years of experience, and to demonstrate the competency in the most complex and sensitive situations with little or no guidance.

The table below captures the expected knowledge, experience, working situations and degree of guidance for each proficiency level. This conceptual framework is applicable to each one of the VA competencies. It is a useful guide for employees and their supervisors in outlining areas for developmental in line with targeted proficiency levels.

Expectations for Employees by Proficiency Level

PROFICIENCY LEVELS	Depth/Breadth of Knowledge and Skill	Typical Amounts of Experience	Complexity of Situations in Which Competency is Applied	Levels of Guidance Received/Given
Level 1 (Novice)	Demonstrates awareness of basic concepts and processes; can recall basic information or facts about the competency	Little or no experience (e.g., brief exposure to the topic in work or training)	Highly structured situations in which steps and procedures are clearly defined and require no judgment to apply	Continuous guidance/supervision to perform tasks associated with competency.
Level 2 (Foundational)	Demonstrates understanding of what the competency means and can describe it in his/her own words; can explain ideas and concepts related to the competency	Some experience with the topic, such as an introductory course or a few years of related work experience	Semi-structured situations in which steps and procedures are defined but which require a minimal degree of judgment to apply correctly	Frequent guidance/help needed to perform tasks associated with competency
Level 3 (Intermediate)	Demonstrates working knowledge of concepts and processes; can apply the competency to new situations	Moderate experience (e.g., several years of on-the-job experience in this area)	Moderately complex situations in which guidelines or procedures require some interpretations to be applied effectively	Performs most tasks associated with the competency independently; requires minimal guidance to complete more complex tasks; can teach others to perform basic tasks relevant to this competency
Level 4 (Advanced)	Demonstrated advanced understanding of concepts and process related to the competency; can make inferences and break down problems into their component parts and analyze them	Substantial (e.g., has used this competency over several years in situations of progressively increasing complexity)	Complex and sensitive situations in which guidelines or procedures can only be applied with significant interpretation	Performs almost all tasks associated with the competency independently; may seek help with only very complex situations; able to provide intermediate level guidance, training and/or coaching to others
Level 5 (Expert)	Demonstrates comprehensive mastery of concepts and processes related to the competency; can generate new ideas and evaluate their value	Extensive (e.g., has used this competency over many years in situations of increasing scope and complexity)	The most complex sensitive situations in which no established guidelines or procedures exist	Is considered an authority in this area; guidance is not needed even in the most complex situations; able to provide advanced level guidance, training and/or coaching to others

Learning Opportunities for VHA Employees

Building a strong and capable workforce entails providing ample opportunities for employees to develop their skills and inspiring employees to take advantage of those learning opportunities wherever they might emerge. VHA leaders play a critical role in this process. Leaders create a culture that fosters open communication, they encourage innovation and creativity, and they ensure all employees can participate in formal and informal opportunities to develop their technical and leadership skills.

Developmental opportunities come in a variety of forms. The one that leaders create for employees on the job and in the workplace are just as important as formal courses and programs. A pivotal factor, however, is the personal responsibility employees take for seeking out these opportunities and for preparing themselves for positions of greater responsibility within the organization.

VHA's portfolio of personal career development opportunities begins with foundational programs for new employees and carries through to programs targeting Senior Executive Service (SES) employees, much the same way the VA competencies follow a continuum from Novice to Expert levels. The goal of each program is to prepare individuals to meet VHA's future succession needs and to ground them in the competencies, core values, and characteristics required to be successful whatever their current positions or scope of responsibilities. Many of the VA developmental programs incorporate use of a Personal Development Plan that includes self-assessments, 360-degree feedback, work projects, self-directed studies, and mentoring.

VHA recognizes that developmental opportunities should occur continuously and take many different forms rather than relying solely on a structured, formal education system. As a result, developing the competencies of VHA employees entails many different learning methods and resources. The sources of these developmental opportunities can be categorized into three broad areas, illustrated in Figure 34: work-related tasks, projects and activities; the employee's own self-directed initiative; and formal training courses and programs.



Figure 34

Workplace Tasks, Projects and Activities

The first source of employee development comes through the job itself. This element is more than the skill mastery that comes with experience on the job. In the context of employee development, particularly leadership development, it involves stretch assignments and various short-term leadership roles. Supervisors and organizational leaders are crucial to this process. Leaders are the primary source for creating opportunities for employees to develop their teamwork and leadership skills by initiating and supporting details and temporary assignments, and by providing opportunities to participate on special projects, shadow other employees, prepare and provide presentations, and lead ad hoc teams. Conscientiously managing workplace opportunities for employees to collaborate together and stretch their abilities reaps benefits beyond the individual's own growth. It also stimulates networking across organizational boundaries, reduces single points of failure by increasing the knowledge and capabilities of all team members, results in new products, processes or services that otherwise might never be developed, and directly contributes to the pool of motivated and future leaders for VHA.

Leaders are the primary source for creating opportunities for employees to develop their teamwork and leadership skills.

Self-Directed Learning

There are a significant number of resources available to employees for their own personal growth and development. Access to these resources is increasing every year. Most provide excellent low-cost or no-cost tools to assist employees with their career planning, give them ideas for developmental activities, or provide direct access to articles, books, briefings and other learning materials.

One of the best emerging resources for employees is the MyCareer@VA web site (<http://www.mycareeratva.va.gov>). The MyCareer@VA site provides interactive career development tools to assist employees in exploring and charting their long-term career paths within VA. It helps them identify their work interests and work environment preferences, and provides career guides for numerous occupations, to include the required competencies, where in the VHA the positions are used, and recommended training for specific career fields.

The VA recently launched another valuable resource: the VA Leadership Development Portal (LDP) (<http://www.leaders4va.com>). The portal serves as a resource library, work collaboration tool, and social networking site all in one. It contains leadership videos, articles, podcasts, links to other sites and more. Books 24/7 gives around-the-clock access to downloadable abstracts and books of interest on a variety of leadership topics. Learning groups, curriculum developers, and multiple other communities of practice use the site to share ideas, work collaboratively on projects, and post group documents or products. First time users will find instructions to establish a user account for the LDP using the link above, and once inside, they will find a wide array of valuable and interesting features to support their personal development.

The Talent Management System (TMS) (<https://www.tms.va.gov>) is the primary training delivery and tracking system for the VA. TMS provides employees with access to innumerable courses covering every conceivable topic, including occupation-specific technical skills and general leadership competencies. Employees can develop their own learning plans based on the competencies required in their occupation or those areas in which they would like to advance their knowledge and skills. Much of the training is provided directly through TMS; however, the registration tool allows employees to register for face-to-face courses, webinars and other learning sessions as well. One significant advantage of TMS is that it provides employees with up-to-date information on their progress in working through their learning plans. Mandatory training courses are automatically suspended for the employee. Reminder emails to the employee and supervisor ensures they are completed within the allotted timeframes. Supervisors have access to the TMS data for their employees to enable them to monitor employee progress as well.

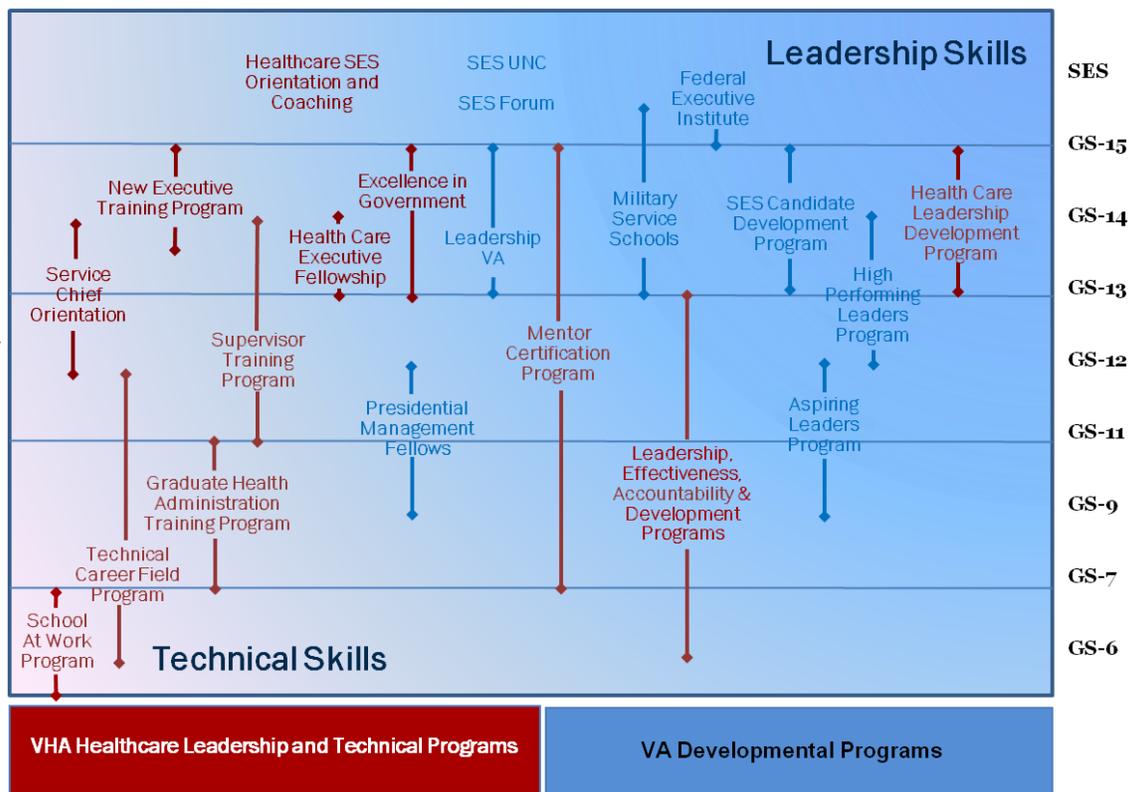
Community organizations and societies (e.g., Toastmasters, Rotary), provide another great resource for employees to engage in their own self-development. VHA leaders across all disciplines have supported participation in professional organizations for many years. Professional organizations (e.g., American College of Health Care Executives, American Organization of Nurse Executives, or American College of Physician Executives) provide employees opportunities for education, networking, team building and leadership development. In addition, VHA involvement with outside organizations and societies demonstrates the commitment VHA has to improving health care in the community at large.

Academic education provides many employees a viable way to advance their careers. The expansion of non-traditional education has made pursuing college or graduate school degrees more accessible than ever before. Gaining additional education enhances an employee's skills, opens doors to higher-level positions, and provides a sense of satisfaction that comes from personal accomplishments. VA offers several venues to support students with their academic pursuits, to include college course payment options and student loan repayment programs. Employees should consult their local Education Office for information and assistance with their academic education plans.

Formal Courses and Programs

In addition to courses available through TMS, conducted locally, or offered through training providers such as the Office of Personnel Management, there are a number of nationally-managed development programs for VHA employees. Figure 35 below captures the flagship national developmental programs that VHA relies upon to build individual competencies and maximize the potential of each employee. The chart reflects the target grade levels for each program and distinguishes whether the program is part of the VHA’s healthcare leadership training portfolio or one of the Department-level offerings. Programs that are physically oriented toward the left of the chart tend to focus on developing technical competencies, while those placed toward the right of the chart are more focused on leadership skill development. Most of the VHA programs below the SES level Descriptions are described in some detail in the next section of this chapter. For information on the VA and VHA SES programs, see the discussion in Chapter 4, VHA Senior Executive Analysis.

National Training and Development Programs



* Participant Grades Include General Schedule, Wage Grade and Title 38 / Hybrid Title 38 Equivalents

Figure 35

Early Career Experiences and Opportunities

New Employee Orientation/Onboarding. The onboarding process in VHA is perhaps the most important step in acclimating new employees to VHA’s culture and the concept of continuous learning. The successful transitioning of employees to VHA begins the day a candidate accepts a job offer and carries through the employee’s first year on the job. A positive experience conveys the value

VHA places on its employees and their personal development. Leaders at every level should ensure that employees receive a thorough and welcoming orientation to their work unit. This includes being logistically prepared for the employee's arrival; providing a good overview of the organization's mission, priorities, strategic direction and policies; and explaining the employee's duties and responsibilities in the context of the organization's function. VHA is piloting a New Employee Experience and Retention (NEER) program to strengthen the onboarding process through better guidance and more robust resources for managers and employees. Many of the resources can be found on a newly-formed Onboarding SharePoint site (<http://vaww.sps.lrn.va.gov/sites/NEO/default.aspx>). The site contains suggested activities to accomplish prior to and during the employee's first incremental months on the job, sample welcome letters and checklists, typical training requirements for new employees, links to other relevant sites, and more. While a good orientation is an essential first step, some employees may need additional early support to get on track for a successful career at VHA. To that end, many VA Medical Centers offer classes and instruction in foundational skills, such as literacy enhancement, resume writing, interviewing, mathematics, medical terms, and General Educational Development (GED) preparation. In addition, many facilities support Veterans transition to employment through programs such as Compensated Work Therapy. Employees can obtain additional information about the program offerings by contacting their local employee education office.

VHA National Workforce Development Programs

VHA Mentor Certification Program



Figure 36

Mentors play a crucial role in VHA's workforce development efforts and they are an integral part of VHA's succession strategy. Mentors provide employees and training program participants the guidance and necessary support to navigate through the complexities of their lives at work. Mentors help prepare VHA's future leaders by modeling VHA's core values and by transferring tacit knowledge that is often not documented and is therefore prone to loss when the holder retires or separates. VHA has a world-class certified mentoring program open to all employees. At the heart of the program is a core training course covering the roles and responsibilities of mentors. The course is a very engaging, interactive experience that lays the foundation for graduates to serve as mentors in a wide variety of work settings. The course teaches mentors how to use the G-R-O-W model (Figure 36) to encourage their mentees to set Goals, analyze the Reality of those goals and their surroundings, develop Options, and determine What's next. The course is taught by certified instructors throughout the country. Employees should contact their local education and training office for a listing of upcoming mentor training courses and registration instructions.

Completing the core mentor training course is just the beginning step in VHA's mentor certification program. Course graduates are considered Apprentices who must apply their knowledge in practical settings to advance in their mentoring competencies to the next level. Each level requires a progressively greater degree of practical experience. Certification at the Resident level requires 25 hours of documented mentoring sessions in the on-line mentor certification application. Certification at the Fellow level requires an additional 25 hours of documented sessions beyond the Resident experience. In addition to receiving local public recognition for their achievement, employees certified at the Fellow level are allowed to include the credential in their signature line. Many VHA Fellow-level

Mentors use the initials VHA-CM in their signature line to designate that they are a VHA Certified Mentor.

The VHA Mentor Certification Advisory Board (MCAB) oversees the mentor program. The MCAB establishes policy, sets priorities, and governs the certification process. This includes approving all requests for certification from individuals who have met the requirements to advance to the next level. In 2011, the majority of facilities met the national performance standard of having 1% of their employees achieve certified mentor status, and most

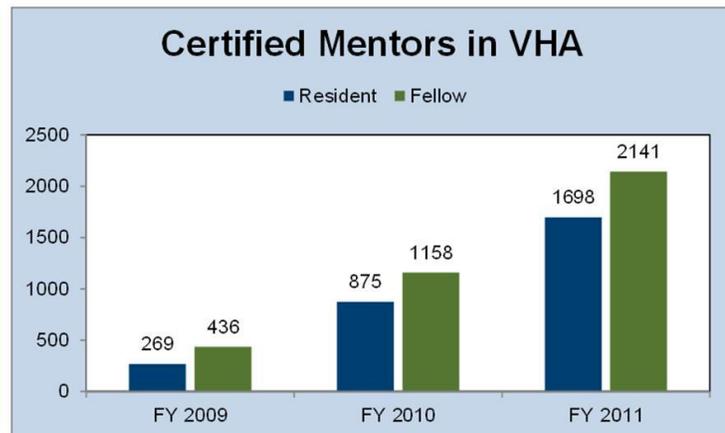


Figure 37

are well on their way to meeting the 2012 standard of 1.5%. However, the performance standard alone does not account for the dramatic increase in the number of mentors certified to the Resident and Fellow levels in the past three years, illustrated in Figure 37. By the end of FY 2011, there were over 3,800 certified mentors registered in the VHA mentor certification database, with over half of these certified at the Fellow level. Projections for 2012 are that this number will increase to nearly 5,000. To a large degree, this reflects how completely the VHA workforce has embraced the mentoring concept.

The increased availability of trained, experienced and motivated mentors enhances the success of VHA's workforce development programs and the daily performance of VHA employees. Whether geared toward training and development of new hires or leadership skills enhancement for VHA's newest executives—all of these programs rely on some level of formal mentoring.

http://vaww.succession.va.gov/Employee_Development/MC/default.aspx

VHA Supervisor Training Program

All new supervisors are required to complete a



comprehensive training program within their first year of appointment that covers the key concepts, programs, activities and competencies that contribute to success as a supervisor in VHA.

New supervisors include employees who are promoted or hired into a supervisory position and have less than 12 months previous supervisory experience in VA. This applies to all disciplines, services and levels. The required training can be accomplished by completing the national Nuts and Bolts of Supervision training course or an EES-approved equivalent. The national Nuts and Bolts of Supervision training program is available in three

VISN and Facility Supervisor Training Practices

- Encourage new supervisors to complete Mentor training
- "Lunch and Learn" sessions taught by local leaders
- Supervisor Communities of Practice
- Book clubs to read and discuss leadership and supervision books and articles
- Face-to-face sessions to reinforce on-line training
- Group projects to enhance employee morale and quality of life
- Guest speakers from throughout VHA and the local community

formats: face-to-face, online instructor-led, or online self-study. Employees may choose their preferred format or complete the training modules through a combination of formats. The online versions are available through VHA's Talent Management System (TMS) portal and consist of 14 separate modules covering everything from daily communications to employee staffing. The VA Learning University is developing a new course based on the Nuts and Bolts curriculum. The New Supervisor Essentials training is anticipated for department-wide release in FY 2013.

VHA supervisors are expected to continue to enhance their supervisory skills beyond the core new supervisor training curriculum by taking additional leadership, management, or professional/technical training appropriate for their grade and responsibility level. Many local training coordinators provide excellent learning opportunities that support the continued development of supervisory skills for assigned staff. These include book clubs, leader-led lunch-and-learn sessions, and cross-functional team projects that contribute to employee morale and quality of life.

http://vaww.succession.va.gov/Employee_Development/SupTraining/default.aspx.

Technical Career Field (TCF) Program

The VHA Technical Career Field (TCF) Program is a national workforce development program designed to meet VHA's need for staff in critical non-clinical occupations. The targeted career fields and the number of interns for any given year are established and managed nationally based on formal applications from each career field's lead office, funding availability, and succession needs. Corporate funding covers participant salaries, benefits, and required training and travel. The program is led by a TCF National Program Manager and executed through individual Career Field Program Managers for each specific TCF occupation. The size of the TCF program has expanded considerably over the years. The number of career fields has grown from 7 in 2003 to 12 in 2012, and the number of interns has almost tripled from 102 to 278 in the same timeframe. The TCF National Program Manager outlines the VHA-approved program policies and parameters, but recruiting and hiring of TCF interns is managed by individual Career Field Program Managers and carried out through local HR offices. HR follows merit system principles in recruiting and hiring a highly-qualified, diverse class of TCF interns.



Technical Career Field Program

There are three TCF sub-programs that differ primarily by the skill levels being targeted:

- **TCF Apprentice Program** – These interns are provided occupation-specific training and work experiences to bring their skills up to the apprentice level over a two-year period. Graduates are placed into non-supervisory GS-6 to GS-9 positions, depending on the career field.
- **TCF Intern Program** – Interns in this program are placed in occupation-specific training positions and complete a two-year program of formal and informal training courses and concerted on-the-job training. Successful graduates are placed in full performance positions up to GS-11.

➤ **TCF Masters Program** - The TCF Masters Program focuses on meeting career field needs for highly-skilled managerial-level staff. As with the other TCF programs, the Masters interns train in their assigned occupations for two years and complete a wide-range of formal courses and work experiences. Graduates are placed in GS-11 or above positions.

Each TCF intern is supervised, coached and mentored by a preceptor at the local level. Preceptors are selected annually through an extensive process that considers the preceptor's technical expertise and commitment to training, and the suitability of their facility as a training location. TCF graduates are generally non-competitively placed into positions for which they have been trained, often with an accompanying promotion.

Over the last five years, TCF program participants graduated at an average rate of 86% as illustrated in Figure 38, with the vast majority continuing to serve in VHA well after they complete the TCF program. A survey of the most recent TCF graduates, preceptors and supervisors found that 93% of all respondents "Strongly Agreed" or "Agreed" that the interns achieved the technical skill levels expected for their career fields and grades.

http://vaww.sucession.va.gov/Employee_Development/TCF/default.aspx

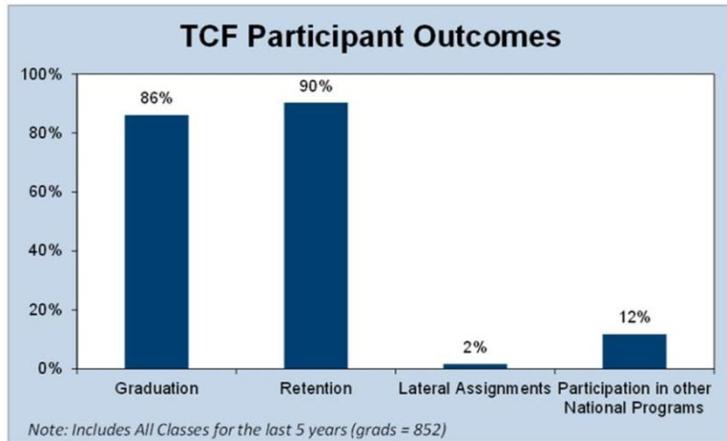


Figure 38



Graduate Health Administration Training Program (GHATP)

The mission of the VHA Graduate Health Administration Training Program (GHATP) is to produce VHA health care administrators and administrative support professionals by providing career development opportunities to highly-qualified individuals. The GHATP Executive Board oversees preceptor certification and selection, training site selection, program content and requirements, faculty selection, and program evaluation. In FY 2008, the Executive Board expanded the eligible degree programs to include MBA and MPA students and graduates as long as the academic programs had a health care focus. The GHATP consists of three major administrative training programs.

➤ **The Administrative Resident/Fellow Program** is designed to bring qualified graduate students into VHA who are in the process of receiving, or have just received, their master's degree in health care administration, public health, or business administration with an emphasis on health care. Approximately 50 funded Administrative Resident/Fellow training positions are approved annually.

➤ **The Health Systems Management (HSM) Trainee** program equips promising VHA employees with the knowledge, skills and abilities they need to advance their careers as health administration support professionals. About 15 nationally-funded HSM trainee positions are approved and filled each year.

➤ **The US Army/Baylor MHA Program** offers VHA employees the opportunity to attend school fulltime through an agreement between the U.S. Army and Baylor University. Students take 12 months of academic courses followed by a 12-month residency program in their host facility and designed to meet both the GHATP resident/fellows criteria and the residency requirements levied by the Army-Baylor program. Students meeting all standards graduate with a master's degree in health care administration and potentially an MBA as well.

The graduation rates for GHATP participants remain very high, as illustrated in Figure 39, with 88% of all participants completing the program. Of the 264 GHATP graduates for the last five years, 81% are still working in VHA, 88% were promoted at least once since they applied for the program, and 7% took at least one lateral growth position over the 5-year period. There has been a general upward trend in the number of GHATP graduates who subsequently participate in other national programs, with 30% of the GHATP graduates over the last five years completing at least one other national leadership development program.

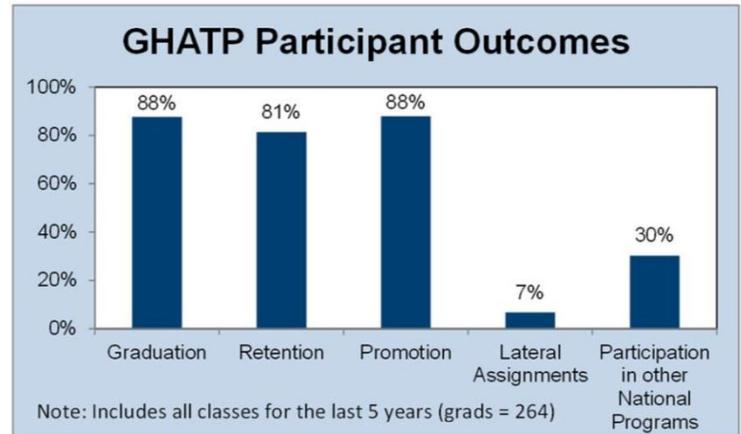
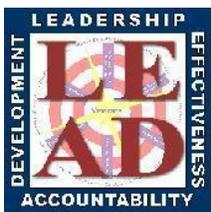


Figure 39

At the conclusion of their program, GHATP trainees undergo a certification process by their assigned preceptor to ensure they meet or exceed all program requirements, to include demonstrating acquisition and application of target competencies. A project addressing a facility need or complicated issue is an integral part of the GHATP training process. Interns are expected to prepare a presentation to their leadership that covers the nature and outcome of their work projects. The interns also present their projects through a poster and/or briefing to a national panel. The winners of the national poster competition are formally recognized for their contributions and given the opportunity to serve on the GHATP Executive Board the following year.

http://vaww.succession.va.gov/Employee_Development/GHATP/default.aspx

Leadership, Effectiveness, Accountability and Development (LEAD)



A variety of formal and informal leadership development opportunities are offered at the facility, VISN and VHACO levels. The LEAD program is the primary program that provides core training for aspiring leaders across VHA. The Facility and VISN/VHACO LEAD programs differ in their content, level of competencies being targeted, and in the principle audience the programs intend to reach. However, the programs do share a common set of themes:

- Open to Title 5, Title 38, and wage grade employees
- Use a wide variety of learning and instructional methodologies
- Follow competency-based learning objectives
- Reliance on formal VHA-certified mentors/coaches
- Use of a Personal Development Plan (PDP) to guide participant learning

- Senior leadership involvement and active support of the program
- Formal evaluation of individual and program outcomes
- Reward and recognition for graduates, mentors, and faculty

The Facility LEAD programs target high potential employees with aspirations to be a future leader in VHA. This typically includes employees in grades GS-5 through GS-9 along with Title 38 and wage grade equivalents. VISN and VHACO LEAD programs are geared toward employees in grades GS-9 through GS-13 and equivalents. Participant eligibility and selection processes, length of courses, and delivery methods vary from one program to another based on unique local workforce needs and circumstances.

The number of graduates from LEAD programs continues to grow, as illustrated in Figure 40, with graduation rates of 97%. Between 2006 and 2011, there were well over 9,400 graduates of Facility, VISN and VHACO LEAD classes. Nearly 2,000 employees enrolled in LEAD classes in 2011 alone. Retention of LEAD graduates from the 2006-2011 classes averaged 92%. In terms of preparing future leaders, 48% of the graduates were promoted over the 5-year period,

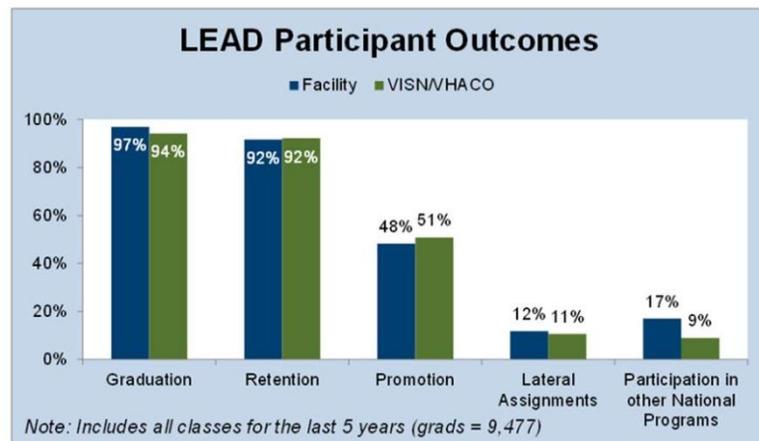


Figure 40

and 12% took lateral assignments to enhance their skills. The data indicate that the Facility LEAD program provides a stepping stone to participation in subsequent developmental programs, namely the VISN and VHACO LEAD programs. A number of TCF and GHATP program graduates enhanced their developmental journey by completing a LEAD course, primarily at the VISN or VHACO level.

http://vaww.succession.va.gov/Employee_Development/LEAD/default.aspx

Excellence in Government (EIG)

Excellence in Government (EIG) is a Partnership for Public Service leadership development program targeted at high-performing GS-13 to GS-15 and equivalent employees. Attendees are from across the Federal sector. The 10-month program incorporates



benchmarking, action-learning, executive coaching, and government-wide networking. There are seven week-long, face-to-face sessions covering different executive topics, such as “Leading People” and “Building Partnerships and Coalitions.” Typically, four of the sessions are in

Washington, DC, and the others are at locations throughout the country. VHA sponsors up to 10 participants each year. The call for applications occurs two

“The interaction and team building with professionals from other federal agencies has been invigorating and rewarding. It is a true pleasure to see the quality of the individuals from these other agencies that have dedicated their lives to public service.”

John Rohrer, VISN 12

to three months prior to the program start date in October. Selection and funding is managed nationally through the VHA's Healthcare Talent Management program office. (http://vaww.succession.va.gov/Employee_Development/EIG/default.aspx).

Executive Career Field Candidate Development Program (ECFCDP)

The ECFCDP officially ended when the final cohort, the 2010 Class, graduated in March 2012. The purpose and content of the ECFCDP has been divided between two new independent programs: the Health Care Leadership Development Program (HCLDP) and the Health Care Executive Fellowship (HCEF) Program.

Health Care Leadership Development Program (HCLDP)



One of the outgrowths of the redesign of executive level development programs in VHA is the HCLDP, a program designed to provide focused leadership training and experiences for high potential employees from the middle management ranks of GS-13 to 15, Nurse IV, and Physician Tier 2 and 3 who do not currently hold a Pentad executive position. Participation in HCLDP is a collateral duty, during which participants remain in their current positions over the course of the program. Selections are made through a national process that includes endorsements by leadership, performance based interviews, and application

reviews by a national rating panel.

HCLDP is a year-long program that includes four face-to-face training sessions and a series of virtual assignments throughout. The emphasis is to take participants on a journey focused on personal leadership, leadership agility, leading others, and organizational leadership. The program is an expansion of the VHA's Health Care Leadership Institute (HCLI), and includes a developmental assessment program to provide valuable feedback to foster growth as an individual and within the organization. Other important components of the program are small group coaching from members of the Executive Career Field that continues between sessions to reinforce the training and draw parallels with real-world work experiences and the preparation of a personal development plan to guide development during the program and beyond. This program is delivered by the Healthcare Talent Management office through a partnership with the Employee Education System (EES) and the National Center for Organization Development (NCOD).

The inaugural HCLDP class began training in February 2011 and graduated in September 2011. Selections occur annually with a call for applications going out during the summer.

http://vaww.succession.va.gov/Employee_Development/HCLDP/default.aspx

Health Care Executive Fellowship (HCEF) Program

HCEF is VHA's newest executive leadership development program. It is designed to meet VHA's need for technically skilled facility executive leadership team members. The targeted positions for this program include Assistant or Associate Directors (AD), Associate Directors for Patient Care Services (ADPCS)/Nurse Executives, and Chiefs of Staff (COS). While the HCLDP provides personal leadership development, HCEF focuses on the day-to-day technical skills needed to successfully serve in one of the key leadership positions. The program is designed to handle up to 25 candidates per year. The Fellows leave their current positions to spend a full year fulfilling a structured training plan and working alongside an experienced incumbent for their specific occupational track. Host training sites are among VHA's highest complexity medical facilities with solid executive leadership teams and demonstrated

capabilities to provide the full scope of training required. HCEF graduates are eligible for non-competitive placement into facility leadership positions for which they were trained. The first HCEF class will begin training in July 2012.

http://vaww.succession.va.gov/Employee_Development/HCEF/default.aspx.

New Executive Training (NExT) Program

The NExT program is required for all first-time appointees to positions as Deputy Network Director (DND), AD, ADPCS and COS. It provides participants with an introductory overview of VHA and the business acumen skills needed to be successful in their new roles. The course includes a week-long face-to-face VHA executive orientation in Washington, D.C. with in-depth discussions of current topics relevant to the overall community. Separate working sessions tailored to each specific discipline introduce participants to their particular discipline's Community of Practice (COP) and help them establish networks of contacts that benefit them throughout their assignments. Individual and group coaching initiated during the VHA orientation, along with case study reviews, independent study, and a detailed personalized health care management development plan continue throughout the new executive's first year on the job. Two NExT classes are held each year.

http://vaww.succession.va.gov/Employee_Development/NExT/default.aspx

Succession Pipeline and Diversity Analysis

VHA's national leadership development programs are essential to meeting its current and future needs for talent. VHA promotes employee development opportunities for all its employees while remaining mindful of the importance of the programs to achieving a diverse workforce. Elimination of potential barriers to individuals or groups wishing to participate in available learning opportunities is fundamental to VHA's leadership philosophy.

The table below gives the percentage of each major diversity group for the major national developmental programs. NExT was not included because it is attended by every newly-appointed facility executive, and HCEF is not included because it is still in the pilot phase. For the other programs, the number of selectees in any given year is relatively small. As a result, the selection of one or two individuals from a particular diversity group can result in dramatic swings in the percentage that group represents of the participant population.

Diversity of National Leadership Development Programs (Percent of Participants)

Race/Gender	TCF FY 2011 %	GHATP FY 2011 %	Facility LEAD FY 2011 %	VISN/ CO LEAD FY 2011 %	HCLDP FY 2011 %
White Male (WM)	30.91	38.10	17.61	23.79	29.63
White Female (WF)	19.27	23.81	38.93	43.18	44.44
Black/African-American Male (BM)	17.09	9.52	9.94	4.39	1.85
Black/African-American Female (BF)	15.27	9.52	22.55	14.09	1.85
Hispanic/Latino Male (HM)	4.00	1.59	2.12	2.88	3.70
Hispanic/Latino Female (HF)	4.00	4.76	4.04	4.39	0.00
Asian Male (AM)	5.82	7.94	0.96	1.82	12.96
Asian Female (AF)	1.82	4.76	2.12	3.79	1.85
Native Hawaiian/Pacific Islander Male (NH/PIM)	0.36	0.00	0.21	0.00	0.00
Native Hawaiian/Pacific Islander Female (NH/PIF)	0.36	0.00	0.34	0.45	0.00
American Indian/Alaskan Male (AIM)	0.36	0.00	0.41	0.30	1.85
American Indian/Alaskan Female (AIF)	0.73	0.00	0.34	0.76	0.00

A description of VHA's efforts to increase the diversity of its workforce can be found in Chapter 8, Recruitment and Retention.

For a listing of other workforce resources including helpful links refer to the 2013 VHA Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>.

Chapter 8: Recruitment And Retention

VHA Recruitment Strategies

Recruitment and retention strategies are critical to meeting current and future staffing. Initiatives are carefully considered for attracting, hiring, training, developing, deploying and retaining a diverse VHA workforce. This chapter describes key recruitment and retention strategies critical to VHA's success in competing for top talent in the health care industry.

Over the next decade “...there will be intense competition to hire talent, and the federal government will lose out unless it overhauls its recruiting and hiring processes” (Bilmes & Gould, 2009). VHA faces major challenges in hiring enough mental health practitioners to care for our Veterans, along with the challenge of serving Veterans in rural and highly rural areas. The Title 38 Personnel System, among other excepted service hiring authorities, gives the Administration flexibility in hiring clinical staff.

The post-war challenges of the 1940s spurred significant and immediate demands on VA hospitals to care for hundreds of thousands of returning Veterans. In 1946, the Title 38 personnel system was established to create a more efficient, effective, and responsive way of recruiting and hiring clinical staff. In 2012, the new demands of returning Veterans with extensive mental health needs, combined with increased recruitment competition from the private sector, and a shrinking pipeline of available health care providers, makes using the flexibilities of Title 38 just as important now as in 1946.

Title 38 flexibilities have been reviewed to ensure compliance with merit principles. In a 1991 study by the U.S. Merit Systems Protection Board (MSPB) titled, “The Title 38 Personnel System in the Department of Veterans Affairs: An Alternative Approach,” no evidence of compromised merit principles and identified advantages were found. In the absence of formalized competition MSPB found that candidates were assessed based on the quality of their clinical experiences, education, skills and knowledge, and that hiring managers were far more engaged than those under the Title 5 personnel system. Professional Standards Boards and peer review practices serve as a check and balance system to protect merit principles. The report went on to recommend flexibilities in Title 38 be applied to other Title 5 health occupations and to further transfer decision making authority from personnel office staffs to line managers. Since that time the expansion to Hybrid Title 38 now covers 38 clinical and associated health occupations.

Title 38 is designed to shorten the hiring process and give line officials more control as they compete with employers in the private sector. Given this history, it is imperative to exploit the flexibilities that Title 38 affords, and avoid the temptation to overlay obstacles or

“...it is imperative to exploit the flexibilities that Title 38 affords, and avoid the temptation to overlay obstacles or unnecessarily apply Title 5 processes to Title 38 in an attempt to ‘standardize’ or simplify benchmarking or reporting requirements.”

unnecessarily apply Title 5 processes to Title 38 in an attempt to “standardize” or simplify benchmarking or reporting requirements. When process decisions are made based on reports and measurements without regard to how those processes impact results, VA becomes less competitive with the private sector. For the types of candidates Title 38 targets, successful recruitment is largely relationship-based requiring a personal touch. The recruitment of health care professionals is often an extended process and the flexibilities of Title 38 allow VHA to create a better experience and outcome for all.

In 2009, the National Recruitment Program was rolled out to bring private sector recruiting practices into VHA. To date, the National Recruitment Program has recruited over 800 health care providers, most of whom are in difficult-to-fill specialties such as Psychiatry, Surgery, Gastroenterology and Radiology. This program's recruiters are averaging 25 placements per year, comparing favorably with the private sector average number of providers recruited of 12-15. This demonstrates that VHA can vigorously compete with the private sector when it uses the flexibilities afforded by Title 38. Other federal agencies have requested that VHA share this recruitment model. A central theme of the model is – "Recruitment" - recognizing that decisions made in the planning and execution stages of recruitment have an impact on future retention. If the needs of the hiring manager and candidate are addressed during recruitment, there is an increased chance the recruitment will be successful and retention will be high.

VHA Recruitment Competency Model

The VHA Recruitment Competency Model, illustrated in Figure 41, was designed to improve recruitment and retention of clinical professionals. The model has five phases which exploit the flexibilities of Title 38 to promote creative and strategic recruitment practices. Improving VHA's recruitment strategies reduces the amount of time positions go unfilled and improves Veterans access to timely, personalized health care. Rolling this model out to the entire HR Staffing Community and Clinical Hiring Managers is a strategic imperative.

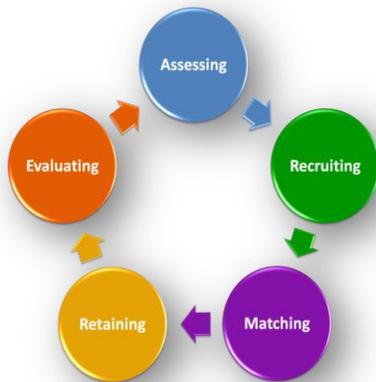


Figure 41

Assessing: Clinical and executive leadership must invest in the recruitment process and work with the recruitment team on the “front end” to ensure a successful recruitment and retention plan and result. Questions asked and answered should assess the need

for new staff and the capability to integrate them in the setting:

- What is the need?
- Is the facility or department prepared to add new staff?
- What can be offered; positive selling points to the position, should recruitment incentives be included based on local market needs and practices by competitors?
- What are the resources?
- What are the limitations?
- What are the growth plans and what future losses might be anticipated?

Thinking through these questions helps avoid surprises during the recruitment process and prepares hiring managers to address candidates' inquiries.

Recruiting: Prior to the marketing and candidate generation phase, hiring managers should meet with their Recruitment & Staffing personnel or their VISN's National Recruitment Consultant to define several elements. These should include:

- The ideal candidate profile –not just the basic capabilities, but specialized clinical skills or medical procedural experience, practice style, etc. This will serve to best ensure a good fit between candidate and practice.
- The core clinical competencies the candidate must have on day one, as well as additional opportunities for those who wish to perform additional procedures or develop additional aspects to the practice.
- The factors that could impact successful recruitment (e.g., salary, location, competition, recruiting for same specialty, practice limits).
- The expectations for the job (e.g., call schedule, work hours, patient volume, travel).

Answering these questions helps define the type of candidate and useful strategies to identify active and passive or non-job seeking candidates. The information from the Assessing phase and these questions can be used to craft advertising content and candidate sourcing strategies.

Candidates are not only exploring VA jobs but those in the private sector as well. The standard practice in private health care recruitment is to initiate immediate interaction between the candidate and someone within the organization. VHA is going beyond passive recruitment strategies such as posting standard announcements. Candidates are being actively sought and contacted soon after they've shown interest, so that questions can be answered and their interest maintained.

“Poor search methodologies lead to wasted motion, principally through interviewing of inappropriate candidates, which needlessly prolongs the process and increases costs.” Merritt, Hawkins & Associates (2009) Guide to Physician Recruiting – 3rd Editions

It is important to note that most professionals applying under Title 38 are not necessarily in need of a job and don't initially consider themselves applicants. They're seeking an opportunity to speak with the hiring manager or another provider to have their questions answered before they decide whether or not to apply. Using the flexibilities of Title 38, every effort should be made to make the application process as simple as possible. VA must move to a resume only approach for initial application just as a resume only is required for Title 5 applications. Additional screening can occur after the resume review. Removing obstacles such as lengthy application forms, transcripts, etc. as the first step to candidate evaluation is strongly recommended. VA's competitors only require a resume and cover letter. Anything more cumbersome is a barrier to receiving applicants from the best, mostly highly sought after clinical candidates.

Marketing job opportunities pays big dividends. Including a balance of job information, along with facility and community information, to “sell” the candidate and potentially the candidate's family on the work and lifestyle they can expect is paramount. Present a long-term view of what the opportunity and community can offer - both in advertising and in conversations with potential candidates.

Prior to formal interviews and ideally, within a few days of when interest is expressed by a candidate, schedule an informal discussion for pre-screening. Recruitment & Staffing personnel and the VISN's National Recruitment Consultant can play a role in pre-screening candidates and potentially save the search committee time in formally interviewing applicants. Some of the areas that can be refined during a pre-screening include:

- What the applicant is seeking in a practice
- Why the applicant is looking
- Any malpractice, licensure, or disciplinary action and gaps in the resume
- What community features are important
- Salary expectations and how it compares with compensation package being offered
- Factors most important in deciding whether or not to accept a position – deal breakers and needs
- Availability

By learning this information early on, the search committee can decide whom they wish to interview formally. At the same time the candidate is engaged and feels the facility is interested in them.

Matching: Determining the best fit begins with evaluating the needs of the hiring manager and the position, and identifying the attributes of the ideal candidate. Learning as much about the candidate as possible is critical during the matching process. This phase is where the Recruitment Competency Model promotes the flexibilities within Title 38 making it easier to find the best match.

The candidate visit is essential to the Matching phase of the process. Leadership and hiring managers should choreograph the visit and allow ample time for the candidate to meet with interviewers and the staff they will be working with, tour the facility, and if the candidate is not from the area, to tour the local community. Family participation should be encouraged; often the family members have as much to do with the decision of accepting or declining a position as the candidate. With proper coordination, inclusion of community stakeholders should be considered. Include the Chamber of Commerce, realtors, school officials, and others. If the spouse or significant other will also be seeking employment, address that as well. Including a social function is a nice personal touch, but keep the attendee list short, to keep the candidate at the center of all conversations.

The facility should reimburse candidates for reasonable travel expenses. This is standard practice in the private sector. When candidates for hard-to-fill and specialty clinical positions are pre-screened and interviews have been done prior to the visit, concerns over funding a visit or two should be secondary, since there will be a good sense as to the qualifications and interest level of the candidate.

At the end of the visit, the hiring manager should be prepared to move forward. Using the steps leading up to this visit – the planning phase, identifying the needs of the practice and defining the ideal candidate – there should be little question as to whether the candidate appears to be a good fit and warrants a potential offer. When the candidate leaves the visit, he or she should walk away with a positive feeling, have his or her critical questions answered and, know what the next steps are and when to expect them. Prior to formal selection, steps that can occur are addressing pay, credentialing, etc., which can shorten the timeline once a decision to select has been made.

Retaining: Retaining starts with a solid recruitment and onboarding experience, mentoring programs and professional development opportunities. Assign mentors early to develop relationships prior to the new employee's entry on duty. Assistance during relocation, orientation to the new community, and introducing the new arrival and their family to professional colleagues and resources is a role a mentor can play ensuring a smooth transition for the new employee and the organization where they will work. Approximately 60% of private sector health care organizations use mentoring as a retention strategy and the focus is to get the new employee off to a good start to be in the best position for success.

Bridging the gap between administration and clinical staff is critical to retention. Commitments made during recruitment must be kept. Efforts to identify and resolve concerns early on are extremely important. Many private sector health care systems are creating positions for “Onboarding Specialists.” These specialists ensure things get off to a good start and provide a one-stop shop when new arrivals have questions or concerns to address. These specialists work to resolve workplace issues and may act to resolve community issues for the family as they relocate.

Monitoring: Monitoring retention through a Provider Relations Program allows clinical administrators to monitor the disposition of the staff along with their needs and interests for employee satisfaction awareness.

Conducting periodic interviews and surveys with staff helps demonstrate a culture of responsiveness to address suggestions, requests, complaints, and other survey results with definitive action. This can foster collaborative partnerships among staff and impact retention in a positive way. A good monitoring program might include:

Sample Monitoring Program	
Week 1	<ul style="list-style-type: none"> • Mentor speaks with new employee and spouse or significant other – how is relocation going, etc. • Facility tour for family • Personal note from Facility Director and Chief of Staff • Introductory communiqué to facility staff • Introduce new employee at next Medical Staff, morning meeting or other appropriate venue • Hold meet and greet events when appropriate • Schedule orientation with Facility Director and Chief of Staff
Week 4	<ul style="list-style-type: none"> • Lunch with physician and significant other to make sure needs are being met • Mentor meets with new employee and family
First 60 Days	<ul style="list-style-type: none"> • Hold a welcome event to introduce new employees arriving since last event • Regularly schedule event that occurs every 30-60 days
6-Month Anniversary	<ul style="list-style-type: none"> • Survey employee about facility and community orientation process • Survey new employee’s mentor and hiring manager about recruitment experience and candidate fit • Find opportunities to integrate new providers into committees
1-Year Anniversary	<ul style="list-style-type: none"> • Lunch with Director and Chief of Staff • Survey employee and spouse regarding their first year’s experience

Recovering: Recovering is the ongoing application of the Retention and Monitoring phases to make the most out of lessons learned. In addition to the VA Exit Survey, which should be offered to all voluntarily separating employees, supervisors and managers should speak with employees leaving their department to help them identify the strengths and weaknesses of the facility. The information gleaned from these discussions can be used to improve policies and processes, and to resolve challenges. An exit interview should focus on what is being done well and what can be done better. Positive and negative departures are valuable. How input from departing employees is gathered must be well planned to ensure a sense of safety so they can be candid, and the organization receives the highest rate of returned surveys possible.

The principles of the Recruitment Competency Model define the needs of the hiring manager and the position, as well as the characteristics of the ideal candidate. Those criteria can then be applied when

crafting and placing advertising. By using the flexibilities of Title 38 in a proactive way, and maintaining personal communication with candidates throughout the process, VHA is positioned to compete with its private-sector counterparts while creating a more positive experience for candidates and managers. When vacancies are filled more quickly, Veterans see improved access, experience shorter appointment wait times and have greater patient satisfaction and confidence in their health care.

Recruitment Sources and Outreach

Veteran Recruitment Outreach Initiatives

Similar to Title 38, VA has additional hiring flexibilities under Veterans excepted service hiring authorities. Special hiring authorities such as Veterans Readjustment Authority (VRA), Veterans Employment Opportunity Act Authority (VEOA), and the authority to hire 30% or more disabled Veterans can be used to bring Veterans on board. These tools can be successfully used to increase the number of Veterans and individuals with disabilities in the workplace. The U.S. Bureau of Labor Statistics reported in June 2012 that the jobless rate among post-2011 Veterans averaged 9.5%, down from 12.7%, but still higher than the national average at 8.2%. Recruiting Veterans into the workplace is a key hiring objective. Veterans currently make up approximately 31% of VA's total workforce, and Secretary Shinseki established a goal to increase that number to 40% by the end of FY 2014. To assist with this goal, VA for Vets was created as an online approach to recruiting, hiring, and reintegrating Veterans into civilian careers (for more information about *VA for Vets*, see Chapter 1, Workforce Succession Strategic Direction.) VA is participating in hiring fairs nationwide. In a recent hiring fair in Washington DC, 500 tentative job offers were made by VA to Veterans. Another hiring fair held in conjunction with the Veterans Small Business Conference in Detroit, Michigan resulted in additional job offers in VHA facilities.

According to results from the VA Entrance Survey, illustrated in Figure 42, 20.4% of the Veterans who came to work for VHA in FY 2011 learned about the job opportunity while on active duty, a 1.4 percentage point increase from 2010. These results could be attributed to targeted recruitment

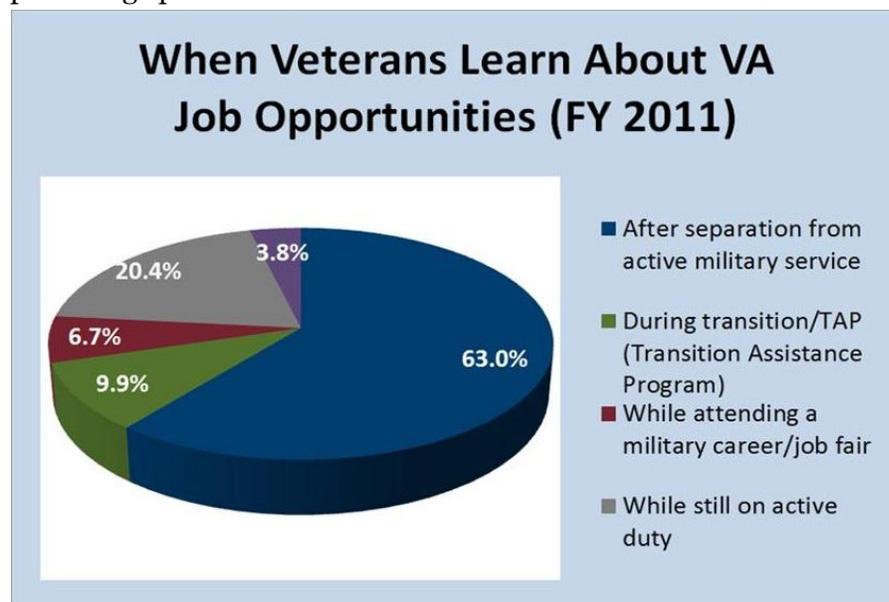


Figure 42

outreach efforts. Increasing numbers of Veterans are learning about job opportunities during Transition Assistance Programs (+1 percentage point over last year), and at Military career/job fairs (+0.4 percentage points). The majority of Veteran new hires (63%) still learned about their VA job opportunity after separation from military service and primarily at <http://www.USAjobs.gov>.

Continuing the expanded use of Veteran hiring authorities will

allow facilities additional flexibility in recruiting staff to meet ongoing needs. The VEOA ensures that Veterans are able to compete for government positions that previously may have only been available to existing civil service employees. The VRA and other hiring authorities allow eligible Veterans to fill certain positions without competition.

Rural Health Outreach

VHA continues in its efforts to provide quality health care to the estimated 41% of enrolled Veterans living in rural and highly rural areas of the country. In the 2010-2014 VHA Office of Rural Health (ORH) Strategic Plan, rural workforce recruitment and retention was identified as a critical area of focus and subsequently established a clear goal to, “Develop innovative methods to identify, recruit and retain medical professionals and requisite expertise in rural and highly rural communities.” This year the Office Workforce Management and Consulting established a partnership with 3RNet, a not-for-profit organizations helping health professionals find jobs in rural and underserved areas throughout the country. Through this partnership VHA can build relationships with providers who share an interest in rural practice sites and place VHA practice opportunities on the 3RNet Internet page. VHA’s presence among the rural health community will increase through attendance at the National Rural Health Conference and the Rural Health Critical Access Hospital Conference. VHA has linked VISN Rural Consultants with respective National Recruitment Consultants to address the unique nuances of rural recruitment.

Workforce Diversity Outreach

To sustain and enhance workforce diversity, VHA employs recruitment strategies that result in obtaining a diverse qualified applicant pool. Collaborative efforts between Equal Employment Opportunity (EEO) Program Managers, HR Management Services’ staff, hiring officials and recruiters are vital to recruit, hire, and retain the best qualified candidates.

VHA’s national recruiting events are aimed at diversity and minority outreach. The majority of these events are directed to the Hispanic and Native American population. VHA maintains a national recruitment calendar and arranges for subject matter experts to attend events to represent their career fields.

To reach Hispanic candidates, VA is spending 15% of its broadcast dollars on Spanish speaking network and cable channels. Specific initiatives are planned in 2013 to reach Asian and Pacific Islanders and ensure a comprehensive recruitment outreach strategy that effectively targets all sectors of the population.

In August 2012, VHA’s Native American Outreach recruitment campaign received a first place award for the Creative Excellence Award competition, one of the most recognized award competitions honoring excellence in recruitment advertising. In addition, the Native American Outreach program was awarded a silver W3 Award, which honors creative excellence in advertising and marketing on the web.

VA is committed to increasing the representation of qualified people with disabilities in all levels of its workforce. According to the Department of Labor statistics for May 2012, the unemployment rate for people with disabilities is 12.9% up from 12.5% the previous month. Unemployment for the general population remained relatively unchanged at 8.2%.

VA's goal is to hire 2% of its new hires from this demographic and maintain an onboard goal of 2% employees with targeted disabilities as part of the workforce. The new hire ratio for permanent employees with targeted disabilities in FY 2011 was 1.9%. Second quarter FY 2012 data shows that of total VA hires to permanent and temporary positions, 2.6% were individuals with targeted disabilities. To maintain the 2% onboard ratio, VA needs to improve the retention rate by providing accommodations if possible when requested, and by providing training to employees on developmental opportunities.

Additional recruitment strategies and concentrated outreach to organizations that support education, training and placement of people with disabilities must be priorities for the coming years. Programs to build development programs and career paths are critical to ensure career development not just entry level employment.

Advertising, Promotional, & Marketing Strategies

“The Best Care—The Best Careers” brand promotes VHA as a provider of quality care and extensive career opportunities. VACareers, the official job board site of VA, can be found at <http://www.VAcareers.va.gov>. VACareers pulls all VA jobs from OPM's job site <http://www.usajobs.gov> into one location. Two primary goals in VHA recruitment marketing are to increase VHA's brand awareness as an employer of choice and to guide individuals to the VACareers home page to explore job opportunities and learn more about the organization.

VHA continues to expand investment in multimedia recruitment marketing campaigns to establish a strong employment brand and awareness of employment opportunities. Traditional media such as print is in decline, but broadcast media continues to play an important part in recruitment marketing efforts. Increased emphasis on social and mobile media such as Facebook and Twitter is increasing awareness too and is leading efforts to develop relationships with people who may be interested in working for VHA. The VACareers Facebook page has more than 9,100 fans and Twitter has over 2,462 followers, which represents an almost 100% increase over followers in 2011. VACareers continues to operate a blog, <http://www.blogs.va.gov/vacareers/> with special emphasis on reaching and educating Veterans engaged in job searches.

VA as a whole is a social media leader among government agencies. Most of VHA's current advertising budget is in online advertising. Online advertising is a cost-effective way to reach Veterans and other potential applicants. The return on investment is evident when reviewing Entrance Survey data from new hires. In several occupations VACareers is the most frequently cited job information source and exceeds USAJobs as a source for employment information, especially for nurses. However, the partnership with OPM and their Spotlight Jobs feature has proven exceptionally helpful in guiding candidates to the VACareers home page and the VHA Placement Service email box. Visitor traffic routinely spikes each time VHA positions are featured on Spotlight Jobs.

Retention Incentives

Financial Incentives

Recruitment, retention, and relocation (3R) incentives continue to be effective tools in recruiting and retaining employees in critical and difficult-to-fill positions. These incentives are increasingly critical for recruitment of clinical professionals. One private sector firm, Merritt, Hawkins and Associates, in

their 2011 study, *Review of Physician Recruiting Incentives*, reported that 92% of physician searches included relocation incentives that averaged \$10,454 and recruitment incentives (i.e., signing bonuses) were offered in 76% of searches with an average payout of \$23,790. Increasingly, VHA hiring managers are seeing physicians decline job offers because of low salary offers, making use of other hiring incentives critical to developing competitive compensation packages. By comparison in FY 2011, the VHA relocation incentive was above the private sector average at \$16,213 and the recruitment incentive was considerably below average at \$15,705. No comparative data, similar to those used in the federal government, were available for retention incentives.

“Signing bonuses, relocation and continuing medical education allowances remain standard in most physician recruitment incentive packages.” Merritt, Hawkins and Associates, 2011 Review of Physician Recruiting Incentives: An Overview of the Salaries, Bonuses, and Other Incentives Customarily Used to Recruit Physicians (2011)

The cost of 3R incentives was capped at FY 2010 levels, and totaled \$142 million, a decrease of \$10 million. The majority of these financial incentives (74.5%) are distributed to employees in the top ten occupations. Unfortunately, financial incentives are now under even more intense scrutiny along with all other federal government spending, leading the Under Secretary for Health to direct all VISN and Medical Center Directors to conduct a 100% review of retention incentive payments (the largest portion of financial incentives) currently in place for all employees. To date, 27% of the retention incentives in place have been reviewed, and 91% of those have been terminated. Another 7,323 incentives are pending review. VHA has mandated that a Retention Incentive Technical Review Board (RITRB) comprised of human resource professionals be established in each VISN to provide oversight for all retention incentives and ensure that all retention incentives adhere to established criteria.

Incentive Type	Total Awards	Total Dollar Amount	Average Dollar Amt	% to Top 10 Occupations
Recruitment	2427	\$28,790,378.30	\$11,862.54	88.19%
Relocation	759	\$10,022,586.74	\$13,204.99	53.61%
Retention	14219	\$103,758,078.27	\$7,297.14	72.72%
3R Total	17350	\$142,571,043.31	\$8,217.35	74.50%

See the 2013 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental> for details on number and amount of recruitment, retention, and relocation awards spent on each of the top ten occupations.

Higher Rates of Pay Based on Specialized Skill

The authority to appoint new employees at a step above the minimum entrance level is available to enhance VHA’s ability to meet its recruitment needs; however, OPM regulations require that a recruitment incentive is considered before approval of an above-minimum rate since it will be significantly more costly as it affects future pay entitlements. VA guidance regarding this subject can be found in VA Handbook 5007, Part II, Chapter 3. This is authorized in 5 U.S.C. 5333(a) and 5 CFR 531.212.

Loan Repayment Incentives

The ***Education Debt Reduction Program (EDRP)*** is a tax-free recruitment and retention incentive for Title 38 and Hybrid Title 38 employees who provide (or support) direct patient care services in hard-to-fill positions and have qualifying loans. In FY 2011, VHA reimbursed over \$17.8 million to EDRP award recipients and approved 265 new EDRP awards, equating to over \$7.4 million. The law allows for payments up to a maximum of \$60,000, and payments are made annually for one to five years. The majority of EDRP awards in FY 2011 (86.3%) were allocated to employees in the top ten occupations.

The ***Student Loan Repayment Program (SLRP)*** is an OPM-authorized incentive used to recruit or retain highly qualified candidates in hard-to-recruit or hard-to-retain Title 5 or Hybrid Title 38 positions. An employee may receive up to a lifetime total of \$60,000, with a maximum of \$10,000 per year, in payments made to the lending institution by VHA. In FY 2011, VHA awarded \$3.6 million in SLRP, and the majority of these dollars (66.9%) went to employees in the top ten occupations. VA policy can be found in VA Handbook 5007/2, Part VI, Chapter 8. The SLRP requires the employee to enter a service agreement for three years.

Non-Financial Incentives

The Society of Human Resources Management's "2010 Employee Job Satisfaction" report found that job security and benefits were the top two "very important" contributors to job satisfaction, while compensation/pay was ranked fifth. Other factors that were strongly related to job satisfaction included elements related to comfort in the work environment, having a good relationship with the supervisor, being recognized by management for performance, workplace flexibility, and a satisfying work/life balance. "Looking toward a stronger economic upturn and improvement in the job market, it will be important for organizations to balance the lessons learned from the recession with viable employee benefits and practices that lend themselves to engage the most productive and talented employees" (Society for Human Resource Management, 2010).

Flexibilities in Work Schedules Telework - Laws addressing telework have been in effect for federal employees for several years. Most recently, the Telework Enhancement Act of 2010 (the Act), was signed into law. The law specifies roles, responsibilities and expectations for all federal executive agencies with regard to telework policies; employee eligibility and participation; program implementation; and reporting. The specific agencies named in the Act are charged with directing overall policy and providing policy guidance to federal executive agencies on an ongoing basis. VHA is seeing an increase in the use of telework and virtual work locations, but significant enhancements in this area may improve retention, and may be especially helpful in retaining HR Specialists.

Educational assistance programs provide recruitment and retention incentives for current employees in hard to recruit occupations who are seeking to develop their career. These programs also provide employee development training to facilitate the succession pipeline.

Phased Retirement - A major retention incentive has been made possible by the July 6, 2012, approval of Phased Retirement. Phased Retirement is a new human resource management and knowledge retention tool made possible by section 100115 of Public Law 112-141, the "Moving Ahead for Progress in the 21st Century Act," or "MAP-21." Phased Retirement allows federal employees to work



part-time while also earning a partial pension. OPM's goal is to implement phased retirement as soon as possible.

This retention incentive will encourage the most experienced federal employees to extend their career continuing to share their significant agency knowledge and contributions to the nation, and will operate as a tool to ensure continuity of operations and to facilitate knowledge management.

For the latest information about current initiatives regarding recruitment and retention, please refer to the 2013 VHA Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>

Chapter 9: Deployment Strategies

Workforce Succession Strategic Initiatives

Based on the analysis of both VHA workforce needs and current workforce succession and development programs, and the goals for diversity and inclusion, the following initiatives are needed to strengthen existing programs and efforts.

<p>Recruitment - Recruitment initiatives will attract a wide range of skilled professionals to provide the highest quality care to our nation's Veterans.</p>	Act on the recommendations of the Recruitment Transformation Workgroup.
	Implementation of the Pathways Program.
	Implement WebHR auto-generation of Entrance Survey requests to increase participation and develop a reporting mechanism for facility participation rates. Encourage action planning by facilities based upon findings.
	Conduct a study on recruitment and retention of physicians.
	Develop aggressive recruitment strategies to reach under-represented minority populations, disabled individuals and Veterans.
	Implement physician recruitment incentives utilizing current authorities.
	Implement Veterans Hiring Initiatives to increase the number of Veterans in the workforce.
<p>Engagement & Retention - Retention initiatives include programs, flexibilities, and developmental opportunities designed to keep highly qualified professionals growing and engaged within VHA.</p>	Assure timely hiring of mental health staff as part of the Mental Health Improvement Initiative.
	Upon approval, implement New Employee Experience & Retention (NEER) Transformation Workgroup recommendations nationwide.
	Implement the standardized New Employee Orientation Program modules that provide an understanding of VHA's health care mission and the employees' role in accomplishing the mission, work team concepts, competency models, diversity, and personal development and career planning.
	Implement the automated WebHR email notification at all facilities to increase the use of the VA Exit Survey in the HR clearance process and develop a reporting mechanism for facility participation rates. Encourage action planning by facilities based upon findings.
	Develop and implement a variety of innovative strategies to recognize and retain nurses in clinical and administrative roles.
Continue workforce and leadership development training in the competencies needed to build and maintain effective, diverse, and culturally competent work units and productive workplace environments.	

<p>Leadership Development - Leadership development is a key strategy for creating a leadership continuum that drives our Veteran-centric organization, engages employees, is results driven, and supports innovation in a constantly changing environment.</p>	Continue implementation and evaluation of the Health Care Executive Fellowship (HCEF) program.
	Update LEAD curriculum for greater consistency and effectiveness in meeting leadership development needs below ECF level.
	Monitor the diversity of applicants and participants in VHA development programs to identify barriers to full participation and initiate actions as indicated.
<p>Workforce Development/Knowledge Transfer - Workforce development provides opportunities and directed experiences to develop employee skills and behaviors needed for continued transformation of VHA into a people-centric, results-driven, and forward-looking culture. VHA knowledge transfer initiatives will organize, create, capture and distribute knowledge and ensure its availability for future users by utilizing technology and practices such as mentoring/coaching, training, documentation, and other methods of collaboration.</p>	Incorporate Servant Leadership principles into VHA Leadership Development Programs.
	Partner with VALU in the roll out of VA's employee and leadership competencies as an enhancement to VHA's High Performance Development Model.
	Incorporate the use of VA core values and characteristics into all aspects of workforce development.
	Encourage use of Personal Development Plans (PDP).
	Develop a pathing model for a selected occupation (e.g., HR).
	Align employee participation in PACT implementation, team training, systems redesign, continuous improvement, and other initiatives that advance the goals of the Under Secretary to other workforce development initiatives.
	Continue development of skilled, certified mentors and coaches for VHA-sponsored health care leadership development programs.
	Implement the Clinical Nurse Leader (CNL) at all points of care throughout VHA by FY 2016.
	Explore the use of SimLEARN applications within workforce development.
	Redefine High Performance Development Model (HPDM) to assure effective crosswalk to new competencies, reduce gaps in leadership programs and create a catalog of related programs.
Implement phased retirement to utilize skills of retirement eligible staff for knowledge transfer and leadership development.	
<p>Workforce Planning - Workforce planning ensures a continuous process that incorporates the very best in analytical and forecasting methodologies in support of VHA initiatives to recruit and retain the right number of employees with the right skills, experiences, and competencies, in the right jobs at the right time.</p>	Enhance the content of and access to workforce and succession planning training opportunities through modalities such as web-based courses and Live Meetings.
	Utilizing data from second year implementation of facility-based planning focus curriculum development on top three areas for improvement.
	Develop skills and competencies for effective facility-based workforce planners.

<p>Organizational Health - VHA is dedicated to creating a healthy organization and productive work environment making it possible for employees to demonstrate the highest standards of compassion, excellence, professionalism, integrity, accountability, stewardship, and commitment to the principles of Veteran-centered care.</p>	Expand deployment of organizational health initiatives.
	Complete a gap analysis on Servant Leadership characteristics in VHA to develop program content for leadership development.
	Create an environment of Veteran centeredness through the implementation of a New Employee Experience Initiative.
	Leverage All Employee Survey (AES) trend data to improve organizational health and employee satisfaction.
	Proceed with the research goals defined by the Organizational Development (OD) research program to validate the strategic Organizational Health model. <ul style="list-style-type: none"> •Research employee health, wellness, and physical safety to improve employee satisfaction and organizational health. •Research the appropriate link between servant leadership and the VHA leadership model.
	Facilitate progress on VHA Learning Organization Transformation.
	Support NCOD and EES in the execution of the Under Secretary's initiative on preparing the workforce for a culture of rapid change.
<p>Deployment - Workforce deployment initiatives facilitate the implementation of an integrated approach to workforce planning and workforce management operations.</p>	Continue implementation and evaluate the effectiveness of the Travel Nurse and Travel Physician Corps.
	Implement VA Nursing Academy to increase entry-level baccalaureate prepared nurses.
	Develop formal plans to use delegated authority for dual compensation waivers for reemployed annuitants.
	Develop tools and guidance on appropriate utilization of appointment authorities (e.g., fee basis, clinical intermittent, part-time, temporary) for meeting clinical needs.
	Expand the availability of WebHR to other VA administrations.
	Increase the utilization of the HR Dashboard for executive decision making related to recruiting, selecting, and retaining talent.
	EPerformance- Partner with the Department to create an electronic performance management system.
	Implement an applicant tracking system (ATS) that will provide recruiters and hiring managers with a rich data source for matching applicant competencies and geographic preferences to vacancies as well as evaluating the effectiveness of recruitment activities.
	Clinical Trainee Registration Tracking (CTRT) - Deploy a registration system for all trainees (administrative and clinical) that rotate through VHA each year that enhances this source of advancement opportunities.
	Partner with VHA Contracting to develop and roll out regional and national Blanket Purchase Agreements (BPAs) for locum tenens. Roll out automated Executive Recruitment Tool to track status of executive recruitment vacancies. Roll out automated Organizational and Position Management tool.

For the latest information about the status of current initiatives, please refer to the 2013 VHA Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2013supplemental>

Legislative/Policy Initiatives

As part of the FY 2012 workforce succession planning cycle, workforce planners identified potential legislative and policy issues that impact workforce succession planning. The following is a summary of policy changes, legislative efforts, policy efforts, and areas of possible consideration for the future.

Implementation of Public Law 111-163, Caregiver and Veterans Omnibus Health Services Act of 2010, included:

- Conversion of Nursing Assistant occupational series to Hybrid Title 38. Appointments completed; finalizing qualification standards and the professional standards boards.
- VA Secretary granted authority to extend Title 38 status to additional occupations. Medical Support Assistant was converted to Hybrid Title 38 in June 2012.
- Prioritization of additional occupations to Hybrid Title 38.
- Increased basic salary limitation for Nurses from level V to IV (\$145,700 to 155,500).
- Increased basic salary limitation for Nurse Anesthetists from Level V to Level I (199,700).
- Increased the aggregate pay limitation for Title 38 Nurse Executives from Level I of the Executive Schedule to the rate for the President of the United States (\$400,000).
- Increased the special incentive pay for Nurse Executive from \$25,000 to \$100,000.
- Eliminated the 60% special rate supplement limitation or the 28-step limitation for Licensed Practical Nurses.
- Increases the basic salary limitation for special rates approved under 38 U.S.C. 7455 from Level V to Level IV (currently \$155,500).
- Authorized special incentive pay for Pharmacy Executives up to \$40K.
- Increased the aggregate pay limitation for Hybrid Title 38 Pharmacist Executives to the rate for the President of the United States (\$400,000).
- Reinstatement of the Health Professional Scholarship Program through 2013. Program will provide financial assistance to competitively selected scholarship recipients in exchange for two year VA service obligations upon graduation and licensing. Expanded to Hybrid Title 38.
- Entitlement of weekend pay and night differential during periods of leave and absence for Title 38, registered nurses, physician assistants, and expanded function dental auxiliaries.
- Modification of Alternative Work Schedule for Nurses (changed the 36/40 alternate work schedule to 72/80).
- Improvements in the Education Debt Reduction Program:
 - Eliminated the 6-month “recently hired” stipulation for program eligibility
 - Increased the statutory cap on the award maximum to \$60,000 paid over a 5-year period
 - Gives the Secretary or designee the ability to waive the cap and payment timeframe for those positions and geographic areas in need.
- Visual Impairment and Orientation and Mobility Professionals Educational Assistance Program

Public Law 112-141, the "Moving Ahead for Progress in the 21st Century Act," or "MAP-21," approved on July 6, 2012.

- Creates a Phased Retirement program which will allow federal employees to work part-time at the end of their federal careers while also earning a partial pension.

Proposed Legislation* in FY 2012-2013 includes:

- Establishing an appointment and compensation system under Title 38 for the VHA positions of Medical Center Director, Veterans Integrated Service Network (VISN) Director, and other positions determined by the Secretary that have significant impact on the overall management of the Department’s health care system. (VA)
- Public Law 111-163, section 603 - the Caregivers Act, reestablished the Health Professionals Educational Assistance Program (HPEAP) by eliminating the previous 1998 sunset date and extending the program through December 14, 2014. VHA has proposed legislation to eliminate the sunset date for the Health Professionals Scholarship Program and indefinitely extending the authority to offer scholarships under this program to help meet recruitment and retention needs for critical health care providers.

Amend definition of liability for breach of contract under EISP.

*If and when these proposals become federal law, they’ll have to be implemented through the policy and regulatory process. In many cases, rules must be published in the Federal Register to give members of the public the chance to comment on them. If a proposed change will affect the way federal benefits are administered, the Office of Personnel Management must prepare a benefits administration letter to inform agency personnel offices how to implement the change. Those offices are then responsible for notifying employees of the change through any means they deem appropriate. This can include emails, training seminars, posters and mailings. OPM will inform retirees if a change will impact them. Only after this process takes place will employees be able to benefit from changes to laws that affect the way retirement benefits are administered.

Policy and Other Efforts Underway

- Continuous enhancements to the USA Staffing and USA Jobs (OPM system) both for applicants and HR professionals
- VA Agency-wide Hiring Reform includes streamlined job announcements, improved timeliness of DEU certificates and HR timely hiring performance metrics.
- Improvements to the Hybrid Title 38 recruitment and boarding process as recommended by Process Action Team.
- OPM delegation for VA to waive the dual compensation reduction to reemploy RN annuitants; approved waivers NTE two years.
- Review of the existing processes for classification and implementation of standardized position descriptions
- The Human Resources Line of Business (HR LOB) initiative for PAID solution

Future Legislative and Policy Efforts

Other efforts to pursue in FY 2013 and beyond include but are not limited to:

- Use of electronic signatures where practical in order to speed up the flow of business.
- Increase the maximum allowable salary under physician and dentist pay bill, increase the level at which the VISN can approve physician pay, and simplify the exception approval process.
- Review and change policy controlling Physician Assistant grades (qualification standards) for GS-14 and 15 equivalents to allow for the higher level responsibilities and compensation.

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Appendix A: Governance of VHA Workforce Succession Planning Process

Oversight and Leadership

In 2011, the overall governance structure of VHA was refreshed, and the National Leadership Board (NLB) became the National Leadership Council (NLC). The NLC is chaired by the Under Secretary for Health (USH) and has a membership consisting of all top level line and staff executives in VHA including all 21 VISN Directors and the heads of all major staff Program Offices in VHA's headquarters. Under the NLC are a number of committees to oversee the major health care and business areas of the organization. One of these committees was the Human Resources Committee (HRC), under which the Succession and Workforce Development Management Subcommittee (SWDMS) was made a standing subcommittee. The HRC is now known as the Workforce Committee (WC). Other standing subcommittees of the WC include the Organizational Assessment Subcommittee (OASC), which partners with the SWDMS in workforce development and succession programs with an expertise and emphasis on workplace improvement, employee satisfaction, and organizational development research; the Strategic Human Resources Advisory Committee (SHRAC) which provides strategic and operational oversight and guidance to VHA HR programs; and the Diversity and Inclusion Subcommittee (D&I), which oversees and sponsors programs to ensure that VHA maintains and capitalizes on the value of its diverse workforce. In 2012 the Leadership Management and Succession Subcommittee (LMSS) was created to establish plans and strategies that develop, strengthen, and support the wellbeing of leadership within VHA's health care system.

In June 2001, the original VHA Workforce Succession Committee established the Succession Planning Deployment Workgroup with responsibility to oversee and manage the development and implementation of the components of the VHA succession program. The workgroup is now known as the SWDMS and is chaired by a senior VHA leader. SWDMS members represent all levels of VHA management along with key staff from the national Program Offices that are directly responsible for developing and administering VHA succession programs. This group has served continuously since its inception, with quarterly face-to-face meetings and intervening teleconferences.

Having a permanent accountable organization linked directly to the top VHA leadership structure, to oversee, manage, and drive the program is considered a key element in the success of VHA's succession and workforce development efforts. The years that VHA has spent cultivating a comprehensive succession planning program have paid off in large part due to the effective program governance and administration provided by the SWDMS, WC, and NLC.

Implementation and Administration

Organizational responsibility to implement, conduct, and administer VHA workforce succession programs was assigned jointly to the EES (responsible for the formal educational components) and the Workforce Management and Consulting Office (WMC; responsible for overall program administration and budgeting along with organization consulting, assessments, and executive coaching functions). In addition, the VHA Support Services Center (VSSC), Office of Policy and Planning, National Center for Organization Development (NCOD), Center for Organization Leadership and Management Research (COLMR) of the Health Services Research & Development Office, and the Occupational Health Office of

the Public Health and Environmental Hazards Office are key partners in VHA workforce succession programs.

Program Approval and Funding

The various components of VHA's workforce succession program are developed under the auspices of the SWDMS, usually by chartering an ad-hoc workgroup to develop a proposal for the program including its implementation strategy, schedule, and budget requirements. The proposal is then reviewed and approved by the SWDMS, the WC, the Finance Committee, and then submitted to the full VHA NLC for approval.

Once approved, workforce succession program funds for each component are provided to the WMC Office. Funds are then disbursed for program expenses. Recurring fund requirements then become a part of the annual budget allocation. Since the WMC Office is the initial budget office for all VHA workforce succession programs, top management can easily identify and control program expenditures.

Program Evaluation

Workforce succession program evaluation is a part of the annual strategic planning process and an integral part of the operation of each individual program. Programs are reviewed within the context of the overall workforce analyses and specific plans and needs identified by each VISN.

Recommendations for program changes are then included in the update process for the national plan. VHA developed a general model for program evaluation, and each program design incorporates the appropriate evaluation methodologies consistent with this overall evaluation model. The general model is depicted in the Continuous Assessment Evaluation Feedback Loop illustrated in Figure 43.

Evaluation efforts incorporate ongoing processes that provide continuous feedback to the governance and oversight functions and the national workforce planning processes including both internal evaluation and external benchmarking. These processes

ensure that programs meet the workforce development and succession needs of VHA, are preparing the right number of employees to fill future positions with the right skills to advance organizational goals, and are cost effective. In addition to and in support of the specific evaluation processes for each program, VHA established a national Organization Development Research Program to bring scientific validity to the clinical and business value of program outcomes and to advance the state of knowledge in these areas.

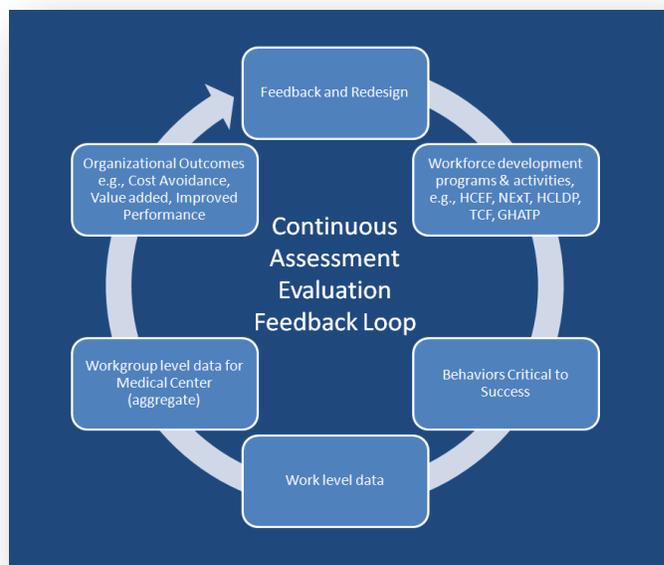


Figure 43



Appendix B: List of Acronyms

Acronym	Title
3R	Recruitment, retention, and relocation
AACN	American Association of Colleges of Nurses
AAPA	American Academy of Physician Assistants
ACA	Affordable Care Act
ACCP	American College of Clinical Pharmacy
ACR	American College of Radiology
AD	Associate/Assistant Director
ADPCS	Associate Directors for Patient Care Services
ADR	Alternative Dispute Resolution
AEP	Affirmative Employment Program
AES	All Employee Survey
AIM	Academy for the Improvement of Microsystems
AMEDDC&S	U.S Army medical Department Center and School at Fort Sam Houston, Texas
APA	American Psychological Association
APRN	Advanced Practice Registered Nurse
APTA	American Physical Therapy Association
ARC-PA	Accreditation Review Commission on Education of Physician Assistant
ARRA	American Recover and Reinvestment Act
ARRT	American Registry of Radiological Technologists
ASHP	American Society of Health-Systems Pharmacists
ASRT	American Society of Radiologic Technologists
ATS	Applicant Tracking System
BEST	Business Engineering System Team
BLS	Bureau of Labor Statistics
BPA	Blanket Purchase Agreements
BPS	Board of Pharmacy Specialties
CACs	Clinical Application Coordinators
CARF	Commission on Accreditation of Rehabilitation Facilities
CBO	Chief Business Office

Acronym	Title
CBOC	Community Based Outpatient Clinics
CDL	Central Dental Laboratory
CIPP/G	Certified Information Privacy for Professionals/Government
CME	Continuing Medical Education
CNL	Clinical Nurse Leader
COHR	Central Office Human Resources
COLMR	Center for Organizational Leadership & Management Research
COP	Community of Practice
COS	Chief of Staff
COTA	Certified Occupational Therapy Assistant
CPAC's	Consolidated Patient Account Centers
CQ	Continued Qualifications
CREW	Civility, Respect and Engagement in the Workplace
CRNA	Certified Registered Nurse Anesthetist
CRT	Certified Respiratory Therapist
CSEMO	Corporate Senior Executive Management Office
CSRS	Civil Service Retirement System
CTRRT	Clinical Training Registration Tracking
CV	Curriculum Vitae
D&I	Diversity and Inclusion Subcommittees
DND	Deputy Network Director
DoD	Department of Defense
DRT	Diagnostic Radiological Technician
EAP	Employee Assistance Program
ECFCDP	Executive Career Field Candidate Development Program
ECQ	Executive Core Qualification
EDRP	Education Debt Reduction Program
EEO	Equal Employment Opportunity
EES	Employee Education System
EHCPM	Enrollee Healthcare Projection Model



Acronym	Title
EIG	Excellence in Government
EISP	Employee Incentive Scholarship Program
EQV	Equivalent
FERS	Federal Employee Retirement System
FY	Fiscal Year
GED	General Education Development
GHATP	Graduate Healthcare Administration Training Program
GME	Graduate Medical Education
HACU	Hispanic Association of Colleges and Universities
HCEF	Health Care Executive Fellowship
HCLDP	Health Care Leadership Development Program
HCLI	Health Care Leadership Institute
HEC	Health Eligibility Center
Hi ²	Health Informatics Initiative
HIAC	Health Informatics Application Coordinator
HIS	Health Informatics Specialist
HIT	Health Information Technology
HPDM	High Performance Development Model
HPEAP	Health Professionals Education Assistance Program
HR	Human Resources
HRC	Human Resources Committee
HRD	Human Resources Development
HRLOB	Human Resources Line of Business
HRML	Human Resources Management Letter
HRRO	Healthcare Retention and Recruitment Office
HSM	Health System Management
HTM	Healthcare Talent Management
I CARE	Integrity, Commitment, Advocacy, Respect, and Excellence
IAPP	International Association of Privacy Professionals
ICU	Intensive Care Unit

Acronym	Title
IOM	Institute of Medicine
IVMH	Improving Veteran Mental Health
JCA	Justice Center of Atlanta
JOLTS	Job Openings and Labor Turnover Survey
JSI	Job Satisfaction Index
LDP	VA Leadership Development Portal
LEAD	Leadership, Effectiveness, Accountability and Development
LIP	Licensed Independent Practitioner
LMSS	Leadership Management & Succession Subcommittee
LPMHC	Licensed Professional Mental Health Counselor
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MCAB	Mentor Certification Advisory Board
MFT	Marriage and Family Therapist
MHS	Mental Health Service
MSPB	U.S Merit System Protection Board
MTT	Medical Team Training
MVC	Mobile Vet Center Units
NBRC	National Board for Respiratory Care
NCCPA	National Commission on Certification of Physician Assistan
NCOD	National Center for Organizational Development
NEER	New Employee Experience and Retention
NExT	New EXecutive Training
NI	Nursing Informatics
NLB	National Leadership Board
NLC	National Leadership Council
NMS	National Matching Services, Inc.
NNEI	National Nurse Education Initiative
NP	Nurse Practitioner
OAA	Office of Academic Affiliations



Acronym	Title
OAI	Organization Assessment Index
OASC	Organizational Assessment Subcommittee
OD	Organizational Development
OEF	Operation Enduring Freedom
OHE	Office of Health Equity
OHRM	Office of Human Resources Management
OIF	Operation Iraqi Freedom
OMHO	Office of Mental Health Operations
OND	Operation New Dawn
ONS	Office of Nursing Service
OPM	Office of Personnel Management
ORH	Office of Rural Health
ORM	Office of Resolution Management
OT	Occupational Therapy
PACT	Patient Aligned Care Team
PBM	Pharmacy Benefits Management Services
PCC	Patient Centered Care
PcTOC	Primary Care Telehealth Outpatient Clinic
PDP	Personal Development Plan
PGY1	Postgraduate Year one
PMDB	Prevention and Management of Disruptive Behavior
PP	Percentage Point
PPACA	Patient Protection and Affordable Care Act
PRRO	Pharmacy Recruitment and Retention Office
PSB	Professional Standards Board
PT	Physical Therapy
PTA	Physical Therapist Assistants
PTSD	Post-Traumatic Stress Disorder
QRB	Qualifications Review Board
QSV	Quality, Safety, Value

Acronym	Title
RRA	Registered Radiologist Assistant
RCLF	Relevant Civilian Labor Force
RHI	Rural Health Initiative
RITRB	Retention Incentive Technical Review Board
RN	Registered Nurse
ROI	Return on Investment
RRT	Registered Respiratory Therapist
RT	Respiratory Therapist
SAP	Special Advancements for Performance
SCAN-ECHO	Specialty Care Access Network and Extension for Community Healthcare
SCIP	Strategic Capital Investment planning
SES	Senior Executive Service
SESCDP	Senior Executive Service Candidate Development Program
SHRAC	Strategic Human Resources Advisory Committee
SLRP	Student Loan Repayment Program
SME	Subject Matter Expert
SPH	Safe Patient Handling
SUD	Substance use Disorder
SWDMS	Succession and Workforce Development Management Subcommittee
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
TCF	Technical Career Field
TJC	The Joint Commission
TMS	Talent Management System
UME	Under-Graduate Medical Education
USH	Under Secretary for Health
VA	Veterans Affairs
VALOR	VA Learning Opportunities Residency
VAMC	Veterans Affairs Medical Center
VANEEP	VA National Employee Education Program



Acronym	Title
VCS	Veteran Canteen Services
VEOA	Veteran Equal Opportunity Act Authority
VERC	Veterans Engineering Resource Center
VESO	Veteran Employment Services Office
VHA	Veterans Health Administration
VHACO	Veterans Health Administration Central Office
VISN	Veteran Integrated Service Network
VOVA	Voice of VA
VOW	Veterans Opportunity to Work
VPS	Veteran Point of Service
VRA	Veterans Readjustment Authority
VRM	Veteran Relationship Management
VSHO	VHA Services Human Resources Office
VSSC	VHA Support Service Center
VTs	Veteran Transportation Services
WC	Workforce Committee
WIN	Wellness Is Now
WMC	Workforce Management and Consulting
WRP	Workforce Recruitment Program for College Students with Disabilities