



Interim Workforce and Succession Strategic Plan

2014



- ▶ Strategic Direction
- ▶ Diversity & Inclusion
- ▶ Workforce Projections
- ▶ Critical Occupations





It is my pleasure to present the 2014 Interim Veterans Health Administration's (VHA) Workforce and Succession Strategic Plan. For over a decade, VHA's workforce planning process has led the way for the Department of Veterans Affairs (VA) to be successful in meeting the Office of Personnel Management mandate for agency workforce planning. That process relies upon the input from workforce and succession plans submitted by each VA Medical Center, Veterans Integrated Service Network, and Program Office.

In March 2012, the VA Workforce Planning and Analysis (WPA) Office, under the Strategic Human Capital Planning Service, released a Concept of Operations document that describes VA's implementation of a new corporate workforce planning capability. The WPA implementation plan and proposed timelines represent an opportunity for VHA Workforce Planning to align, improve and take advantage of WPA's resources. Therefore, in 2013, VHA performed a focused review of the existing workforce planning process to identify opportunities to improve its agility to respond to future needs. As a result, this interim plan provides a summary of the findings and outcomes of the workforce planning process redesign efforts and includes an introduction to the key drivers affecting the workforce, an analysis of the impact of those drivers, and the organization's strategy for mitigating identified risks.

Those in responsible leadership and management positions will find this plan a valuable resource for understanding their own workforce and succession challenges and opportunities. It outlines the 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.

An electronic version is available 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.

A handwritten signature in black ink that reads "Robert A. Petzel".

Robert A. Petzel, M.D.
Under Secretary for Health

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Overview

VHA's workforce planning process has led the way for the Department to be successful in meeting the Office of Personnel Management's (OPM) mandate for agency workforce planning for more than a decade. The annual VHA Workforce Succession Strategic Plan is built upon the latest workforce and succession plans from each VA medical center, VISN, and Program Office. While this process has been recognized as a best practice in government, the Administration strives to continually improve, learn about and develop processes to ensure a superior workforce plan.

To that end, the traditional VHA Workforce Planning Team was chartered to review the current workforce planning capability and design new processes. The result is an implementation plan that outlines the primary goals identified by the team's analysis which include improving the alignment and integration of workforce planning strategies with the strategic and budget planning process, establishing infrastructures to improve timeliness, and supporting existing governance structures that will strengthen leadership support for workforce planning.

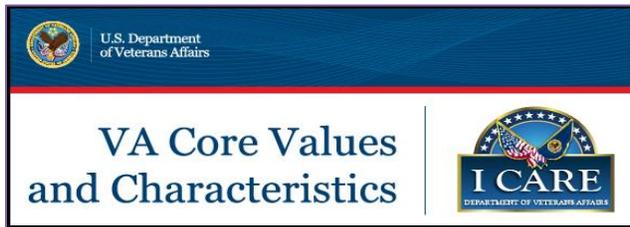
To help accomplish this review, the team received approval to temporarily suspend the production of the printed Workforce Succession Strategic Plan in FY 2014. This 2014 Interim Workforce Succession Strategic Plan includes:

- ▶ Strategic Direction Chapter which highlights the VA and VHA mission, vision, and strategic initiatives, and provides an introduction to key drivers affecting the workforce in FY 2014.
- ▶ Chapter 2 further analyzes the impact of those drivers and the organization's strategies for mitigating identified risks, to include discussion of the VHA mission critical occupations.
- ▶ Chapter 3 provides more detail regarding the workforce planning process redesign.
- ▶ Chapter 4 describes current national workforce and succession planning initiatives.

Additional workforce data are available in the electronic Supplemental Workforce and Succession Planning Report (<http://vaww.succession.va.gov/2014Supplemental>).

Chapter 1: 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 to meet the transformation challenges of the 21st century. Strategic succession planning is essential to maintain 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 by outlining the mission, vision, and strategic goals of the organization and identifying the workforce planning drivers and succession challenges that must be addressed to successfully achieve that mission.



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 core values and characteristics that describe VA's culture and character 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, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence ("**I CARE**"). According to the Draft VA Strategic Plan, our characteristics describe "what we stand for" and help guide how we will perform our mission. They shape our strategy, guide the execution of our mission, and influence key decisions made within VA. The characteristics are Trustworthy, Accessible, Quality, Agile, Innovative, and Integrated. Our core values and characteristics are an integral part of VA's strategic goals.

VA Agency Priority Goals

- ▶ Improve Veteran Access to VA Benefits and Services
- ▶ Eliminate the Disability Claims Backlog
- ▶ Eliminate Veteran Homelessness

VA Strategic Goals (FY 2014-2020)

- ▶ Empower Veterans to Improve Their Well-being
- ▶ Enhance and Develop Trusted Partnerships
- ▶ Manage and Improve VA Operations to Deliver Seamless and Integrated Support

VHA has developed new priorities and strategic goals that have been carefully aligned to the VA priority and strategic goals, including several critical workforce strategies for the objectives most relevant to recruiting, developing, and retaining a competent, committed, and diverse workforce.

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

VHA's principles are the philosophical pillars that are embedded in VHA's vision. They are embodied in our goals, objectives, and every initiative undertaken.

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

VHA Strategic Goals

1. Provide Veterans Personalized, Proactive, Patient-driven Health Care
2. Achieve Measureable Improvements in Health Outcomes
3. Align Resources to Deliver Sustained Value to Veterans

VHA Workforce and Succession Goal

VHA's workforce and 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.

VHA Workforce and Succession Planning Initiatives

Based on the analysis of VHA strategic goals, workforce needs, current workforce succession and development programs, and the goals for diversity and inclusion, the following categories of initiatives have been developed. A full description of these initiatives and their related strategies is provided in Chapter 4.

- ▶ Recruitment
- ▶ Engagement and Retention
- ▶ Leadership Development
- ▶ Workforce Development/Knowledge Transfer
- ▶ Workforce Planning
- ▶ Organizational Health
- ▶ Deployment

Introduction to Key Workforce Planning Drivers

The key internal and external drivers that affect workforce planning are introduced below. Further examination of each of these drivers is discussed in Chapter 2.

Internal Drivers

Health Care Delivery

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. In an effort to enhance the Veteran experience and access to health care, VHA is moving from emergency care to more preventive care, from long-term institutional care to non-institutional care options, and from VA hospitals to its expanded network of community-based options. In addition, e-connected health innovations are helping VHA right-size the government footprint as well as connecting patients wherever they are, creating greater access for patients in rural areas as well as greater convenience for non-rural patients.

- ▶ 5.5 million Veteran patients in 2012 and there are 5.6 million Veteran patients projected for 2013
- ▶ 21 Veterans Integrated Service Networks (VISNs)
- ▶ 152 medical centers
- ▶ 990 outpatient clinics¹
- ▶ 135 community living centers

¹ Includes Hospital Based Outpatient Clinics (HBOC), Independent Outpatient Clinics (IOC), Mobile Outpatient Clinics (MOC), Community Based Outpatient Clinics (CBOC)

- ▶ 103 Domiciliary Residential Rehabilitation Treatment Programs (DRRTP)
- ▶ 300 Vet Centers

VA has developed an enterprise-level Telehealth infrastructure from a series of strategic investments between 2002 and 2013. From 2002 to 2009, these targeted investments were made to expand access to care through Telemental Health, Home Telehealth, the Polytrauma Telehealth Network, and Teleretinal Imaging Program. From 2009 to present, Telehealth became a focus of a SECVA major transformational (T21) initiative and the SECVA Telehealth Expansion Taskforce, through which VHA invested more than \$460 Million over a 4-year period (FY 2010-FY 2013) in clinical technology, staffing assets and associated resources to support VISNs in rapidly implementing and growing Telehealth. In the last 11 years, the number of Telehealth encounters has increased nearly 80-fold from approximately 21,000 to over 1,750,000 per year. The future of health care continues to move in the direction of virtual modalities for the delivery of services.

Established in 2010, Office of Patient Centered Care and Cultural Transformation (OPCC&CT) is charged with “catalyzing and sustaining cultural transformation in healthcare for and with Veterans” from a primarily reactive, disease focused, physician-centered care model to a personalized, proactive, patient-driven approach to healthcare that prioritizes the Veteran and their values, and partners with them to create a personalized strategy to optimize their health, healing and well-being. To deliver this care, both the experience and practice of health care must radically change, and any culture change of this magnitude requires several years to successfully implement. The “practice” has the Veteran at the center, and begins with their vision of health and their values and goals. It links the Veteran’s personalized health plan to what matters to them in their lives, and it supports them in acquiring the skills and resources they need to succeed in making sustainable changes in their health and life. The “experience” establishes continuous healing relationships and provides optimal healing environments. The ultimate results are better health outcomes, improved quality of care, greater patient and provider satisfaction, and greater cost effectiveness.

VHA Workforce

At the end of FY 2012, VHA had over 277,000 employees, which makes it the second largest civilian employer in the federal government, after the Department of Defense (DoD; US OPM, 2013), 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 and 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.

Between FY 2013 and FY 2019, 40.6% of the VHA workforce will become eligible for regular retirement, with 23.3% projected to actually retire. The retirement rate has rebounded from the decline that occurred in 2009 and is expected to increase to 3.8% of the projected onboard. Among senior leaders, the rates of retirement eligibility are staggering, with more than three quarters of the Senior Executive Service (SES), Title 38 executives, chiefs of staff, and nurse executives, and about half of Associate, Assistant, and Deputy Network Directors eligible for retirement within the next 7 years.

Hiring Initiatives

Targeted Disabilities

In September 2010, Secretary Eric Shinseki reaffirmed VA's position as a federal government leader in its commitment to maintaining a workforce that reflects the great diversity of America including the employment of people with disabilities. In fiscal year 2013, the hiring goal was increased from 2% to 3% of total hires. The FY 2013 cumulative data show that of total VA hires to permanent and temporary positions (excluding medical residents and trainees), 1,233, or 3.2% were individuals with targeted disabilities. The National Cemetery Administration (NCA) led with 7.3%, Veterans Benefits Administration's (VBA) total was 4.6%, VHA's total was 3.1%, VA Central Office's (VACO) total was 3.9%, and VHA Central Office's (VHACO) total was 4.3%.

Veterans

In November 2011, President Obama signed the Veterans Opportunity to Work (VOW) to Hire Heroes Act. The Act requires federal agencies to treat active duty Servicemembers seeking employment as preference eligibles before their honorable discharge and ensures these individuals do not lose the opportunity to be considered for federal service. At the same time, Secretary Shinseki introduced *VA for Vets* to help Veterans launch or advance their civilian careers at VA (www.VAforVets.VA.gov). The Secretary also set a goal for the VA to increase its Veteran workforce from 30% to 40%. Since September 30, 2011, the number of onboard Veterans in VHA has remained at approximately 31.0% and VHA trails behind the other Administrations in achieving the Secretary's goal, primarily due to low numbers of Veterans in Title 38 health care occupations. Although VHA actively pursues efforts to hire and retain Veteran employees, a recent examination of the pipeline from DoD Active Duty occupations showed that there is not an adequate number of Veterans to meet VHA's hiring goal. Therefore, there is a project underway to "reset" the Veteran hiring goal for employees in Title 38 health care occupations. In addition, the Assistant Deputy Under Secretary for Health (ADUSH) for Workforce Services is now a member of the DoD Chief Human Capital Officers Healthcare Executive Council to actively partner with DoD Health Affairs, Army, Navy and Air Force to improve recruitment of recently discharged medical and health professionals.

Mental Health

In April 2012, the President issued an Executive Order to improve access to mental health services for Veterans, Servicemembers, and military families. VHA established the goal of hiring 1,900 new mental health clinicians and clerical staff to fill over 2,000 existing vacancies. By the end of the hiring initiative, VHA had exceeded the goal and hired 4,308 mental health providers. VHA will continue to recruit mental health professionals to sustain the mental health program and the Office of Mental Health Operations is re-examining their staffing model for potential improvements. As a result of the mental health hiring initiative, additional effort was put into identifying all mental health direct care providers regardless of occupation or service line. By combining data from three different systems, outpatient providers can now be identified down to the person level, allowing an assessment of gains, losses, and bench strength and a better understanding of the workforce gaps that may still exist in mental health.

External Drivers

Veteran Population, Enrollees and Patients

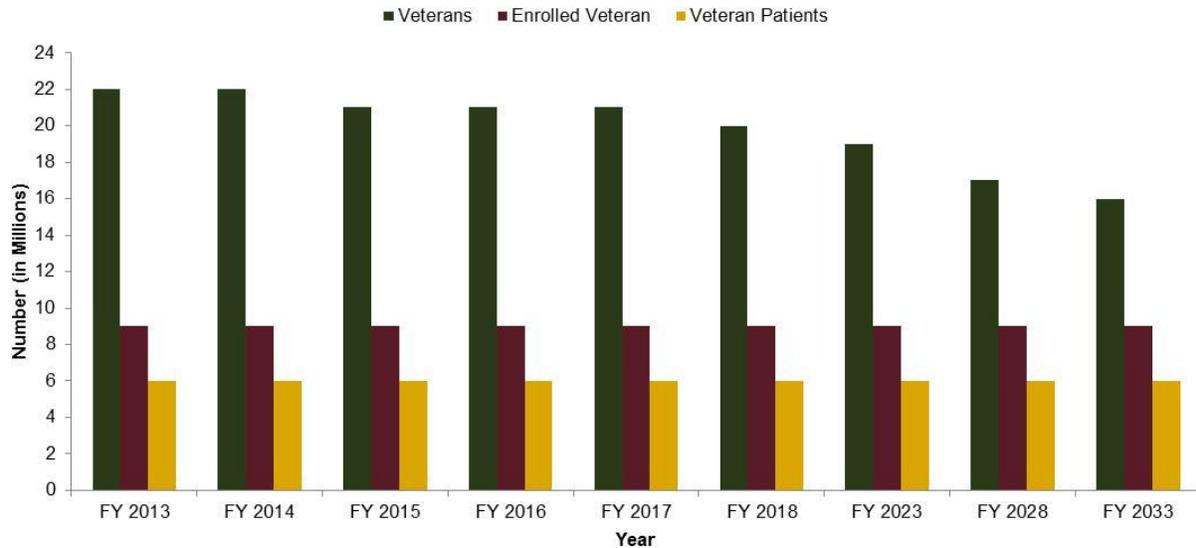


Figure 1: Veteran Projections

Based on projections from the Enrollee Healthcare Projection Model (EHCPM), there will be a decrease in the total Veteran population from 2013 – 2033, resulting in a total of nearly 9.3 million Veteran enrollees in 2033, and a projected increase of over 300,000 Veteran patients by 2033 (Figure 1).

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

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 2015, the largest segment of the VHA enrollee population will be between 65 and 84 years of age. By 2017, the number of Veteran enrollees age 85 and older will increase from approximately 650,000 to approximately 700,000. 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.

Shortage of Health Care Professionals in VHA Top (Mission Critical) Occupations

To achieve VHA's mission of providing exceptional patient centered 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.

Affordable Care Act (ACA)

As the nation moves forward with the full implementation of the Affordable Care Act (also referred to as ACA or the Health Care Law), many unknowns remain about its impact on VHA. What is clear is the fact that the implementation of ACA will not sway VHA from its mission of honoring America's Veterans by providing exceptional health care that improves their health and well-being. However, the way the VHA workforce carries out that mission in the future may look very different.

As the transformation of the health care delivery system unfolds under ACA it will be critical for VHA to ensure that it is still able to recruit and retain a talented workforce to provide the best care for our nation's Veterans.

Workforce and Succession Planning Trends

Recruitment

Current political views on the size of the federal workforce seem to indicate a reduction will take place in the upcoming years. Already most federal agencies have reduced their workforce (about 87,000 jobs were cut federal governmentwide in the last 12 months; Katz, 2013); however, the VA, because of demand for services to our Veterans, has continued to recruit and hire, especially for health care positions.

According to the U.S. Bureau of Labor Statistics (2012a), 10 of the 30 fastest-growing occupations in the country are health care-related. VHA is in direct competition with the private sector medical community for all health care occupations. Recruiting individuals into these occupations will continue to prove difficult because of limited use of financial incentives. The use of recruitment, retention and relocation incentives has been reduced in the past three years and it is expected that this trend will continue. This will require the organization to look for creative ways that speak to the top reasons why employees join our organization (i.e., career opportunities, benefits and mission) as captured in the VA Entrance Survey. We must also capitalize on the available large pool of candidates, approximately 120,000 associated health professionals and administrative trainees that are trained by VHA each year.

Retention

Retention is particularly critical in the health care field as the need for workers is immense and continues to increase. Demand for the services of top health care talent has intensified as the country's population has aged and public budgets have shrunk, making it more difficult to hire and train more personnel. According to the VHA annual quits by year analysis, VHA loses between 26-32% of new hires within the first five years of employment, and 10-15% of new hires within the first year of employment. Since the current fiscal environment limits the use of financial incentives to retain talent, it will be critical to emphasize the use of non-financial incentives. These non-financial incentives should address the top reasons why employees leave VA (i.e., career advancement and professional development) as captured in the VA Exit Survey. A 2010 Career Builder survey of health care workers also found that 51% of respondents identified lack of advancement opportunities as their biggest challenge. Employees are looking for solid, well-defined career paths. Career and professional development programs, mentoring, job reengineering, cross-training, telework arrangements, or alternate work or part-time schedules could help retain needed talent.

Generations in the Workplace

CNN (Gargiulo, 2012), reports that by the end of this decade the balance in the U.S. workforce will flip from approximately 50% Baby Boomers and 25% Generation Y (Millennial) workers to 25% Baby Boomers and 50% Generation Y (Millennial) workers. The implications of this suggest that we need to recognize the values that each of these generations bring to the workplace since they impact the quality of care we provide to our Veterans. Most importantly, understanding the values of each generation will also aid in developing customized strategies that will allow us to attract and retain the best and the brightest of all four generations represented in our workforce. It is imperative that the organization discovers and implements ways to accommodate differences in perspectives and workplace expectations.

The U.S. Census Bureau (2011) estimates that Millennials (Generation Y) represent 27.7% of the U.S. population, Baby Boomers make up 26.4%, and Generation X makes up only 19.8% of the population. This means there is a shortage of Generation X to fill the positions that Baby Boomers will soon vacate. The 27.7% of the Millennial cohort includes the youngest members of the population who have yet to enter the workforce. In response to these challenges, VHA has created and maintained a number of programs to assist in meeting its hiring needs. These programs are described in Chapter 2.

Leadership Development

Given the high percentage of the workforce eligible to retire within the next 5 years, particularly within the senior leadership ranks, developing and sustaining a leadership pipeline will be critical to the success of VHA achieving its mission. Yet many new challenges have impeded this progress within the last year; new conference requirements caused several key leadership development programs to be cancelled or significantly delayed during FY 13: Healthcare Leadership Development Program (HCLDP), Leadership VA (LVA), and Leadership, Effectiveness, Accountability and Development (LEAD) programs, just to name a few. Although many of these programs have been redesigned in order to continue functioning, the loss of one

year of leadership ‘pipeline’, as well as future reductions in student throughput, has had a negative impact on the preparation of future leaders.

Like other federal agencies, the issue of developing the next generation of leaders has been an identified risk to the future of the administration. Although VA has been recognized as having a robust array of quality leadership development opportunities, the lack of clear career ladders, or logical paths of progression from entry through upper levels of leadership make the system confusing to navigate and negotiate. Each independent leadership development program, by itself, is of high quality and meets its own objectives. But because the overall system of leadership development is not synchronized or aligned, there are overlaps and gaps between the programs. Additionally, student capacity is driven by budgetary and other constraints, not by the actual numerical need for graduates. The VA has developed some enterprise-wide solutions in order to mitigate these issues; new VA Leadership Competencies, VA Learning University (VALU) course offerings (commercial, off-the-shelf) and virtual opportunities for self-development. However VHA still requires health care-specific leadership training, and a system to move high performing individuals into positions of greater responsibility, where they are prepared to become ethical, effective and enduring leaders who are able to affect future change within VHA.

Workforce Planning Process Refresh

VHA’s workforce and succession planning capability has been in existence for nearly a decade. It has been recognized as a best practice among government agencies (Rothwell, Alexander, & Bernhard, 2008) for being a robust and comprehensive process that provides for the strategic alignment of workforce planning needs and action plans at every level of the organization.

Stalwart workforce planning processes have undergone significant modifications and improvements during the last decade and enhanced VHA’s ability to gather input and analyze its workforce. The initiation of a new corporate workforce planning initiative introduced new thinking that resulted in a full review of VHA’s workforce planning process to ensure it maintains its relevance and value. The result is an implementation plan that describes the goals identified by the Rollup Team and a phased approach to implementing the revised workforce planning process.

Goals for Improving the Workforce Planning Process

- ▶ Improve timeliness of workforce planning data
- ▶ Mitigate the risk of delays in the VHA workforce planning process
- ▶ Promote the focus on strategic objectives and action planning at the national level by fostering a workforce planning relationship to the Administration’s Planning, Programming, Budgeting, and Execution (PPBE) process
- ▶ Strengthen the process to ensure that the workforce planning governance structure is clearly defined and recognized within the organization

This is a time of unprecedented transformation in VHA. Changes in the delivery of health care will require a workforce that is ready to address the needs of new and existing Veteran patients.

In addition, VHA will need to be proactive and agile enough to address the emerging challenges brought about by implementation of the Affordable Care Act, an aging workforce, and an aging general population that will require more intensive health care services.

To meet the charge of providing a skilled, highly qualified workforce, the ADUSH for Workforce Services has developed the Human Capital Lifecycle Model which depicts the core elements of the VHA employee experience from attraction to recruitment to retention to retirement. This model extends beyond the individual elements and employee encounters throughout his or her tenure with the VHA, and also incorporates the workforce succession and planning functions that drive the recruitment process and facilitate career development. More information about the model can be found in Chapter 2.

Effective workforce planning processes will ensure a workforce that is diverse, agile, flexible, engaged, psychologically safe, creative, civil and ethical. In addition, by realigning the VHA workforce and succession planning process to VA and other planning processes, VHA will be better positioned to clearly identify, articulate and focus on systemic workforce issues and subsequently align resources to address them.

Chapter 2: Workforce Planning Drivers

Internal Drivers

Health Care Delivery

As VHA shifts its focus from emergent and institutional care to more preventive care and from VA hospitals and hospital-based clinics to community-based options, it continues to make inroads to developing new models of care. Two new models of care being supported by VHA include:

- ▶ Patient Aligned Care Team (PACT)
- ▶ Telehealth

PACT

A PACT is a partnership between the Veteran and their health care professionals. They work together to make sure the patient receives whole-person care, which is individualized to help the patient meet agreed upon health care goals. The emphasis is on prevention and health promotion. In a PACT, the patient and their health care professionals focus on:

- ▶ **Partnerships** with Veterans
- ▶ **Access to care** using diverse methods
- ▶ **Coordinated care** among team members
- ▶ **Team-based care** with Veterans as the center of their PACT

A PACT offers many ways to access health care. In addition to personal visits with the primary health care provider, visits may be scheduled with other members of the team. The Veteran also has access to group clinics and educational seminars, plus a wealth of information on the Internet through My HealtheVet (www.myhealth.va.gov). Communication with members of PACT is conducted by telephone or through Secure Messaging via My HealtheVet.

A PACT achieves coordinated care through collaboration. All members of the team have clearly defined roles. They meet often to talk with the Veteran and each other about the patient's progress toward achieving their health goals. The focus is on forging trusted, personal relationships, and the result is coordination of all aspects of the Veteran's health care.

A PACT uses a team-based approach. The Veteran is the center of the care team that also includes family members, caregivers and health care professionals—primary care provider, nurse care manager, clinical associate, and administrative clerk. When other services are needed to meet your goals and needs, another care team may be called in.

Telehealth Services

Telehealth involves the use of information and telecommunication technologies and is part of a spectrum of Virtual Care. Other Virtual Care Services include:

- ▶ Secure messaging
- ▶ My HealtheVet
- ▶ Mobile Health (mHealth)
- ▶ Teleradiology
- ▶ Electronic Consultations (eConsults)
- ▶ Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN ECHO)

VHA Telehealth Services is a program office that supports VISNs to develop Telehealth services and is developing national standardized models of clinical care in collaboration with other Services/Offices. VHA Telehealth Services also coordinates quality management activities for the delivery of safe, effective and efficient Telehealth services. Telehealth programs are supported by an interdisciplinary group of staff who are employed in VISNs. In FY 2013, these staff engaged in providing Telehealth-based care to over 608,000 Veteran patients through more than 1.7 million visits. There are approximately 3,400 staff who are employed to provide or support Telehealth services to Veterans nationally. These include more than 1,000 Telehealth clinical technicians (TCTs), 900 Teleretinal imagers, 800 home Telehealth care coordinators, 150 facility Telehealth coordinators (FTCs), and many additional staff that provide Telehealth imaging and reading services and Telehealth management and support at the VISN level. In addition to these staff, there are a large number of clinicians who provide health care services using Telehealth exclusively, or who alternate between providing Telehealth and in-person care based on clinical appropriateness, availability and patient preferences.

VA is the largest provider of Telehealth services in the United States. To provide safe, efficient and cost-effective services that appropriately meet the needs of Veteran patients, Telehealth programs in VHA require standardized and robust education and training that are not routinely incorporated in the training of clinical staff in medical or nursing schools, or in technical/allied health profession training programs. Since 2004, VA has had a national Telehealth Training Center that provides systematic training for Clinical Video Telehealth (CVT), Home Telehealth (HT) and Store and Forward Telehealth (SFT). These activities support the development and assessment of competencies for field-based staff as well as the professional development of Telehealth experts (i.e. Preceptors/Master Preceptors). Almost all of Telehealth curricula is provided virtually (98%) and enable VISNs to have competent, skilled staff to support and sustain safe, quality and effective Telehealth programs that meet the growing needs of individual VISN Telehealth programs that will enable achievement of national targets for Telehealth.

Cultural Transformation

The role of the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) is to help clearly define the future state of healthcare, provide the tools and support the field needs to make it happen, and to help identify and remove barriers to success. The Vision for VHA, through the efforts of OPCC&CT as well as other transformational initiatives such as the implementation of the PACT model, is to transform from a problem based disease care system, to a patient centered health care system. The OPCC&CT is providing training to VHA clinicians

through a clinical curriculum called “Whole Health – Change the Conversation.” Additionally, the Office has Field-based Implementation Teams (FIT) who work in partnership with VHA facilities providing Leadership, provider and staff training to further the facility’s journey to a patient-centered culture. FIT teams lead listening sessions with Veterans and their family member and support local efforts to develop and implement new and innovative strategies to transform the practice and the experience of care based on patient preferences. The OPCC&CT holds national community of practice calls to maintain close contact with the field at large. National updates and strong practices are shared on these calls and are widely promoted on the OPCC&CT website Health for Life and SharePoint site.

VHA Voices is a new initiative that is being developed under the leadership of the Office of Patient Care Services and in collaboration with Primary Care and Mental Health, OPCC&CT, Office of Informatics and Analytics, Workforce Management and Consulting and participating facilities. Its goal is to develop a workforce that engages and activates patients in the maintenance of their health and health care. VHA Voices concentrates on relationships by designing a health care system that recognizes behaviors and embraces relationships between employees, Veterans and families to deliver personalized, proactive patient driven care.

To establish the organizational focus throughout the health care system, the program’s overarching goals have been developed to promote relationship focus and empathetic awareness among leadership, all staff, care teams, and providers to:

- ▶ support Veteran engagement in their health and health care;
- ▶ support Veteran activation in achieving their health and well-being goals;
- ▶ promote relationship building to support strong team function and healthy team dynamics;
- ▶ align the health care system to implement practices that support relationships aimed at serving Veterans and improving the Veteran and staff experience;
- ▶ demonstrate ongoing leadership support, commitment, and training;
- ▶ deliver interactive experiential staff training with quality feedback and ongoing evaluation;
- ▶ enhance hiring and workforce management practices with emphasis on ability to function in a team and deliver patient-driven care;
- ▶ creatively utilize clinically integrated quality improvement with transparent and effective data and feedback to promote improvement in the clinical setting;
- ▶ improve space and infrastructure to enhance patient centered care delivery.

Working under the auspices of the Veteran Experience Committee (VEC) and in collaboration with field facilities for all aspects of design and implementation, VHA Voices complements the remarkable work that has been accomplished over the past three years and represents a partnership among several program offices to create an organizational culture that values relationships with the Veteran and emphasizes the Veteran experience as a foundation for integrating and uniting all staff and programs.

VHA Workforce Trends

For more detailed information and data, please refer to the 2014 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2014Supplemental>

Although onboard strength in VHA has increased by 15.8% since FY 2008 (37,906 employees), the rate of growth continues to decline (Figure 2). At the end of FY 2012, VHA’s total onboard workforce including full- and part-time employees was 277,152, up from 239,246 in FY 2008.

Over the same five years, VHA experienced losses of over 105,246 employees, nearly half (47.4%) of which were the result of resignations and external transfers (i.e., quits), and 34.2% of which were from voluntary retirements (Figure 3). To maintain and grow the workforce, a total of 164,135 new hires were required.

VHA experienced sharp reductions in resignations and retirements in FY 2009 associated with the nationwide downturn in the economy. Since then, loss rates have continued to climb as depicted in Figure 4.

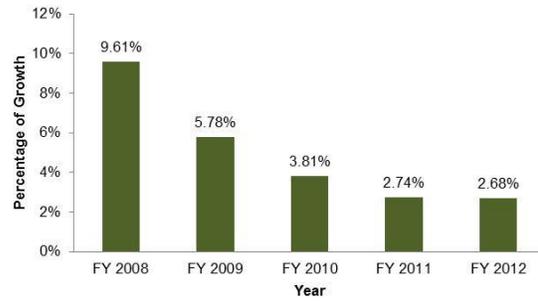


Figure 2: Decreasing Rate of Growth in Onboard

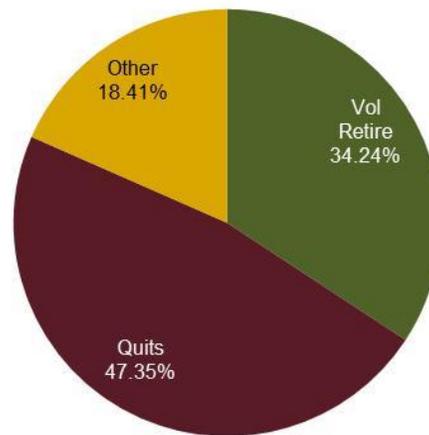


Figure 3: FY 2008 to FY 2012 Percentage of Total Losses by Type

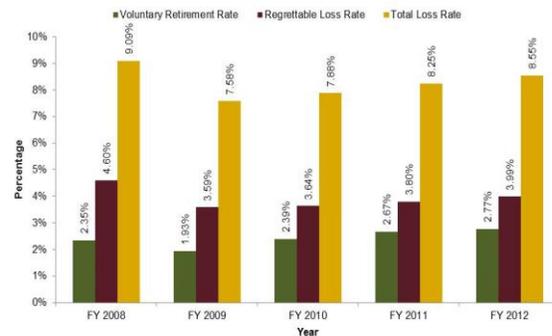


Figure 4: Loss Rate by Year

Loss Rate Comparisons

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.

Quits, which are defined by JOLTS as employees who left voluntarily (excluding external transfers), were much higher in the private sector, at 21.1% as compared to the federal government rate of 4.7%. Quit rates among the health care and social services industry were 16.5% in calendar year 2012 as compared to 4.3% for VHA total workforce (Figure 5). For comparison purposes, the VHA total workforce data in Figure 6 includes full-time, part-time, intermittent, medical residents, trainees, and employees in a pay status.

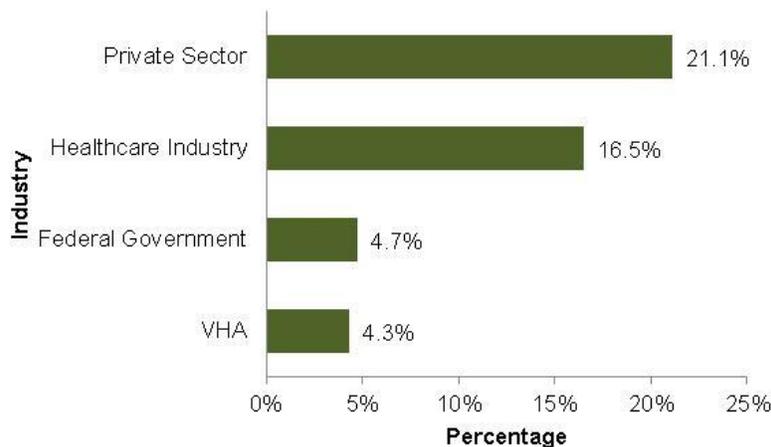


Figure 5: JOLTS Survey Rate Comparisons

Note: JOLTS data (Private Sector, Healthcare, and Federal Government) are for Calendar Year 2012, and VHA data is for Fiscal Year 2012.

Another source of comparison data is the OPM FedScope database, which combines personnel data submitted by each agency to support statistical analyses of federal personnel management programs. FedScope defines quits as voluntary resignations, but does not include transfers to other agencies, and does not exclude medical residents, intermittent employees, and trainees. Using the FedScope criteria, the VHA quit rate of 4.0% compares favorably with the average for all cabinet level agencies (3.7%). Total losses for VHA at 10.1% were slightly lower than the average for all cabinet level agencies (10.5%).

Quits by Year of Employment

VHA performs an annual analysis that tracks quits among new hires for five years from their date of hire. The most recent analysis conducted for employees hired through FY 2011 concludes:

- ▶ On average, 28.8% of all employees who were newly hired between FY 2005 and FY 2007 quit within the first five years of employment. Of those losses, nearly half occurred within the first year, and 71.9% occurred within the first two years (Figure 6).
- ▶ The rate of first year quits dropped from 15.2% for hires in FY 2005 to 9.7% for hires in FY 2009. Since then, the rate has increased to 11.0% in FY 2011.
- ▶ For more recent hires (those hired between FY 2005 and FY 2010), an average of 12.2% quit within the first year and 18.5% quit within the first two years (Figure 7).
- ▶ A focused examination of losses in the first year is being planned in order to identify appropriate recruitment and retention strategies.

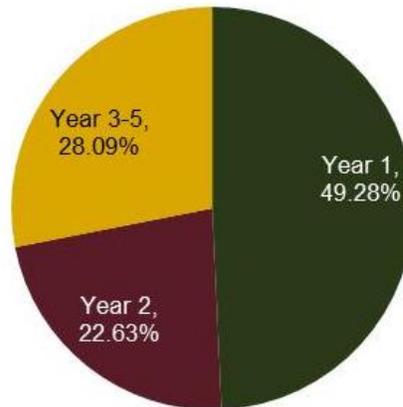


Figure 6: Distribution of Quits Within the First Five Years of Employment for FY 2005-2007 New Hires

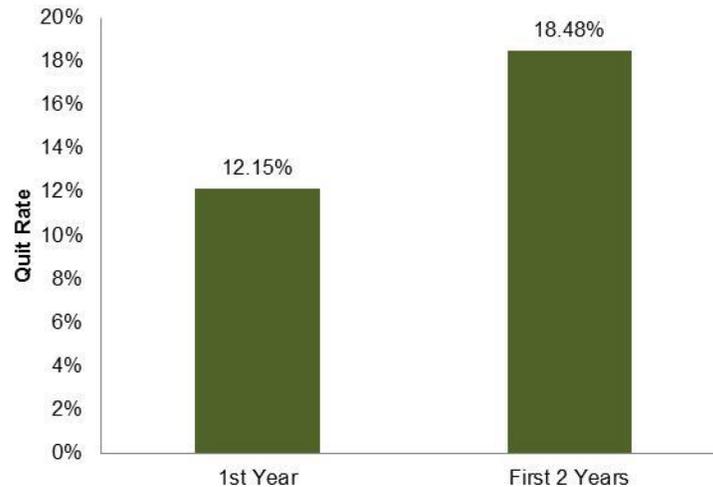


Figure 7: Percentage of Quits Within the First Two Years of Employment for FY 2005-2010 New Hires

Reasons for Leaving (VA Exit Survey)

The VA exit survey is a means for employees who voluntarily separate to communicate their reasons for leaving. To be most effective and to ensure the highest response rates, the opportunity to complete the survey should be provided during the clearance process. The completion of the exit survey is completely voluntary and confidential. The survey results are useful because they provide supervisors, managers, human resources officers, and senior leadership with valuable information to help improve employee retention and morale. An analysis of FY 2012 survey participants' responses to the question of why they chose to leave VHA employment indicates that the top three reasons were:

- ▶ 20.8% normal retirement
- ▶ 16.6% advancement (unique opportunity elsewhere)
- ▶ 10.7% attend school

Exit survey data also indicate that 28.1% of exiting employees experienced a single particular event that caused them to think about leaving VHA. And while 80.3% of exiting employees would consider working for VA again, only 25.8% reported that their manager or supervisor tried to get them to change their mind about leaving.

Reasons for Choosing VA (VA Entrance Survey)

The VA entrance survey provides a means of assessing newly hired employees' reasons for choosing VA, and provides insight into ways VA can improve recruitment and marketing efforts. Like the exit survey, the completion of the entrance survey is completely voluntary and confidential. An analysis of FY 2012 survey participants' responses to the question of why they chose to work for VA indicates that the top three reasons were:

- ▶ 21.5% advancement
- ▶ 16.9% benefits (retirement/health and life insurance, etc.)
- ▶ 12.9% mission/serving the Veterans

In addition, more than half of new employees who responded to the survey in FY 2012 identified electronic resources, such as the OPM/USA Jobs website and VA Careers, as their main sources of information about the job.

Projections

In total, onboard strength is projected to increase by 13.8% by FY 2019. The Medical and Dental, and Social Science occupational groupings had the largest onboard growth increases in FY 2012. Projections are that the growth in total onboard will level off to 1% by FY 2019. 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.

VISN, facility, and program office projections are based upon local estimates of the budget outlook and anticipated hires, rather than anticipated needs. However, these field estimates have historically under-projected the growth. The VHA workforce planning team in the

Healthcare Talent Management Office compares the field estimates, received in April of each year, with the actual onboard and historical trends and makes adjustments as necessary for the current fiscal year. Figure 8 below displays the difference between field estimates, the adjusted onboard estimates, and the actual onboard for each fiscal year between FY 2009 and FY 2013. Although the field estimates predicted negative growth in FY 2011 and 2012, the actual growth rates were 2.7% for each year. In FY 2013, field estimates predicted 1.7% growth. The adjusted estimated growth was 2.3%. Actual growth was approximately 4.2%. One goal of the corporate (VA) workforce planning process is to provide the tools and training necessary to improve the Agency's ability to predict onboard estimates according to an analysis of supply, demand, and gaps in the workforce. Furthermore, initiation of the Succession and Workforce Analysis and Planning Subcommittee (SWAPS) and integration with the Planning Programming Budget and Execution (PPBE) process will assist in gathering valuable information that will help planners better anticipate their future workforce needs.

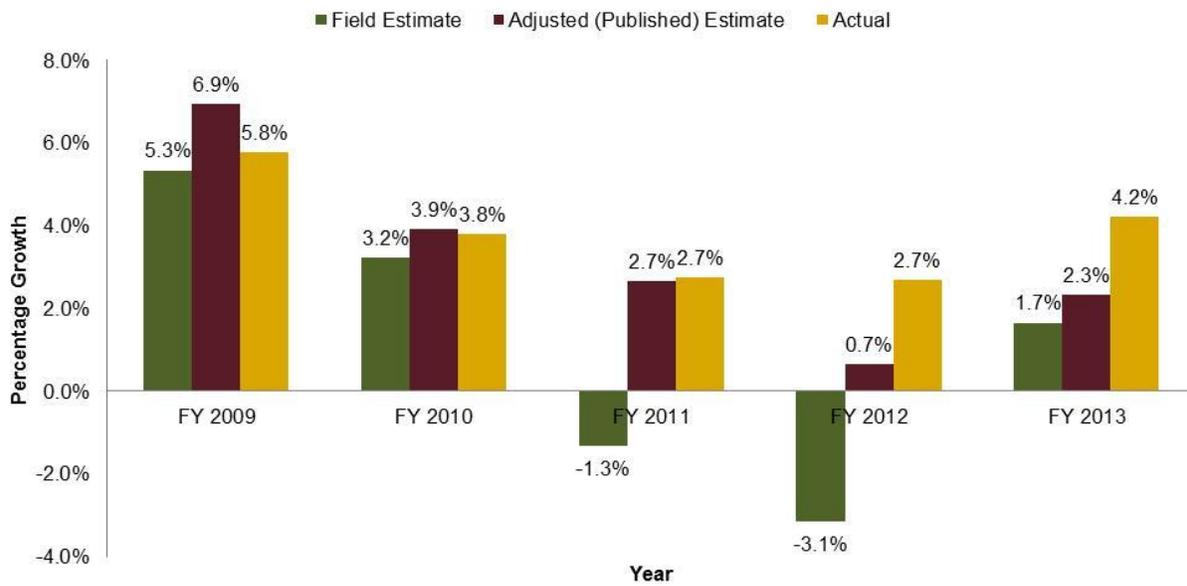


Figure 8: Comparison of Field Estimated Onboard, Adjusted Estimated Onboard, and Actual Onboard

Between FY 2013 and FY 2019, 40.6% of the full- and part-time workforce will become eligible for regular retirement, and more than half will be eligible as soon as FY 2014 (Figure 9). By FY 2019, the retirement rate is expected to increase to 3.4% of the projected onboard. Quits due to resignations and transfers to other government agencies are expected to remain at approximately 3.8% between FY 2013 and FY 2019. All other losses are projected at 1.8% of the average onboard employees. Based on these projections, VHA anticipates the need to hire an average of 31,575 employees annually.

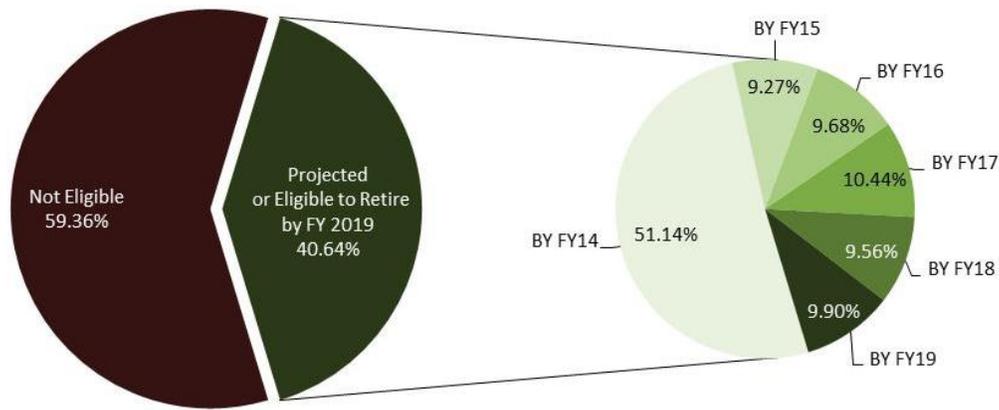


Figure 9: FY 2012 Employees Projected or Eligible to Retire by FY 2019

Average Age and Generational Makeup

The average age of VHA employees has remained stable at around 48 years of age for the last five years. Over the last five years, the percentage of employees age 55 and over increased from 30.4% to 33.7%. The percentage of employees under age 35 has also increased from 13.7% to 14.8% in that same time period (Figure 10).

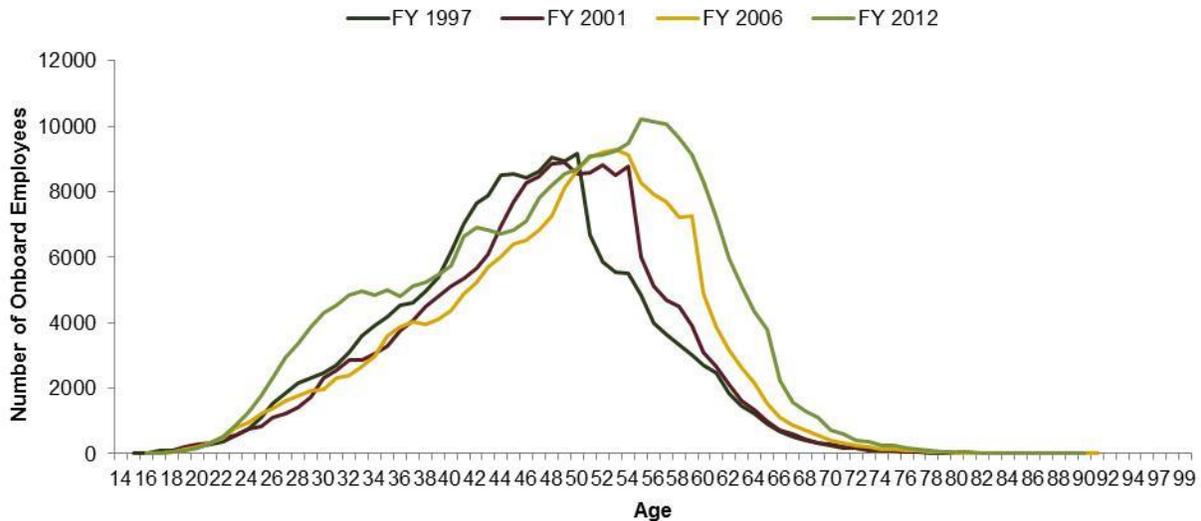
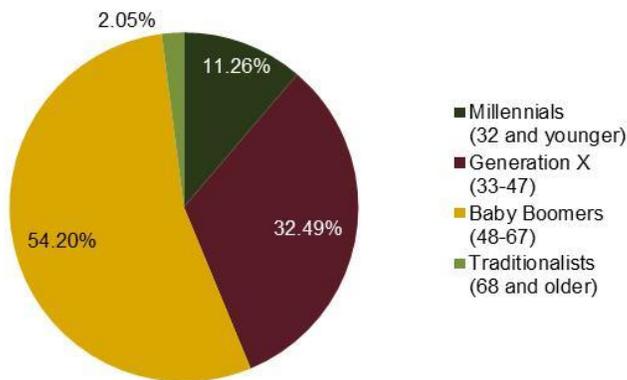


Figure 10: Age of VHA Employees

The average age of new hires has increased from 38.6 in FY 2000 to 39.9 in FY 2012. Nevertheless, new hires in VHA are approximately 8 years younger on average than the total onboard (39.9 compared to 48.2 years in FY 2012). “Baby Boomers” continue to make up the majority (54.2%) of the VHA workforce, but the percentage is declining by about two percentage points each year. While “Millennials” only make up 11.3% of the workforce, they make up 18.2% of the total losses (Figure 11).

VHA Workforce by Generation



VHA Losses by Generation

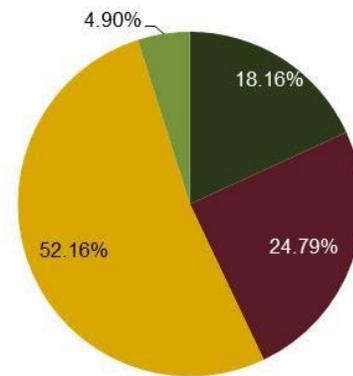


Figure 11: VHA Workforce and Losses by Generation

Race/Gender Summary Data

Overall, VHA's workforce is 39.4% minority and 60.9% female. Hispanic females (at 3.7% of the workforce) represent the only minority group, besides Other/Multiple Race, that is below the Relevant Civilian Labor Force (RCLF) comparison statistics provided by the Bureau of Labor Statistics. The RCLF data are based on the 2000 census and reflect the percentage of the civilian workforce in each race/gender category for VHA occupations. All other minority groups have a participation level that is equal to or greater than the RCLF. VHA continues to pursue national recruiting events that are aimed at diversity and minority outreach.

Disability & Veteran Summary Data

The workforce distribution of individuals with non-targeted disabilities continued to increase to the current level of 9.9%, while individuals with targeted disabilities increased to 1.9% (Table 1). 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 maintaining a 2% rate of representation for persons with targeted disabilities.

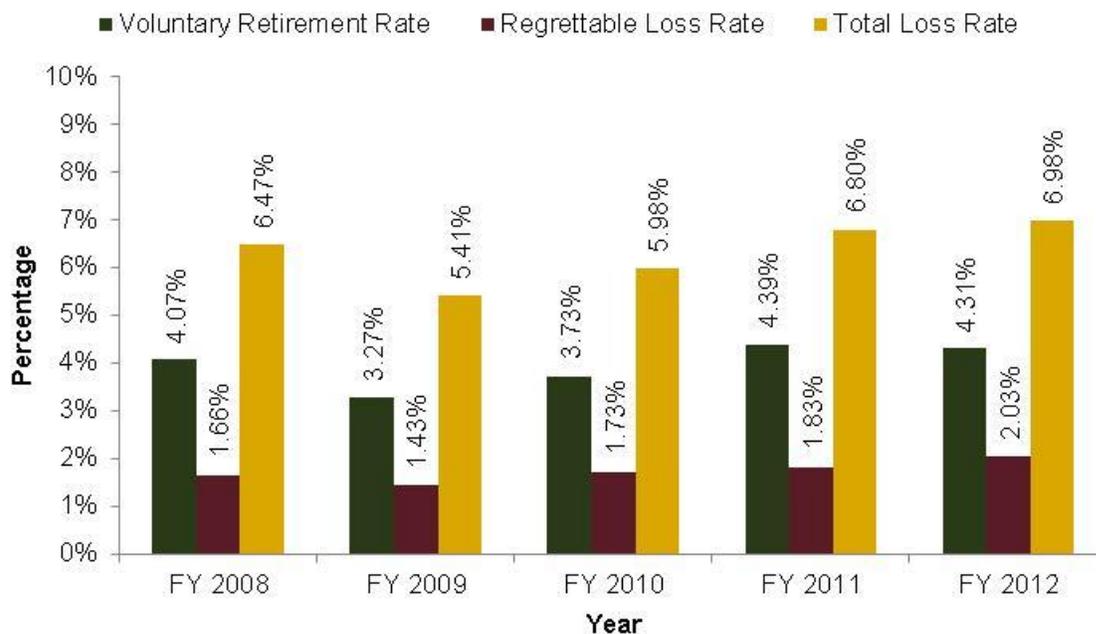
At the end of FY 2012, the percentage of Veterans in the VHA workforce was 30.6%, reflecting an increase from the FY 2008 level of 29.1% (Table 1). However, as discussed in Chapter 1, there are not enough Veterans in the health care professions pipeline to allow VHA to achieve the 40% goal. Consequently, there are efforts underway to adjust the Title 38 Veteran hiring goal. VHA will continue to utilize special hiring authorities such as the Veterans Readjustment Authority (VRA), Veterans Employment Opportunity Act (VEOA), and the authority to hire Veterans with service-connected disabilities rated 30% or higher. In addition, VA for Vets provides an online approach to recruiting, hiring, and reintegrating Veterans into civilian careers.

Table 1: Disability and Veteran Representation for VHA Employees

EEO Category	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Non-Targeted Disability	7.44%	7.78%	8.03%	8.73%	9.92%
Targeted Disability	1.38%	1.38%	1.48%	1.64%	1.87%
Veteran	29.08%	28.68%	28.59%	30.78%	30.64%

Supervisors

The number of supervisors in VHA has increased by 24.2% over the last five years. The majority of this growth (17.9%) occurred between FY 2008 to FY 2010. Supervisors currently make up 9.0% of the total workforce. VA has identified a best practice supervisor to workforce ratio of 1:15. VHA has maintained a ratio of 1:11 over the last several years. Like the workforce overall, supervisors also experienced a reduction in resignations and retirements in FY 2009. Since then, however, loss rates have continued to climb and are at a five year high. Voluntary retirements were up from a five year low of 3.3% in FY 2009 to a five year high of 4.4% in FY 2011. Regrettable loss rates increased from 1.4% in FY 2009 to 2.0% in FY 2012. Total loss rates also increased from 5.4% in FY 2009 to 7.0% in FY 2012 as shown in Figure 12.

**Figure 12: Loss Rate by Year for Supervisors**

The number of supervisors is expected to continue to grow for a total increase of 14.0% over the next seven years with growth of 3.6% in FY 2013 and 3.3% in FY 2014, before leveling off to approximately 1% by FY 2019. To replace losses and increase the onboard number of supervisors as projected, VHA will need to gain approximately 16,444 supervisors by the end of FY 2019, for an average of 2,350 per year.

By the end of FY 2019, 54.0% of the current (FY 2012) full- and part-time supervisory workforce will become eligible for regular retirement with 32.6% projected to actually retire. The average

age of VHA supervisors has remained stable at around 52 years of age for the last 5 years. This is approximately 3.5 years older than the VHA total workforce.

VHA EEO Analysis for Supervisors

Overall, the supervisory workforce is less diverse than the VHA total workforce. As of FY 2012, 31.2% of supervisors were minorities (8.2 percentage points below VHA overall) and 51.3% were female (9.6 percentage points below VHA; see Figure 13). Furthermore, they are under-represented in almost every minority race/gender category when compared to the total workforce. However, the percentage of supervisors in minority categories has been steadily increasing (from 29.9% in FY 2008 to 31.2% in FY 2012).

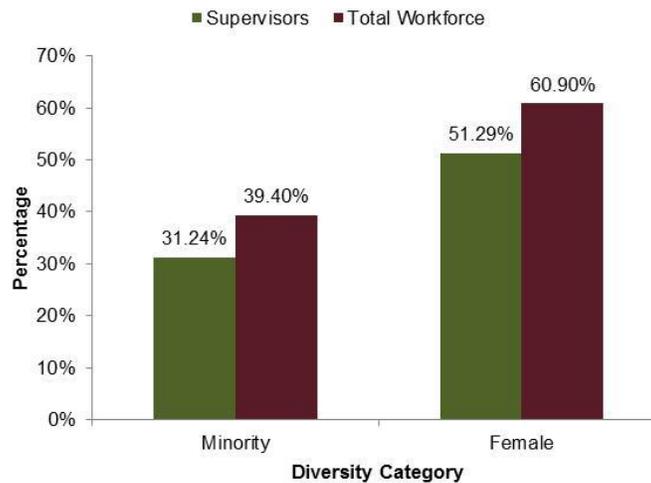


Figure 13: FY 2012 Minority and Female Representation Among Supervisors Compared to VHA Total Workforce

Compared with the total workforce (Table 2), fewer supervisors have targeted and non-targeted disabilities. However, representation of supervisors with disabilities has steadily increased since FY 2008. Supervisors who are Veterans are represented at a greater percentage (33.1%) than the Veterans in the total workforce (30.6%).

Table 2: Disability and Veterans Representation for Supervisors

EEO Category	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	VHA Total Workforce	% Difference	Ratio
Non-Targeted Disability	6.27%	6.70%	7.03%	7.88%	9.09%	9.92%	-0.83%	0.92
Targeted Disability	0.84%	0.88%	0.98%	1.12%	1.18%	1.87%	-0.69%	0.63
Veteran	32.27%	31.81%	31.50%	33.06%	33.10%	30.64%	2.46%	1.08

VHA Executive Leadership Retirement Eligibility

A crisis exists in VHA leadership positions, as evidenced by the fact that 42.3% of senior leaders will be eligible for retirement within the next year. Furthermore, in the next seven years, senior leaders' retirement eligibility is expected to increase to the following levels:

- ▶ 75.6% of all senior leaders
- ▶ 85.5% of SES
- ▶ 91.2% of T38 SES
- ▶ 85.9% of Chiefs of Staff
- ▶ 77.6% of Nurse Grade V
- ▶ 48.3% of Associate, Assistant, and Deputy Directors

VHA EEO Analysis for Executive Leadership Positions

Based upon the premise that leadership should reflect the “people we employ,” comparisons for executive leadership EEO data are based on relevant VHA employee groups, including physicians (O602), registered nurses (O610), VHA’s total workforce, and VHA Central Office (VHACO) employees, as appropriate. Generally, White males exceed their expected participation rate in non-nurse executive positions. White females, on the other hand, exceed their expected rate only in Nurse Executive positions. All leadership groups have less representation in every minority group when compared to their relevant workforce comparison group. Nurse Executive is the least diverse level of leadership in VHA, with only one minority male.

Employee Satisfaction

Federal Employee Viewpoint Survey

According to the Office of Personnel Management (OPM; 2013), “The Federal Employee Viewpoint Survey (FEVS) is a tool that provides a snapshot of employees’ perceptions of whether, and to what extent, conditions characterizing successful organizations are present in their agencies.” In 2013, OPM issued the FEVS to approximately 781,000 federal full- or part-time, permanent, civilian government employees representing 81 federal agencies. More than 376,000 federal employees responded to the survey, for a response rate of 48.2%. Department of Veterans Affairs (VA) had a 37.9% response rate (up from 30.9% in 2012).

The survey contained 84 items that measured federal employees’ perceptions about how effectively agencies manage their workforces. The governmentwide results revealed a significant drop in employee satisfaction, which continued the declines seen in the 2012 survey. This year’s score showed continued decreases across the government in satisfaction with pay, and a decrease in positive responses to whether employees had sufficient resources needed to get their jobs done. This drop led to fewer employees recommending their organizations as good places to work. However, scores for levels of engagement remained steady.

The 2013 results showed VA had indicated higher scores than the governmentwide average for the Talent Management, Job Satisfaction, and Intrinsic Work Experience sub-factors. The most significant negative differences were for Leadership and Knowledge Management, Results-Oriented Performance Culture, and the Supervisors and Leaders Lead sub-factors of the Employee Engagement Index (Figure 14).

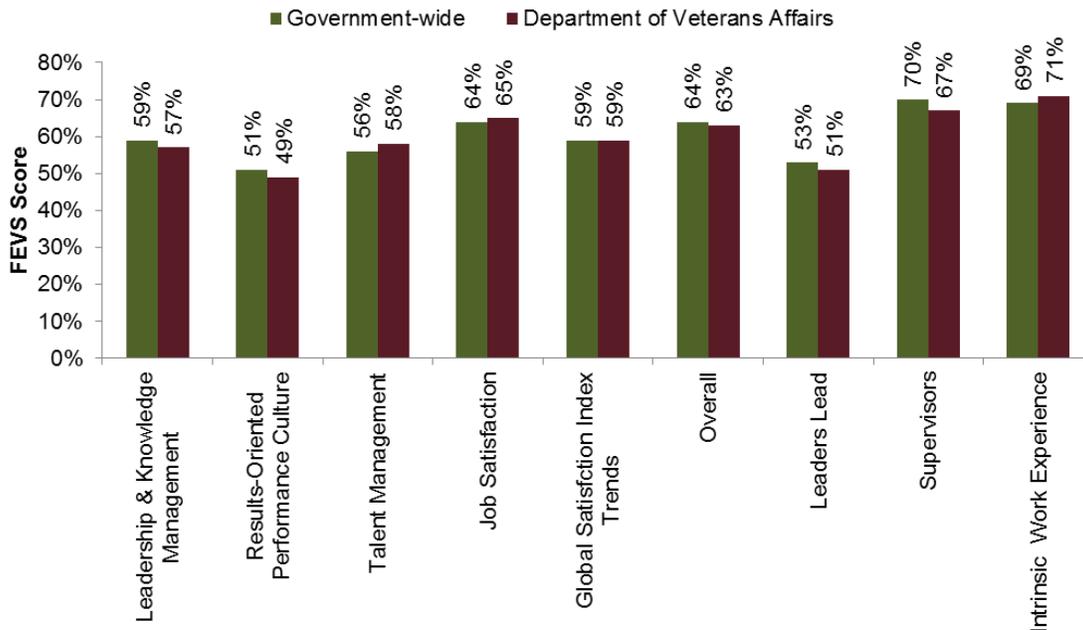


Figure 14: Most Significant FEVS Scores for VA Compared to Governmentwide

VA All Employee Survey

While the FEVS highlights external VA comparisons of agency and administrative data, the All Employee Survey (AES) highlights internal comparisons. Both instruments assess comparable workplace concepts such as: Employee Satisfaction, Employee Development, Health/Safety, Innovation, Cooperation, Respect, Planning/Evaluation, Work/Life Balance, Rewards, and Promotion Opportunity. However, the AES includes unique concepts of Customer Service/Satisfaction, Civility, Psychological Safety, Burnout, and Turnover. It supports the precise and highly sensitive analyses that the VHA National Center for Organization Development (NCOD) routinely conducts in order to inform specific associations between employee workplace ratings and their demographic and attitude-related determinants.

According to a presentation by NCOD (2013), the 2013 AES VHA response rate was 56.3% reflecting a steady downward trend in response rates since the FY 2010 high of 73.0%. The 2013 survey included several new metrics to help better serve VA's informational and organizational needs. The national-level VHA AES scores reflected the highest levels of satisfaction/agreement with employee engagement, competency, safety resources, relationship (with supervisor), work/family balance, and safety climate. The lowest areas of satisfaction/agreement were with senior management, promotion opportunity, praise, engagement with the organization (i.e., general satisfaction at work), and reduced personal achievement (achieving worthwhile

accomplishments in the job). Overall job satisfaction scores decreased from 3.82 in FY 2011 to 3.77 in FY 2012 and 3.66 in FY 2013. This corresponds with a governmentwide decline in job satisfaction, as discussed below.

Best Places to Work Report

The Partnership for Public Service (2013) issues its annual *Best Places to Work in the Federal Government* report utilizing data from the FEVS to rank agencies according to an index score. The score utilizes employee satisfaction, as well as ten additional workplace categories, such as effective leadership, employee skills/mission match, pay, teamwork and work/life balance. These scores allow a side-by-side comparison of how agencies or their subcomponents rank in various categories, and examine how they compare to other agencies to see if they have improved or regressed over time. There was a governmentwide decline in job satisfaction scores from 64.0 in 2011 to 60.8 in 2012 and 57.8 in 2013. The 2013 score was the lowest since the rankings were first launched in 2003. There was also a governmentwide decline in all of the other workplace categories that the Partnership examined. The most significant drop across the government was in satisfaction with pay, followed by decreased satisfaction with training and development opportunities, and rewards and advancement.

Among other large federal agencies, the Department of Veterans Affairs moved from 18 out of 19 on the list of Best Places to Work in 2012 to 13 out of 19 in 2013. VA also had increases in overall satisfaction, satisfaction with training, and rewards and advancements, but ranked last among other large agencies in satisfaction with pay.

American Association of Retired Persons (AARP) Award

The VHA was one of 50 winners of the AARP's 2013 Best Employers for Workers Over 50 award. According to the AARP (n.d.), "Since its inception in 2001, this award has recognized employers who are ahead of the curve. Award winners have set outstanding examples through programs that help them retain, retrain, engage and recruit the older workers who will be increasingly crucial to their success and the success of the U.S. economy over the coming decade."

Hiring Initiatives

Targeted Disabilities

To reaffirm VA's position as a federal government leader, Secretary Shinseki increased the goal for hiring of persons with targeted disabilities from 2% to 3% in FY 2013. While the rate of representation of VHA onboard employees with targeted disabilities hovers just below 2% ([see Table 1](#)), the rate of hires for employees with targeted disabilities in VHA was 3.0%.

Losses due to terminations, removals and separations in FY 2012 were 2.8% for employees with targeted disabilities as compared to 1.3% for the total workforce. The rate of quits for employees with targeted disabilities was also higher than the total workforce (4.9% vs. 4.0%). If we are unable to retain employees with targeted disabilities, the hiring goal will need to be increased.

Accommodations and training and developmental opportunities are areas of particular concern for this group of employees. The Office of Diversity and Inclusion (ODI) recommends ensuring that employees receive timely accommodations when appropriate. Further, they recommend reviews prior to termination of an employee with a disability to determine whether an accommodation would help the employee perform. According to ODI, 42.5% of EEO complaint findings in FY 2012 against VA were based on disability.

Veterans

VHA continues to make positive steps towards accomplishing the Secretary's Veteran hiring goal of 40%. The percentage of Veteran employees onboard in VHA has increased from 29.1% in FY 2008 to 30.6% in FY 2013. Furthermore, the percentage of new hires who are Veterans has increased from 25.7% in FY 2008 to 35.9% in FY 2013.

While VACO, VBA, and NCA have exceeded the Secretary's goal for Veteran representation (Figure 15), it continues to be difficult to attain for VHA due to the low percentages of Veterans in Title 38 health care occupations. As of FY 2013, fully one-third of the VHA workforce is comprised of employees in Title 38 health care occupations; however, only 14.9% of Title 38 non-hybrid employees are Veterans (Figure 16). Efforts are currently underway to improve partnerships with the Department of Defense (DoD) to recruit Veterans in health care occupations who are exiting DoD. The ADUSH for Workforce Services is VA's first and only member on the DoD Chief Human Capital Officers (CHCO) Healthcare Executive Council. The Council offered VHA the opportunity to review its FY 2012 Health Manpower Personnel Data System (HMPDS) Report, which provides a fiscal year end snapshot of the status of the medical manning for DoD, including active and reserve components and DoD medical civilians. A review of this report examined losses among active duty DoD members in clinical occupations that corresponded with those in VHA. The review concluded that VHA is in competition with DoD to hire its Veterans in Title 38 positions due to the seamless transition of active duty to civilian duty, and that the DoD pipeline will not be sufficient to reach the Veteran hiring goal. A discussion of the findings for specific occupations is presented in the VHA Mission Critical Occupations section of this plan.

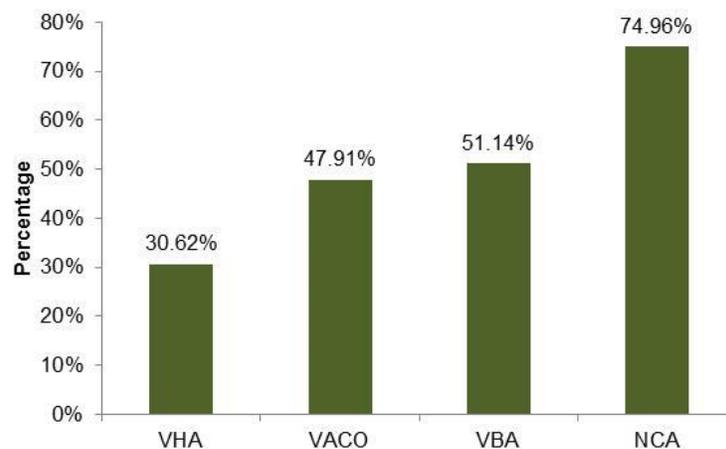


Figure 15: FY 2013 Percent of Veterans for all VA Organizations

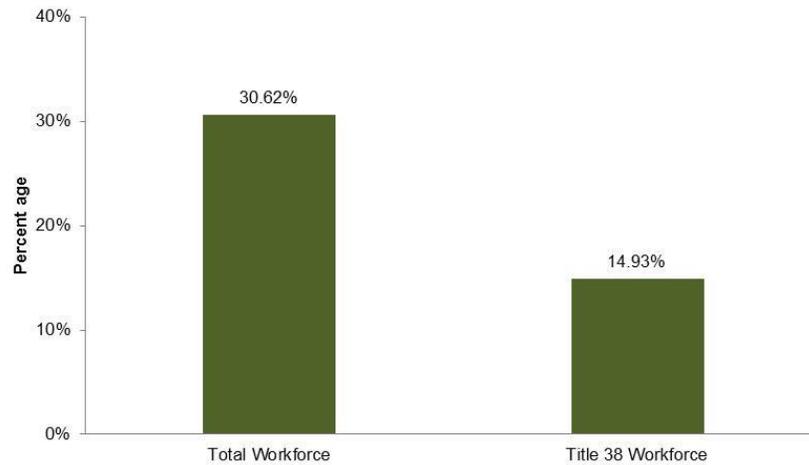


Figure 16: FY 2013 Percent of Veterans in the Total Workforce as Compared to Those in Title 38 (Non-Hybrid) Occupations.

The average age of onboard Veteran employees in FY 2013 was approximately 49.9, which is slightly higher than the total workforce average age of 48.1. In addition, the voluntary retirement rate for Veterans is also higher than the total workforce. Veteran employees' retirement rates increased from 3.2% in FY 2008 to 3.4% in FY 2013. In comparison, the voluntary retirement rate for the total workforce was 2.4% in FY 2008 and 2.8% in FY 2013 (Figure 17). The Draft 2014 VA Strategic Implementation Plan describes a performance measure to decrease VA's Veteran employee turnover rate.

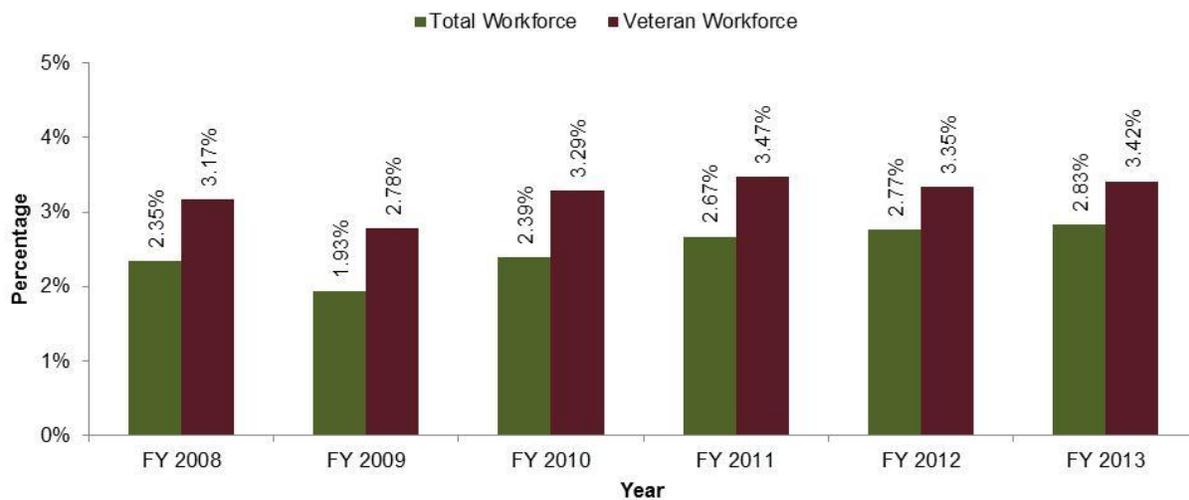


Figure 17: Retirement Rates for Total Workforce vs. Veterans

Mental Health

Since FY 2005, there has been substantial growth in VA mental health treatment demand, which has outpaced growth in the overall VA population. In 2008, VA began implementation of the Uniform Mental Health Services Handbook, which outlined mental health services that were to

be available at VA facilities nationwide. In addition, initiatives to increase staffing to meet the increased demand and help implement some of the new Handbook requirements were undertaken. While these initiatives did increase the mental health staff-to-patient ratio between FY 2005 and FY 2010, continued growth in the mental health patient population limited, and even began to reverse some of those gains. In FY 2012, concerns about the adequacy of mental health staffing due to long wait times and limited Veteran access to VA mental health services, led to work on an outpatient mental health staffing model. VHA developed and pilot implemented a general mental health staffing model in four VISNs, using a team-based care approach with the goal of improving patients' access to and continuity of care, care quality and efficiency, and staff satisfaction, morale, and organizational function. This pilot of the general mental health staffing model is being expanded to include pilot implementation at all VA facilities in FY 2014. Additionally, an overall outpatient mental health staffing model, focusing to ensure adequate overall staffing across all levels of outpatient care for mental health patients seen at the facility, has been drafted and is under review.

Immediately prior to the start of the Mental Health Hiring Initiative, the national mean ratio of Mental Health Outpatient Clinical (MHOC) staff per 1,000 mental health patients was 7.72. The initial goal of the Initiative was to bring all facilities up to the facility average. The Initiative entailed intensive, focused, and coordinated efforts of human resource staff and mental health leadership to recruit new mental health professionals at the majority of VA facilities. The effort netted an increase of nearly 1,450 mental health providers in FY 2013 through August.

Lessons Learned

Onboarding new employees, particularly those in clinical occupations, requires time for orientation, acculturation, and training and habituation in organizational and clinical process. In addition, new hires need time to build up a full case load. New clinicians rarely begin delivering care immediately, and their clinical productivity should be expected to start low and increase over time. Full improvements in clinical access, care quality, and clinical productivity will lag substantially from the time of hiring.

Current Efforts

The Office of Mental Health Operations continues to collect and validate staffing data with facility and VISN leadership. This validation helps to ensure that the data being captured most accurately represents true mental health staffing as seen on the ground.

Ongoing growth in mental health patient numbers will require on-going growth in mental health staffing levels across the system to maintain current staff to patient ratios. Lack of availability of mental health providers or VA's ability to attract them, plus the extent to which new provider's positions include time for administrative, research or training work, will limit the ability to bring facilities up to the minimum facility staffing ratio that is yet to be determined. Additionally, there are significant variations in projected mental health patient growth across facilities, and in staff-to-patient ratios. Current recommendations call for facilities to meet at least the minimum ratio.

Staffing measures are based upon levels of care rather than occupations. There are three levels of outpatient mental health care: Primary Care Mental Health Integration (PCMHI), General

Mental Health (GMH), and Specialty Mental Health (SMH). There is currently wide variation in organization and distribution of staff across these levels of care even within high performing facilities. While current GMH and PCMHI initiatives may reduce variation in distribution of workload and staffing across facilities, variation in the distribution of staffing across levels of care are expected to continue. Much of this variation is due to local characteristics of the patient population served, and therefore it will be important to continue to allow flexibility in staff allocation across levels of care. Other factors that may alter the need for outpatient mental health clinical full-time equivalent employees include facility complexity levels, the existence of residential programs, the use of contracted community services, and vacancy rates.

External Drivers

Veteran Population, Enrollees, Patients

VHA anticipates a slow decline in the Veteran population over the next 10 years, primarily due to deaths in key populations (i.e., WWII, Korea, and Vietnam era Veterans), and a smaller population of new Veterans entering the system. However, predictions indicate a national increase both in the number of enrollees and in the number of Veteran patients. Regional changes in the number of enrollees show a significant difference in the level of growth across the VISN's, with the most growth predicted to occur in the Southeast, South, and West.

Regional changes are also influenced by the growing number of women Veteran enrollees. The number of women Veterans who use VHA services have nearly doubled in the past decade. To prepare for the increase and the accompanying complexity of treatment needs women Veterans will require, additional training in critical health care services such as primary care, mental health, specialty care, and gynecology services will be necessary to develop a proficient workforce focused on women Veterans health care.

Access for female Veterans is compounding the issue of overall access and the number of primary care providers in VHA's workforce. In general, female Veterans require more patient visits than males, and they are more likely than men to use Non-VA Care (Fee) than the male population. At least 1,000 primary care providers will need to be hired or trained in women's health issues to continue to meet the needs of the growing population. Further, as VHA continues to implement the new PACT system, women's health PACT teams will need to be adequately staffed, so that women Veterans receive high-quality primary health care from a single primary care provider and team, thereby decreasing fragmentation and improving quality of care for women Veterans.

The reproductive health needs of women evolve across the life span. Currently, 90 of 152 facilities have gynecology services on site, other facilities choose to provide Non-VA Care (Fee) or contract services. Innovative technology resources should be considered to help meet this demand. In addition, the needs for mental health services are more focused and complex for females. According to the Office of Women's Health Services, more than 50 percent of female OEF/OIF/OND Veterans seen receive a mental health diagnosis. As such, there is a growing need for critical up-to-date reproductive mental health information and providers focused on treating them.

VHA will also need to plan for the recruitment and retention of Women Veteran Program Managers (WVPM). A full-time position in the facility, WVPMs serve as advocates for women Veterans by providing program leadership and coordinating high-quality health care services with multiple disciplines within medical facilities. There are efforts underway to gather more information about recruitment and retention of the WVPM workforce.

As mentioned in the Strategic Direction chapter, the predicted broad-based changes in the age and demographics of our Veteran population will require new competencies and skills to address the resulting changes in Veterans’ expectations. While the oldest segment of the Veteran workforce will continue to impact the demand for health care services, new OEF/OIF/OND enrollees will impact the demand for preventive health. These changes may result in a decrease in utilization of care. Estimates indicate a decline of inpatient usage by 2,000 bed days (15%) over the next 10 years. Estimates also predict an increase in usage of primary care, medical and surgical specialty care, and mental health care of approximately 20-25% over the next 10 years.

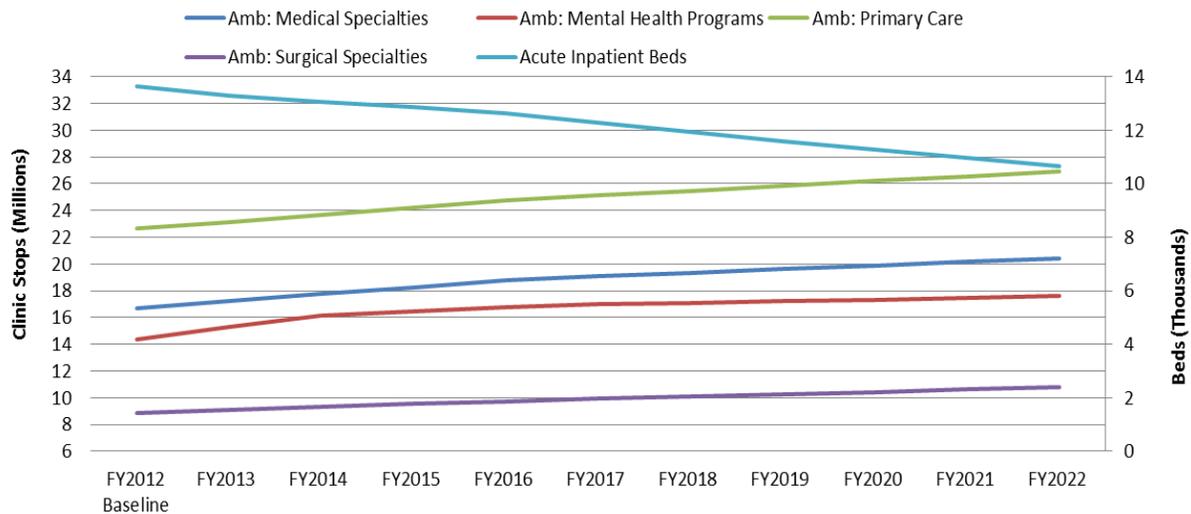


Figure 18: Changes in Utilization of Care

One of the key objectives under the VHA strategic goal of providing Veterans personalized, proactive, patient-driven health care is to strengthen collaborations. The strategy is to accomplish improved collaboration by leveraging relationships with private organizations, academic affiliates, and other federal agencies such as Health and Human Services, Indian Health Service, and DoD in an effort to offer the most complete spectrum of services possible for our Veterans.

Shortage of Health Care Professionals in VHA Mission Critical Occupations

This section provides an analysis of issues regarding recruitment and retention challenges for VHA's mission critical occupations. For more detailed information and data specific to each occupation, please refer to the 2014 Workforce Succession Strategic Plan Supplemental Report at <http://vaww.succession.va.gov/2014Supplemental>.

Table 3: 2014 Mission Critical Occupations

Rank	Top Ten Occupations	Projected Losses FY 2013 Through FY 2019	Projected Hires FY 2013 Through FY 2019
1	0602 Medical Officer (Physician)	15,102	18,368
2	0610 Nurse	31,556	40,334
3	0201 Human Resource Mgmt	1,653	2,199
4	0633 Physical Therapist	888	1,193
5	0644 Medical Technologist	2,404	2,743
6	0180 Psychology	2,823	4,176
7	0603 Physician Assistant	1,306	1,506
8	0631 Occupational Therapist	576	733
9	0660 Pharmacist	2,805	3,545
10	0605 Nurse Anesthetist	436	649
Total		59,549	75,446

Consolidated data from the VISN Workforce Succession Strategic Plans submitted in the spring of 2013 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 2014 mission critical occupations table. A total of 59,549 losses are anticipated between FY 2013 and FY 2019 among these occupations. A total of 75,446 new hires will be needed to maintain staffing levels and grow these occupations as projected through FY 2019 (Table 3).

In addition to the top ten occupations for recruitment and retention, the five physician and nurse specialties are also identified and aggregated through the VISN and facility planning process and occupational priorities that ranked 11 to 15 are identified as other targeted occupational priorities (Table 4).

Table 4 - Top Physician & Nurse Specialties and Other Occupational Priorities

Top 5 Physician & Nurse Specialties	
Physician	Nurse
31 Psychiatry	88 Staff Nurse
25 Gastroenterology	87 RN, Mgr/Head Nurse
07 Orthopedic Surgery	75 Nurse Practitioner
P1 Primary Care	Q1 RN/Staff-Outpatient
E6 Cardiology	N4 NP Mental Health SUD

Other Targeted Occupations (Ranked 11-15)
0647 Diagnostic Radiologic Technologist
0620 Practical Nurse
0649 Medical Instrument Technician
0801 General Engineering
0640 Health Aid & Technician

Onboard Growth

While the number of employees onboard in the top occupations group continued to grow since FY 2009 (with the exception of Medical Technologist and Physician Assistant), the rate of that growth has slowed considerably. However, at 2.8%, the FY 2012 top occupations group average growth rate is still slightly higher than the VHA total workforce growth rate of 2.7%. Psychology (9.3%) had the highest growth rate. Human resources management (7.1%) and physical therapist (4.0%) had higher rates as well. See Figure 19 for the growth rate of all occupations.

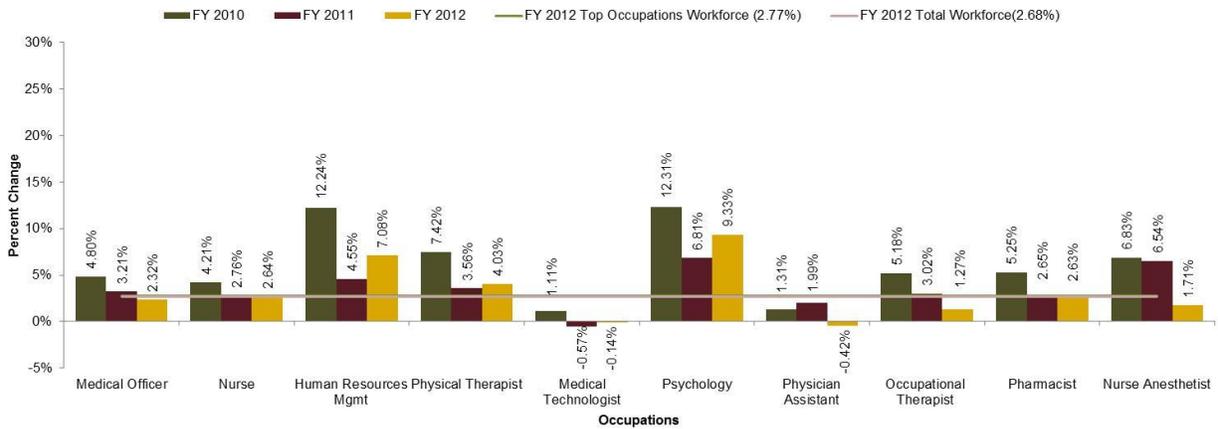


Figure 19: Percent Change in Onboard for Top Occupations Compared to Top Occupations Combined and VHA Overall

Loss Rates

The rebound in losses that began in FY 2010 continued in FY 2011 and FY 2012, also resulted in increases in loss rates for most of the top occupations. However, the total loss rate average for the top occupations group (7.5%) was lower than the VHA total workforce average (8.6%) for FY 2012. Many VHA retention programs focus on the mission critical top occupations and may be the reason for our success in keeping the loss rates lower among this cohort. The programs are discussed later in this chapter.

The voluntary retirement rate (Figure 20) increased in FY 2012 by 0.1 percentage points (pp) for the top occupations group over FY 2011. Half of the top occupations had an increase in voluntary retirements while the other half had decreases. The largest increases in retirements were seen in nurse anesthetist (+0.8 pp).

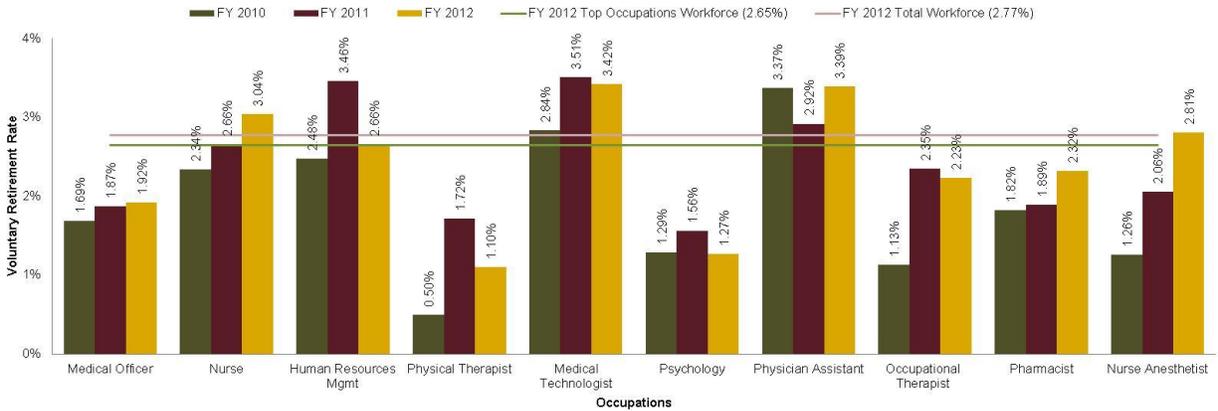


Figure 20: Voluntary Retirement Rate for Top Occupations Compared to Top Occupations Combined and VHA Overall

The quit rate (Figure 21) for the top occupations group increased slightly (+0.1 pp) in FY 2012, as did four of the individual occupations' quit rates (medical officer, nurse, medical technologist, and occupational therapist). Human resource management had the largest decrease in quit rate (-1.2 pp), while medical technologist (+0.9 pp) had the largest increase.

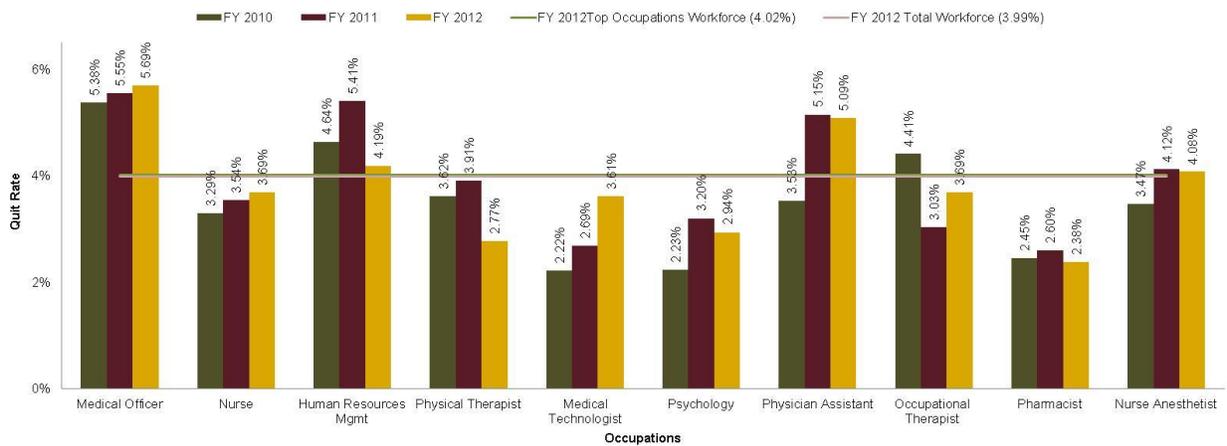


Figure 21: Quit Rate for Top Occupations Compared to Top Occupations Combined and VHA Overall

The total loss rate (Figure 22) for the top occupations group increased by 0.3 pp overall in FY 2012. Specifically, physician assistant, occupational therapist, nurse, and medical technologist increased by 0.6 pp; medical officer increased by 0.3pp), and pharmacist increased by 0.2 pp in FY 2012.

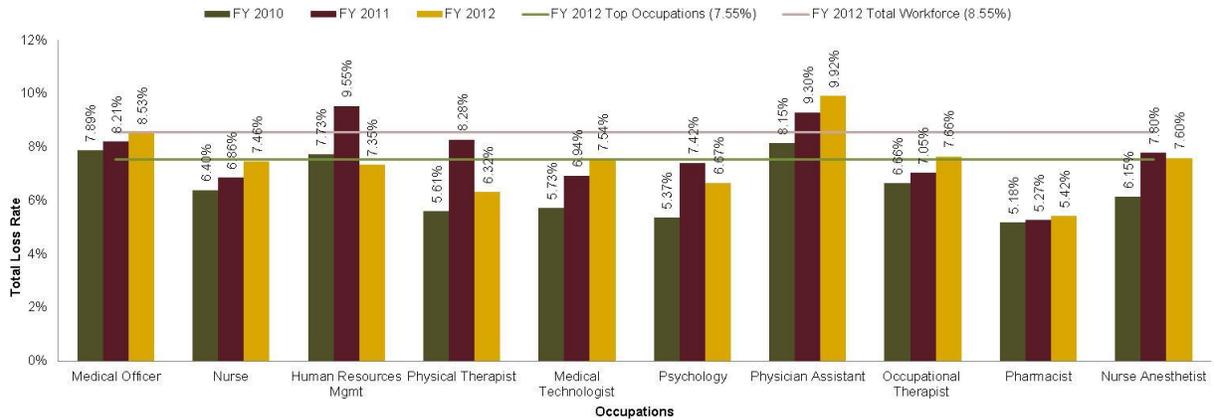


Figure 22: Total Loss Rate for Top Occupations Compared to Top Occupation Combined vs VHA Overall

Average Age

The top occupations group average age (Figure 23) in FY 2012 was 48.8 years, as compared to the total workforce average age of 48.2 years. Medical officer (51.2 years), nurse (49.1 years), physician assistant (49.7 years), and nurse anesthetist (50.0 years) all had higher average ages than the total workforce. Physical therapist (43.0 years) had the lowest average age.

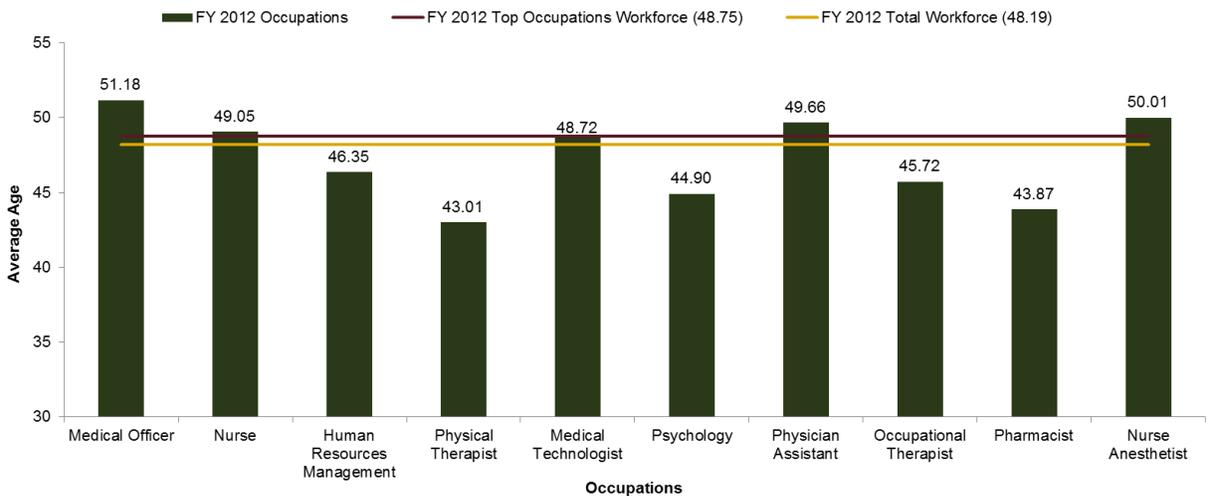


Figure 23: Average Age for Top Occupations Compared to Top Occupations Combined and VHA Overall

Quits by Year of Employment for All Top Occupations

- ▶ On average, 31.5% of all new hires in the top occupations quit in the first five years of employment; 2.7 percentage points more than for the workforce overall.
- ▶ Nearly half (49.3%) of the employees who quit between FY 2005 and FY 2007 did so within the first year; another 22.6% quit in the second year. This means that nearly three quarters of quits occur within the first two years of employment (Figure 24).

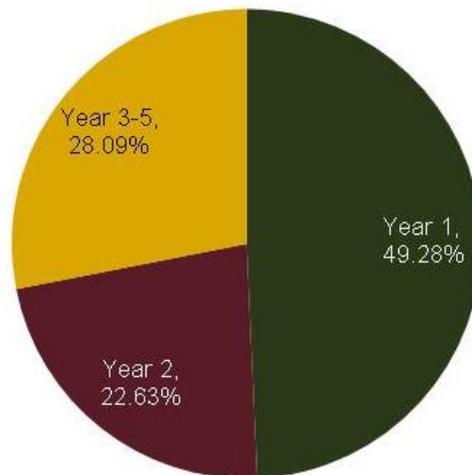


Figure 24: FY 2005 – 2007 Quits as a Percentage of New Hired Losses Within the First Five Years

An examination of individual occupations' new hire quit rates (Figure 25) within the first two years of employment (for those hired between FY 2005 and FY 2011) reveals that the occupations with the highest loss rates within the first two years are human resources management (23.7%), nurse (21.6%), nurse anesthetist (21.3%), and medical officer (20.7%). Psychology (9.1%), physical therapist (14.6%), pharmacist (14.6%), medical technologist (16.3%), occupational therapist (16.7%), and physician assistant (18.0%) had the lowest quit rates within the first two years. Human resources management is the only occupation in the top occupations that is not health care related. Also, unlike the other occupations, the highest percentage of quits among human resources management continue to be due to transfers to other government agencies rather than resignations. A more complete discussion of the human resources management occupation is included later in this chapter.

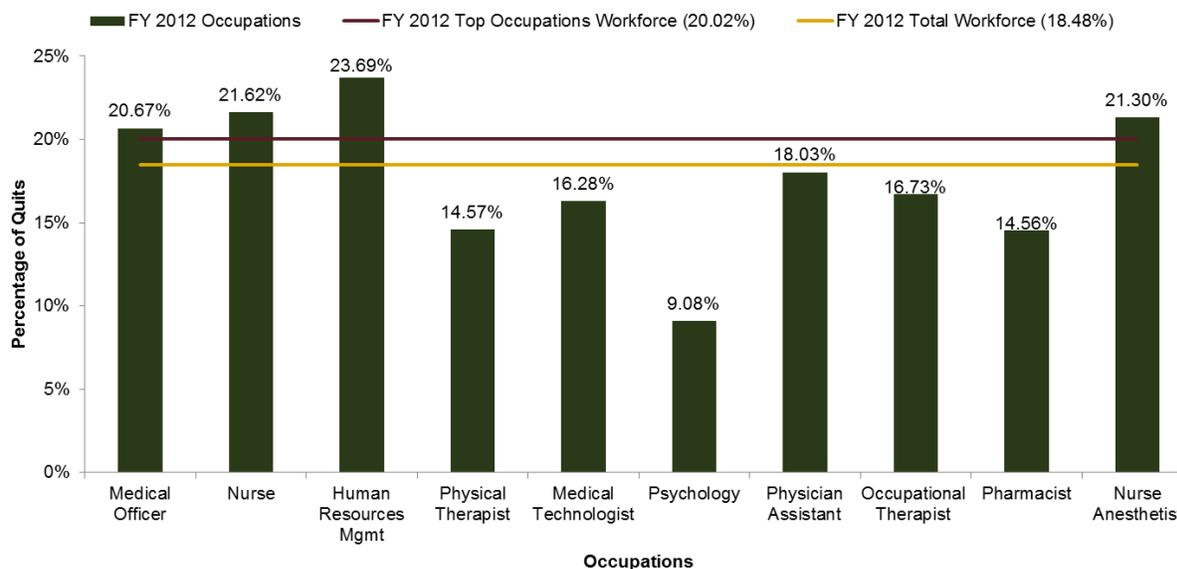


Figure 25: Quits Within the First Two Years of Employment

VA Entrance Survey Results

The VA entrance survey provides a means of assessing newly hired employees' reasons for choosing VA, and provides insight into ways VA can improve recruitment and marketing efforts. Like the exit survey, the completion of the entrance survey is completely voluntary and confidential. An analysis of FY 2012 survey participants' responses to the question of why they chose to work for VA indicates that the top three reasons were:

- ▶ 21.7% career opportunity/advancement/professional growth/development
- ▶ 20.2% benefits (retirement/health and life insurance, etc.)
- ▶ 13.0% mission/serving the Veterans

Those in the top occupations chose "advancement/career opportunity" and "mission" somewhat less frequently than the total workforce. However, they chose "benefits" as a reason for choosing to work at VA slightly more frequently than the total workforce. Like the total workforce, more than half of top occupation respondents identified electronic resources, such as VA Careers and the OPM/USA Jobs website as their main sources of information about the job.

VA Exit Survey Results

The FY 2012 VA Exit Survey indicated that those in the top ten occupations left VHA for the following reasons:

- ▶ 21.6% normal retirement
- ▶ 18.4% advancement (unique opportunity elsewhere)
- ▶ 9.8% relocation with spouse

Those in top occupations selected “advancement (unique opportunity elsewhere),” “family matters,” “relocation with spouse,” and somewhat more frequently than those in all other occupations. Like the workforce overall, those in the top occupations chose normal retirement and advancement for unique opportunities elsewhere as their top two reasons for leaving. Instead of “attend school,” however, they chose relocation with spouse as their third reason for leaving 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, which may explain the decreased need to pursue additional education.

Minority Representation

The percentage of minorities among the top occupations (Figure 26) is generally lower than the total workforce. The top occupation’s group percentage of minorities in FY 2012 was 33.3%, compared to the total workforce percentage of 39.4%. The occupations with the highest percentage of minorities were human resources management (39.6%), medical technologist (36.7%), and medical officer (36.0%). The occupations with the lowest percentage were psychology (14.1%), nurse anesthetist (17.7%), and physician assistant (19.7%).

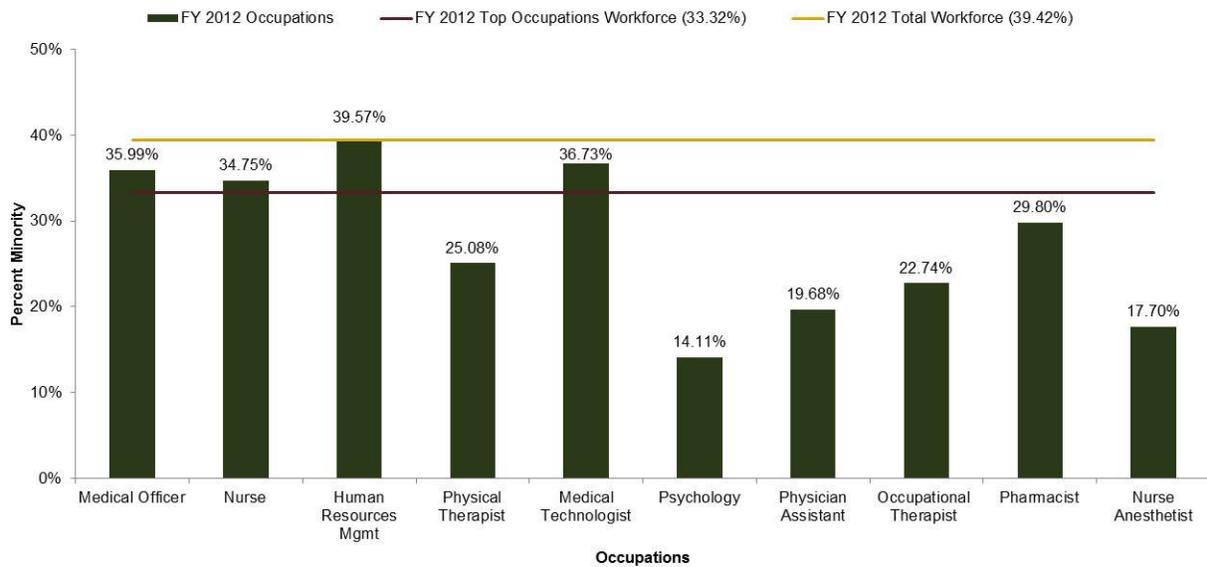


Figure 26: Minority by Occupation Compared to Top Occupations Combined and VHA Overall

The top occupation's group percentage of females (Figure 27) was 68.6% as compared to the total workforce average of 60.9%. With the exception of medical officer (35.3%), physician assistant (51.7%), nurse anesthetist (53.2%), and psychology (59.3%), the percentage of females is higher for most of the top occupations as compared to the total workforce.

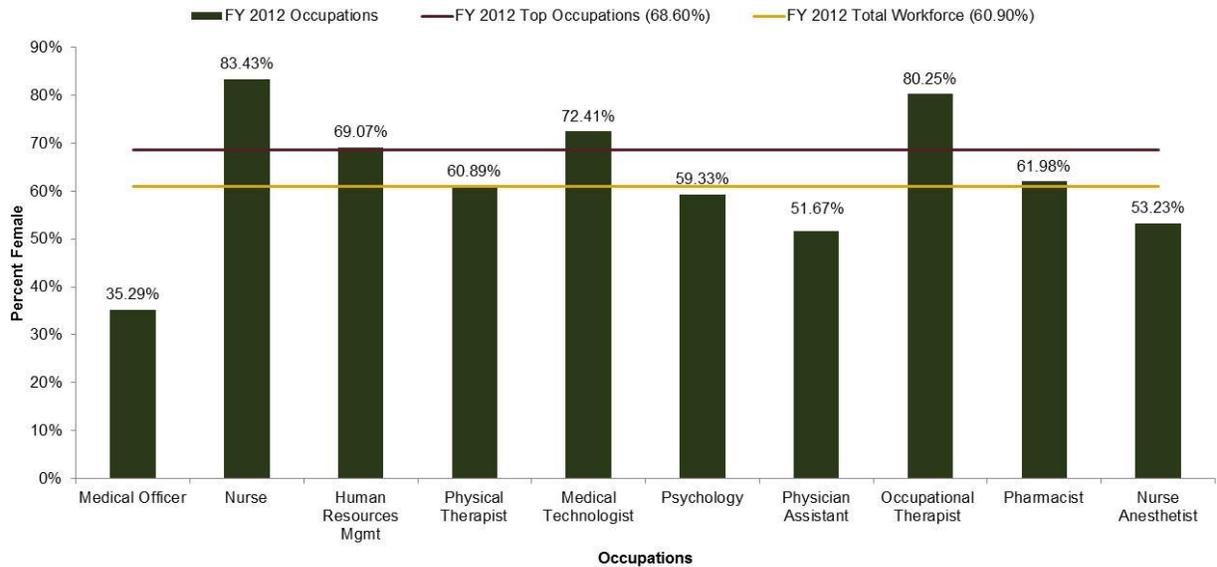


Figure 27: Females by Occupation Compared to Top Occupations Combined and VHA Overall

Veteran Representation

Due to the fact that most of the occupations in the top occupation list are clinical, and because of the low representation of Veterans in clinical occupations, the FY 2012 percentage of Veterans among the top occupations group (Figure 28) is much lower (14.8%) than the total workforce rate of 30.6%. Human resources management (39.9%), nurse anesthetist (33.9%), and physician assistant (30.9%) had Veteran percentages higher than the total workforce. Pharmacist has the lowest percentage of Veterans (7.2%). The review of the pipeline of Active Duty DoD health care professionals compared to VHA's health care workforce needs show that there is an inadequate number of Active Duty sources to meet the Veteran hiring goal in these Title 38 health care occupations. Therefore, as mentioned in Chapter 2, VHA is pursuing a reset of the Veteran hiring goal for health care occupations.

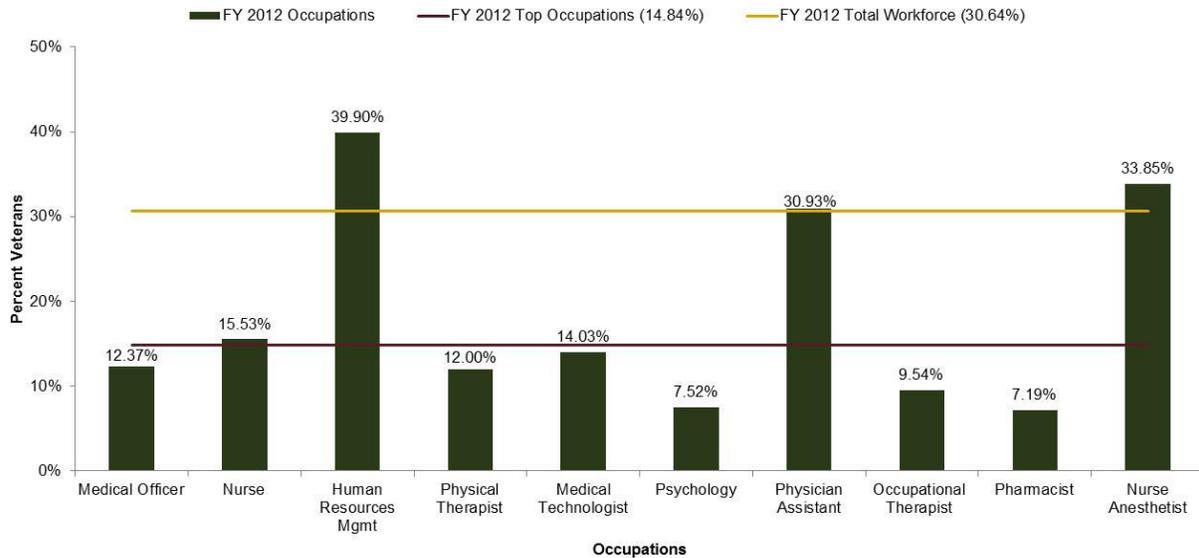


Figure 28: Veterans by Occupation Compared to Top Occupations Combined and VHA Overall

Veteran New Hires

In FY 2012, the rate of Veteran representation among new hires (Figure 29) in the top occupations group was 16.8%, compared to the total workforce at 35.5%. 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 (53.3%), nurse anesthetist and physician assistant, at 29.1% and 24.3% respectively, had representation rates higher than the top occupations average for new hires. The occupations with the lowest percentage of new hire Veteran representation were psychology (4.8%) and pharmacist (5.0%).

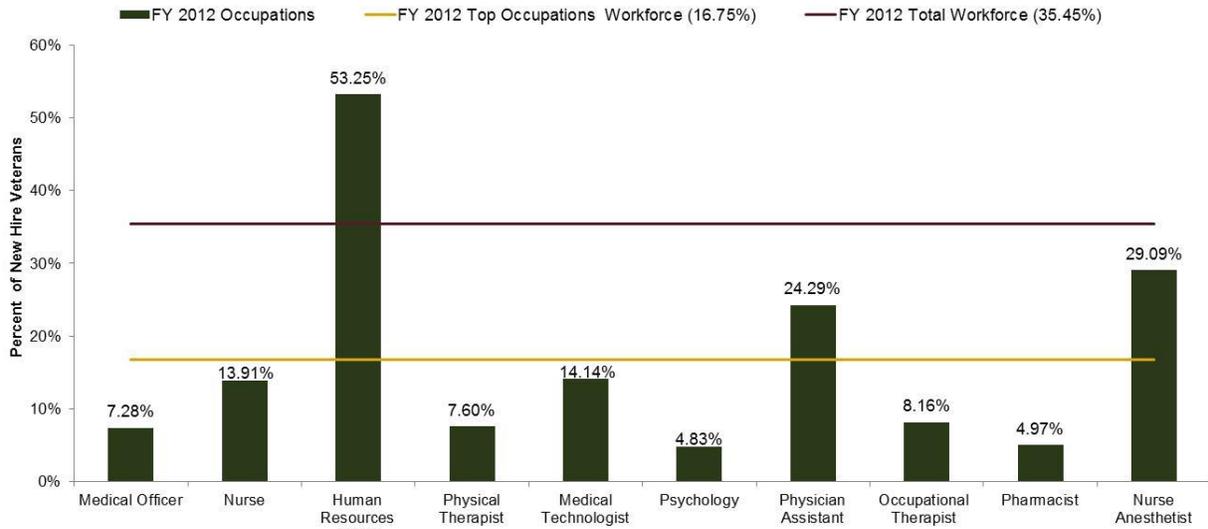


Figure 29: Veteran Representation Among New Hires by Occupation Compared to Top Occupations Combined and VHA Overall

Disability Representation

VHA’s goal for targeted disability participation is 2%. The top occupations’ group average is 0.6%, as compared to the total workforce average of 1.9% (Figure 30). Human resources management (2.1%) was the only occupation with a targeted disability participation rate higher than the goal. Many of the top occupations are physically demanding, such as physician and nurse positions that require many hours of standing, lifting, and assisting the mobility of others, which may contribute to the low employment rates of individuals with targeted disabilities in these occupations.

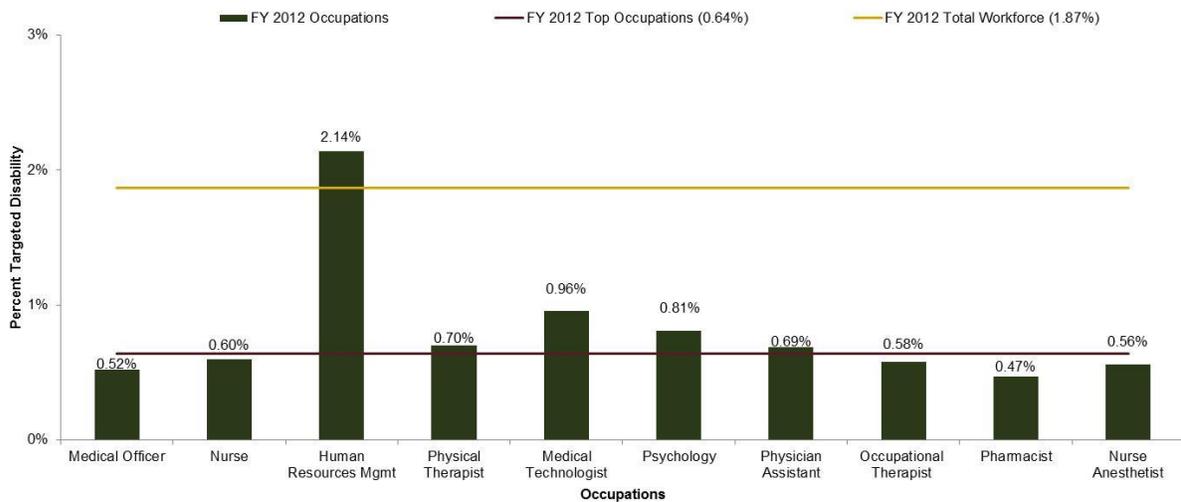


Figure 30: Targeted Disability by Occupation Compared to Top Occupations Combined and VHA Overall

Occupation Specific Issues

Medical Officer (Physician)

While the number of onboard physicians in VHA has continued to rise since FY 2010, the rate of that growth slowed dramatically between FY 2010 and FY 2012. However, the FY 2013 rate of 4.8% growth was higher than the total workforce rate of 4.2%.

The total loss rate, at 8.5% in FY 2012 was the second highest among the top occupations (see [Figure 22](#)). The bulk of the losses for this occupation continue to be due to quits; and the majority of quits are due to resignations. In fact, the quit rate, at 5.7% in FY 2012, was the highest of all of the top occupations, and was much higher than the total workforce average of 4.0%. Voluntary retirements remain lower than the VHA workforce average, and make up less than one quarter of the total losses for this occupation (Figure 31). Physicians also have one of the highest average ages (51.2) when compared to the top occupations average (48.8), and the total workforce average (48.2), which is indicative of the fact that physicians tend to retire later than other occupations.

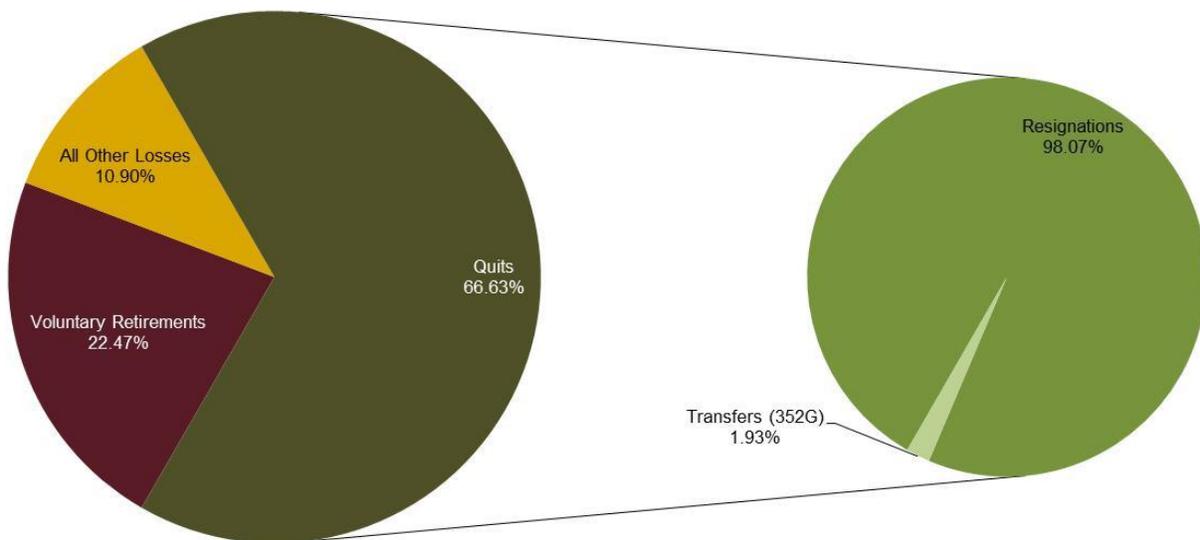


Figure 31: Physician Percent of Losses by Type of Loss (FY 2012)

An examination of quits among newly hired medical officers indicates that 33.8% of new hires quit within their first five years of employment, five percentage points higher than the total workforce. More than half of those quits occur within the first two years. Furthermore, the rate of quits within the first year reached a seven-year peak in FY 2011 (12.8%), which is the second highest first-year quit rate among the top occupations.

The number of physicians onboard and is projected to increase from 21,304 in FY 2012 to 24,570 by FY 2019. This reflects a higher growth rate (15.3%) than for the total workforce (13.8%) between FY 2013 and FY 2019. Approximately 48.9% of physicians will be eligible to

retire by FY 2019, which is higher than the total workforce percentage of 40.6%. The total loss rate is projected to continue to increase to 10.5% in FY 2019. Projections indicate that the majority of losses will continue to be attributed to quits.

Of the 345 physician exit survey respondents in FY 2012 (a 21.6% response rate), the highest percentage (31.9%) indicated that their reason for leaving was due to advancement (unique opportunity elsewhere), followed by normal retirement (14.8%), and relocation with spouse (9.9%). Although 61.5% indicated that their supervisor or manager did not try to get them to change their mind about leaving VA, approximately 83% indicated that they would consider working for VA again.

Among the top physician specialties identified by VHA workforce planners in FY 2013, Gastroenterology and Primary Care had the highest increase in growth in FY 2012. (Note: Psychiatry growth rate increased from 2.4% in FY 2012 to nearly 7.0% in FY 2013 as a result of the mental health hiring initiative.) Psychiatry and Orthopedics had the highest total loss rates (8.9% and 9.9% respectively). Quits make up the highest percentage of total losses among all of the top five specialties with an average rate of 5.4% (compared to 4.0% for the total workforce). The average retirement rate for the top five specialties remains low at 2.2% (the VHA total workforce rate is 2.8%).

***Top Physician Specialties
Identified in FY 2013***

- 1. Psychiatry*
- 2. Gastroenterology*
- 3. Orthopedics*
- 4. Primary Care*
- 5. Cardiology*

Nurse (Registered Nurse)

The Lewin Group (2012) study conducted on the workforce implications of ACA suggested that registered nurses (RNs) are, and will continue to be, the largest component of the health care workforce. The same is true for the VHA workforce. At the end of FY 2012 there were 55,297 nurses in VHA, comprising 20% of the workforce and making it the single largest occupation in VHA.

The Bureau of Labor Statistics (n.d.) predicts a 26% increase in total employment of registered nurses by 2020. In VHA, the number of nurses onboard has continued to grow since FY 2008, although, as with the total workforce, the rate of growth has slowed considerably from 9.6% in FY 2008 to 2.6% in FY 2012. The rate of growth among nurses in FY 2012 is only slightly lower than the total workforce average of 2.8%. VHA projections indicate growth of 15.9% by FY 2019 (64,705 nurses).

Total losses among nurses have continued to rise since the low of 5.7% in FY 2009 to 7.5% in FY 2012. While quits (at 3.69% in FY 2012) continue to make up the highest percentage of losses for nurses, losses due to retirements have increased considerably from the five-year low of

1.82% in FY 2009 to the FY 2012 rate of 3.0%. The average age of VHA nurses onboard has remained constant over the last five years at approximately 49 years of age, somewhat above the VHA average of 48.2 years. However, the average age of a new hire nurse has decreased from 42.8 in FY 2008 to 41.4 in FY 2012.

Between FY 2005 and FY 2007, an average of 32.1% of quits occurred within the first five years of employment, which is 3.3 percentage points higher than the workforce overall.

Exit survey data for nurses shows that the top reason for leaving is normal retirement. However, the second most frequently identified reason for leaving is for advancement (unique opportunity elsewhere). While the majority of exit survey respondents in FY 2012 indicated that there was not a single particular event that caused them to think about leaving VA and that they would consider working for VA again, nearly three quarters (72.7%) of the respondents said that their supervisor or manager did not try to get them to change their mind about leaving VA.

Among the top nurse specialties identified by VHA workforce planners, Nurse Practitioners and Staff Nurses had the highest increases in onboard growth in FY 2012. However, over the past five years, RN Manager Head Nurse and RN Staff-Outpatient have had the highest growth in onboard (16.5% and 16.1% respectively between FY 2008 and FY 2012). Total loss rates were highest for Nurse Practitioners (NP) in Mental Health (SUD), Staff Nurses and General Nurse Practitioners in FY 2012 (8.1%, 8.0%, and 7.9% respectively). More than two thirds of the losses for Staff Nurses and NPs were due to quits, whereas more than half of the losses for NPs in Mental Health (SUD) were due to retirements.

***Top Nurse Specialties
Identified in FY 2013***

- 1. Staff Nurse*
- 2. RN, Mgr/Head Nurse*
- 3. Nurse Practitioner*
- 4. RN/Staff-Outpatient*
- 5. NP Mental Health SUD*

Human Resources Management (HRM)

HR Management continues to be a mission critical occupation. The Bureau of Labor Statistics has projected a growth rate of 21% between 2010 and 2020 for all HR practitioners and a 13% increase for HR managers. At the end of FY 2008, VHA mandated a Human Resources (HR) Hiring Initiative to address the gap of HR practitioners to employees in the organization. In 2010 the the HR Delivery Model was approved which encouraged facilities to reduce the gap. The model provides a comprehensive approach for improving human resource management in VHA and recommended, among several items, implementation of an HR staffing plan that encouraged a ratio of 1 GS-201 HR practitioner for every 85 VHA employees by the end of FY 2012.

Since implementation of the recommended staffing plan, HR offices have experienced a steady growth in HR staff. In August 2008, the HR staff to employee ratio was 1 to 142. In September

2013 the ratio was 1 to 103. The number of HRM onboard increased by 52.9% (937 employees) between FY 2008 and FY 2012. Growth increased from 4.6% in FY 2011 to 7.1% in FY 2012, but then decreased again to 6.2% (169 employees) in FY 2013. Workforce planner projections indicated a need for 2,199 additional HRM staff to grow and maintain the workforce through FY 2019. However, given the existing shortage of HRM staff, and the fact that the VHA workforce is projected to continue to grow at an average rate of 1.5% per year, it will be difficult to reach the 1:85 ratio in the foreseeable future. A targeted recruitment and hiring campaign focused on the HR occupations will be necessary to close the HR staff to employee ratio gap.

The total loss rate for the GS-201 series has held steady at about 7% for the past two years since a high of 9.6% in FY 2011. Quits continue to make up the largest percentage of losses, although the rate of quits decreased from 5.4% in FY 2011 to 4.2% in FY 2012. Unlike the total workforce, the largest number of quits continue to be due to transfers to other government agencies.

Like most of the other top occupations, exit survey results show that normal retirement and advancement (unique opportunity elsewhere) have consistently been the two most frequently selected reasons for leaving between FY 2010 and FY 2012. While the majority of exit survey respondents in FY 2012 indicated that there was not a single particular event that caused them to think about leaving VA and that they would consider working for VA again, more than two thirds (67.1%) of the respondents said that their supervisor or manager did not try to get them to change their mind about leaving VA. This information highlights the need for supervisory training on employee appreciation and recognition.

A troubling fact for the GS-201 series is that 21% of the onboard employees currently in this occupation are within the ages of 55–64. Retirements for this group continues to be a source for losses of valued technical HR expertise. This intensifies the need for succession planning efforts at both the national and local levels of the organization.

Recruitment & Retention Strategies

- ▶ Utilize the Technical Career Field (TCF) for HR Interns and the Pathways Internship Program appointment to create a pipeline of qualified candidates.
- ▶ Promote the utilization of the use of the upcoming Phased Retirement program to retain seasoned HR professionals in local HR offices in training roles to assist with the development of junior staff members.
- ▶ As budgets allow, consider the use of recruitment, retention and relocation incentives.
- ▶ Continue to focus on utilization of tools to enhance the employee's work experience such as telework, compressed work schedules, and virtual work assignments.

Major Impacts on the Workplace

One of the greatest responsibilities HR professionals have is to ensure the organization has the resources to carry on with its mission to care for our nation's Veterans. As the organization is reacting to shifting priorities and demands, HR offices constantly have to rethink, restructure or change current processes to ensure strategies are in place to meet the needs of the organization. Areas where major emphasis is occurring or likely to occur include:

- ▶ **Technology** - Implementation and usage of HR automated systems has been major focus since 2008. USA Staffing, e-OPF (electronic Official Personnel Folder) and e-Class (electronic Classification) are now in use throughout VHA HR offices. Additionally, WebHR was successfully rolled out throughout VHA and is the sole source for Requests for Personnel Actions (SF-52s) and reports measuring the effectiveness and timeliness of HR actions (e.g., Time to Hire report data). With the upcoming implementation of HR Smart (VAs new solution for Human Resources) in FY 2015, it is expected that operational efficiencies will improve because of the streamlined business process flows. The new system will also introduce the use of employee and manager self-service capabilities.
- ▶ **Social Media** - The increased use of social media tools such as Twitter, Facebook and LinkedIn will drive increased usage of these tools to attract and recruit individuals to our organization. Additionally, due to the current budgetary and travel restrictions use of e-learning tools is expected to have broader impact.
- ▶ **Recruitment** – In recent years, along with the day-to-day hiring, there has been an enormous increase in recruitment actions in response to specific hiring initiatives such as T-21, Mental Health Hiring Initiative, and Peer to Peer Support Specialist. This additional workload trend is expected to continue and HR will continue to look for ways to improve our ability to hire high quality employees.
- ▶ **Metrics** – VA's initiative to transform human capital management includes improved recruiting, hiring and retention. The VA goal for Speed of Hire is 60 days. In FY 2013, VHA met the goal at the rate of 81.57%. HR offices are continuously encouraged to look for ways to streamline hiring and improve the hiring experience and timeframes.
- ▶ **Training and Development** – Development of technical skills and HR competencies needs to continue into the future as retirements take place and new HRM staff are hired. Current staff members also need to build and maintain their professional knowledge by acquiring needed training and continuously learning from peers, mentors and HR sessions such as the HR Café.

Psychology

The Bureau of Labor Statistics (BLS, 2012b) predicts a growth rate for psychologists nationwide of 22% by 2020, which is faster than the average for all occupations. As a result of the expansion and transformation of VA mental health care, and the recent mental health hiring initiative, the number of VHA onboard full and part-time, permanent and temporary psychologists has grown 58.3% (1,597 employees) since FY 2008. This represents the largest growth rate of any of the other mission critical occupations. Additional growth of 31.2% is projected through 2019.

Total losses among psychologists in FY 2012 (6.7%) are lower than the total workforce rate of 8.6%. In addition, among those newly hired between FY 2005 and FY 2011, psychologists have one of the lowest quit rates within the first two years of employment (9.1% for psychologist vs. 20.0% for the top occupations average).

The average age of a psychologist has decreased over the last five years from 46.3 to 44.9 years, as compared to the VHA average of 48.2 years. The rate of employment of Veterans among the psychology workforce, at 7.5% (compared to 30.6% for the total workforce) is one of the lowest of the mission critical occupations.

Medical Technologist

The BLS (2012b) 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 by 2020. In VHA, the medical technologist workforce has increased by 2.5% (106 employees). However, although the occupation has been in the VHAs mission critical occupation list for several years, the workforce decreased by 0.6% in FY 2011, and then decreased again in FY 2012 by 0.1%. At the same time, loss rates have increased to their highest level in five years (7.5% in FY 2012). The majority of losses over the last 5 years are due to voluntary retirements, which reached a peak of 3.5% of the average onboard in FY 2011, and at 3.4% for FY 2012. Quits have also rebounded from the low of 2.2% in FY 2010 to 3.6% in FY 2012. The new hire quit rate within the first two years of employment (FY 2005-FY 2010) was 16.3% for medical technologists, as compared to 20.0% for new hires in the overall VHA workforce. However, 27.5% of new hires quit within their first five years of employment (FY 2005 – FY 2007), which is approximately 1.6 percentage points higher than for the workforce overall.

Physician Assistants

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. 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 are in high demand in the general health care workforce. The BLS (2012b) projects that the occupation will expand by 30% by 2020. The VHA PA workforce grew at an average rate of 7.5% between FY 2008 and FY 2012. Like the overall VHA workforce, the growth rate for PAs peaked in FY 2008 (8.7%), and has since declined rapidly. The FY 2012 growth rate dropped to -0.42% (from 1,893 employees in FY 2011 to 1,885 in FY 2012). Despite this drop in growth, consolidated data from the VISN Workforce Succession Strategic Plans indicated that the occupation increased in its priority ranking among the national critical occupations from 9th place in the FY 2013 rankings to 7th place in FY 2014.

The decline in growth rate corresponds with a continued trend of increased losses due to retirements, regrettable losses, and lower gains. Current recruitment of new hires continues to be insufficient to compensate for losses. With the increasing percentage of the PA workforce reaching retirement age, this trend is likely to continue. The average age of PAs has increased over the last five years from 48.7 to 49.7 years. This is slightly above the FY 2012 VHA average of 48.2 years. In FY 2012, approximately 4.8% of PAs were 65 or older, while 33.4% were age 55 to 64. Consequently, the PA retirement rate is one of the highest among the top occupations (3.4% for PAs vs. 2.7% for the top occupations average). In addition, quit rates among this occupation are also one of the highest among the top occupations. The average rate of quits for PAs in FY 2012 was 5.1% as compared to 4.0% for the top occupations overall average.

Exit surveys for PAs resigning from VHA employment cite advancement opportunities elsewhere as the second most frequently identified reason for leaving (behind retirement).

Affordable Care Act

The Affordable Care Act (also referred to as ACA or the health care law) represents comprehensive reform of the health care delivery system and is intended to expand access to coverage, control health care costs, and improve the health care delivery system. Under ACA, certain individuals, based on their income, may be eligible for tax credits which defray the tax payers' cost of health insurance premiums. The most significant provisions of the ACA are the individual mandate requirement, which requires most individuals to have health insurance coverage and the Medicaid expansion provision, which expands Medicaid eligibility to up to 138% of the federal poverty level. States have the option to expand their Medicaid eligibility programs.

Education Efforts for VA's Workforce

There have been a variety of efforts to educate VA's workforce on the impact of ACA to VA operations to ensure VA employees have information for themselves and for our Veteran patients. Education efforts have focused on providing the right information to allow employees to effectively conduct outreach with Veterans, eligible beneficiaries and their family members.

VA has developed a variety of training modules in the Talent Management System (TMS) for VA employees and a large number of employees continue to access these training modules. There is also a specific training module to provide information about ACA for VA employees and their families.

VA's Office of Human Resources has also been engaged in a variety of efforts to educate VA's workforce on ACA. Efforts include disseminating materials from the Office of Personnel Management (OPM) and disseminating ACA information throughout the VA ACA HR community.

Impact on Veterans

When the key provisions of ACA are fully implemented in 2014, it will provide some Veterans with new options for health care. For instance, Veterans may become newly eligible for Medicaid if they meet the income requirements and reside in a state that is expanding Medicaid. VA is developing strategies to provide Veterans with personalized, proactive, patient-driven health care and establish itself as a highly effective, innovative, data-driven, evidence-based, continuously improving, and reliable health care system.

The landscape of health care is continuing to evolve and there remain a number of unknowns such as states deciding whether they will expand Medicaid eligibility and how they will stand up their health insurance marketplace. It is likely that it will take several years for Americans to understand ACA and settle on their desired choices for health care. VA is monitoring the ACA implementation and has been an active partner with federal agencies developing implementation regulations.

Impact on Supply of Workers and Demand for Health Care

Initial analyses suggest that implementation of ACA may also affect VHA's ability to recruit, retain and manage health care talent. Industry-wide employment in all health professions, except laboratory technology and nurse anesthetist positions, is expected to grow by more than 20% between 2014 and 2016. Overall, demand for mental health workers, including social workers who provide mental health and substance abuse treatment will increase by approximately one-third. For physician providers, 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.

Some of the programs and efforts established by ACA to improve the supply of health care workers throughout the entire health care delivery system include:

- ▶ Implementation of Nurse Managed Health Clinics (NMHC) that will improve access to primary care, enhance nursing practice by increasing the number of clinical teaching sites for primary care and community health nursing students, and develop electronic processes for establishing effective patient and workforce data collection systems. NMHCs will also serve as primary care access points in areas where primary care providers are in short supply (U.S. Department of Health and Human Services, n.d.)
- ▶ Modification of the primary care medical student loan program to make it more attractive to students to accept the loan and serve in primary care to obtain loan payback. According to the Association of American Medical Colleges (AAMC) (n.d.) the program:
 - ▶ Establishes a more reasonable default rate;
 - ▶ Caps loan recipients' service requirement at 10 years (or the date the loan is repaid);
 - ▶ Amends loan guidelines to eliminate the requirement for parental information to determine financial need for independent students.
- ▶ Increases to the National Health Service Corp's (NHSC) Loan Forgiveness program in the number offered and the flexibility of the program which may include part-time work. The changes offer higher monetary awards, an option of working half-time to fulfill the service obligation (two years of service at health care facilities in medically underserved areas), and provides credit for some teaching hours (U.S. Department of Health and Human Services, 2010).
- ▶ Increases in federal funding for nursing educational loans and increases to the annual cap on the amount that an individual may borrow.
- ▶ Grants for training in general, pediatric, and public health dentistry.
- ▶ Grants for education and training of mental health professionals.
- ▶ Incentives for primary care practice through increased Medicare and Medicaid payments for primary care services

Current Efforts and Strategies in VHA

VHA will continue to monitor workforce trends through a robust succession planning process that will gather input from workforce planners at every level of the organization (facility, VISN and program office) through their submission of workforce plans. These plans provide vital information on the implementation of recruitment and retention strategies and hiring needs for both the total workforce and for mission critical occupations. Additionally, they ensure alignment of workforce planning strategies and initiatives with strategic goals and objectives.

The phased implementation of a newly designed workforce planning process (described in detail in Chapter 3) will begin in FY 2014. One significant improvement is that planners will receive quarterly (rather than annual) updates of workforce planning data via a “portal” or “dashboard”. These data include onboard, losses, and gains needed. Continuous and more timely monitoring of these metrics will help VHA be agile enough to proactively assess and minimize any potential impact of the ACA.

Beginning in FY 2014, planners will receive guidance that includes a synthesized list of prioritized issues. Planners will be asked to address key questions about those issues. In turn, planners will also be instructed to identify their own local priority issues and describe their action plans for dealing with those issues. This input will provide valuable insight into local recruitment and retention strategies which can be used to inform national initiatives.

VHA continues to make significant progress in providing increased access to mental health care services for our Nation’s Veterans. The mental health hiring initiative that occurred in FY 2013 resulted in the addition of 4,308 mental health providers. As discussed in the Strategic Direction chapter, VHA will continue to recruit mental health professionals in accordance with staffing models developed by the Office of Mental Health Operations. The continuous monitoring of data that was implemented during implementation of the initiative also resulted in improvements in the ability to identify outpatient mental health providers. These improvements will assist in assessing gains, losses, bench strength and gaps that may still exist in the mental health workforce.

VHA is committed to attracting and retaining a diverse workforce equipped to deliver personalized, proactive, patient-driven health care to our Nation’s Veterans. In recognition that demand for health care providers may increase, VHA will continue to maximize the utilization of hiring flexibilities and retention incentives by:

- ▶ Expediting the Title 38 hiring process;
- ▶ Offering higher rates of pay based on specialized skill;
- ▶ Providing retention, relocation, and recruitment incentives;
- ▶ Advertising Educational Debt Reduction Program (EDRP), Student Loan Repayment Program (SLRP) and Educational Assistance Program; and
- ▶ Offering flexible work schedules.

To remain competitive with the health care industry, VHA will continue to evaluate the pay ranges of health care providers and will recommend adjustments as necessary.

Workforce and Succession Planning Trends and 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.

Recruitment

Recruitment challenges continue to exist. VHA faces direct competition from the private, public, and government sectors medical community for recruiting all of the health care occupations it employs. Recent limits on the use of recruitment, retention and relocation incentives have shifted the focus of recruitment efforts to identifying creative ways to continue to attract and retain a highly qualified and committed workforce. Because of the VHA's large network of academic affiliations, it enjoys access to a rich talent pool of trainees from thousands of colleges and universities around the country. Over 65% of all U.S. trained physicians have received some or all of their training in VA. However, the lack of utilization of a system to track those trainees has hampered its ability to capitalize on that sector of the workforce.

In response to these recruitment challenges, VHA utilizes several strategies to position itself as an employer of choice for health care professionals.

- ▶ The Healthcare Recruitment & Marketing Office (HRMO) focuses on strategic workforce planning and filling anticipated gaps. There are two cohesive entities within the HRMO: Recruitment Marketing and Advertising (RMA) and the National Recruitment Program (NRP). Both entities work together to cohesively develop extensive recruitment and marketing campaigns aimed at attracting talent to our organization. They use the latest recruitment strategies such as social networking (e.g., LinkedIn, Twitter, and Facebook) and employer branding to attract prospects to achieve positive results. “*The Best Care-The Best Careers*” brand promotes VHA as a provider of quality care as well as promotes the extensive career opportunities available. They initiated electronic marketing of national health care recruitment events and public affairs partnerships to enhance VHA recruitment efforts.
- ▶ NRP places experienced health care recruiters in each VISN, to target the hardest to fill health care and executive vacancies by using innovative recruitment planning and outreach. To leverage the VHA trainee talent pool, NRP coordinates the “Take A Closer Look” campaign, in collaboration with the Office of Academic Affiliations, to market to and inform trainees about VHA career opportunities. In FY 2014, NRP rolled out the “Recruiter yoU” online course, to develop the talent of HR staff nationwide. The course trains the VHA Recruitment Competency Model and current industry best practices for recruiting hard-to-fill clinical and executive specialties. NRP also maintains the Applicant Tracking System (ATS), a shared VHA database of candidates interested in careers in VHA. Over 600 field-level users have received training on searching and referring candidates from this resource.
- ▶ The Education Debt Reduction and Student Loan Repayment Programs (EDRP & SLRP) are designed to serve as recruitment and retention incentives via service agreements for hard-to-fill positions and highly skilled employees. EDRP helps Title 38 and Hybrid

Title 38 employees on permanent appointments in professional clinical positions pay back their qualifying educational loans. Similarly, SLRP helps Title 5 and Hybrid Title 38 employees pay back their qualifying student loans. Local HR offices link EDRP program management to their recruitment, selection, and retention processes.

- ▶ The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care occupations leading to appointments or retention in certain Title 38 or Hybrid Title 38 health care positions. The National Nursing Education Initiative (NNEI) and the VA National Education for Employees Program (VANEEP) are policy-derived programs that stem from the legislative authority of EISP. These programs help alleviate the health care workforce shortages in VA by requiring scholarship recipients to complete a service obligation at a VA health care facility after graduation and/or licensure/certification. These types of obligations secure the employees' services for up to three years. VHA projects an increased use of NNEI and VANEEP in 2014 and 2015 to support various initiatives including efforts to increase the number of mental health professionals, clinical nurse leaders, and participants at rural VA facilities.
- ▶ The VA Health Professional Scholarship Program (HPSP) and the Visual Impairment and Orientation and Mobility Professionals Scholarship Program (VIOMPSP) allow VA to provide scholarship awards to non-VA employees. VIOMPSP provides financial assistance to individuals pursuing a program of study leading to a degree or certificate in visual impairment or orientation and mobility. HPSP allows VA to provide tuition assistance, a monthly stipend, and other required education fees for students pursuing education or training that would lead to an appointment in a Title 38 or Hybrid Title 38 occupation. VHA anticipates awarding the first VIOMPSP scholarship awards in 2014. Currently, HPSP has a sunset date of December 31, 2014. VA has proposed legislation to extend the sunset date five years.
- ▶ VHA routinely uses hiring and pay incentives established under Title 5 and Title 38 to appoint individuals to positions that are hard to fill.

Retention

Over the last five years VHA has experienced losses of 105,246 employees. Most of these losses are a result of resignations, transfers to other federal agencies and retirements. Retention of employees will be critical as the majority of our employees are at or near retirement age. Retention efforts need to focus on tools that address the needs of employees. As mentioned in the Strategic Direction chapter, data from the VA Exit Survey indicate that in addition to retirement, employees are leaving for career advancement and professional development opportunities. Employees are looking for well-defined career paths. Career and professional development programs, mentoring, job reengineering, and cross-training could assist in retaining some of these employees. Striving to achieve better work-life balance with telework arrangements or alternate work or part-time schedules could also help retain needed talent.

To build a strong and capable workforce leadership must provide opportunities to employees to develop their technical skills and competencies. The Talent Management System (TMS) is the primary training delivery and tracking system for the VA. TMS provides employees with access

to innumerable courses covering many diverse topics, 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 expand their knowledge. These courses can be taken online at the convenience of employees. The recently added Individual Development Plan (IDP) guide provides employees an opportunity to learn about and create their IDPs. Employees are enabled to guide the direction of their careers and develop their knowledge and skill set. Supervisors have access to the TMS data for their employees to enable them to monitor employee progress as well.

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 environment preferences, and provides career guides for numerous occupations to include the required competencies, where the positions are utilized, and recommended training for specific career fields.

The VA Leadership Development Portal (LDP; <http://www.leaders4VA.com>) 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.

The VHA Mentor Certification Program is an integral part of VHA's succession strategy. 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. The program is open to all employees. At the heart of the program is a core training course covering the roles and responsibilities of mentors. The course teaches mentors how to use the G-R-O-W model 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. VHA is continuously taking steps to improve its mentor certification program. For FY 2014, the Mentor Certification Advisory Board plans to develop a robust mentor toolkit to provide readily-accessible resources for VHA mentors; incorporate mentor training modules in national employee development programs, migrate the current face-to-face core training course to other viable learning platforms to include an e-learning format with expanded content; and reestablish a strong cadre of mentor trainers and mentoring experts to support the development of new mentors in the field. There are currently 5,960 certified mentors in VHA with at least 25 hours of documented practical experience.

VHA has been supportive of the use of alternative (flexible, compressed or part-time) work schedules in the workplace as long as the proper care and treatment of patients is the primary consideration. Many employees enjoy the benefits of these work schedules as they balance family and work/life.

The Telework Enhancement Act of 2010 is a key factor in the federal government's ability to achieve greater flexibility in managing its workforce through the use of telework. Telework

programs provide a valuable tool to meet mission objectives while helping employees achieve work/life balance. Telework.gov indicates that telework: 1) is a useful strategy to improve continuity of operations to help ensure that essential federal functions continue during emergency situations; 2) promotes management effectiveness when telework is used to target reductions in management costs and environmental impact and transit costs; and 3) enhances work-life balance, i.e., telework allows employees to better manage their work and family obligations, retaining a more resilient federal workforce able to better meet agency goals. VHA is seeing an increase in the use of telework and virtual work locations. The percentage of employees in eligible positions who telework has increased from 27.5% in FY 2011 to 47.0% in FY 2013.

Like most federal agencies, VHA has a significant number of employees that are eligible for regular retirement. Retirements will continue to be a major source of loss of talent and institutional knowledge for at least the next decade. OPM recognized the need to retain this valuable knowledge and is currently working on the final regulations to implement **phased retirement**, a new human resources tool that allows full-time employees to work a part-time schedule while beginning to draw retirement benefits. This new retention tool would apply to employees in both the Civil Service Retirement System and the Federal Employees' Retirement System. The purpose of phased retirement is to allow the federal government to continue to benefit from the services of experienced employees, who might otherwise choose to retire, and require that they spend a percentage of their time mentoring and training less experienced employees. Participation will be voluntary and both the employee and Agency must consent. The final regulations are due in December 2013. Implementation of this new tool may assist managers and workforce planners in their efforts to retain valuable knowledge across VA and assist in training our future workforce.

Leadership Development

Leadership development is an integral component of succession and workforce planning. The high percentage of the workforce that will be retirement eligible in the next five years, particularly in leadership positions, makes development of talent a critical aspect of this planning process. While there are on-going budgetary and policy challenges to meeting these needs, as described in the introductory section of this report, VHA continues to offer numerous training and development opportunities that significantly enhance the VHA talent pool and workforce succession pipeline. The primary VHA development programs are:

- ▶ **Technical Career Field (TCF) Program.** TCF is open to current employees and external candidates. It provides two years of full-time, structured formal and on-the-job skills training for those entering succession-critical, non-clinical occupations. Programs differ in the depth of skill and target grade level of the participants. Graduates may be non-competitively placed into occupation-specific positions.

- ▶ **Graduate Healthcare Administration Training Program (GHATP).** GHATP is a year-long program focused on providing hands-on project management and organizational leadership experiences to prepare the next generation of VHA health care administrators. It is open to graduate students in health care related academic disciplines and current VHA employees with proven capacities to serve as health care leaders.
- ▶ **Leadership Effectiveness Accountability and Development (LEAD) Program.** LEAD is a series of programs designed for junior and intermediate-level employees to explore and build their foundational leadership and teamwork skills. LEAD programs are locally-administered throughout VHA following a national curriculum structure and standards. LEAD is the most widespread leadership development program in VHA, with nearly 1,000 enrollees per year.
- ▶ **Health Care Leadership Development Program (HCLDP).** HCLDP is an 8-10 month collateral duty program for upper-level employees. It focuses on strengthening leadership skills of participants and their ability to lead teams and organizations. Multiple integrated, week-long face-to-face training sessions are interspersed with coaching, assignments and workplace activities.
- ▶ **Health Care Executive Fellows (HCEF) Program.** HCEF is a year-long immersion training program to prepare aspiring VHA Assistant/Associate Directors, Chiefs of Staff, and Associate Directors for Patient Care Services. This highly-selective program is open to internal and external candidates. HCEF training occurs in VHA's most complex medical facilities under the guidance of seasoned incumbents in the specific target occupations/positions.
- ▶ **New Executive Training (NExT) Program.** The NExT program is designed to get newly-appointed facility executive team members and Deputy Network Directors off on the right foot in their new positions. It includes an in-depth, face-to-face orientation session covering a broad range of VHA technical and leadership topics, one-on-one executive coaching, Community of Practice activities, and independent study.
- ▶ **New Supervisor Training.** The VHA Nuts and Bolts of Supervision course is mandatory for all first-time VHA supervisors within their first year of appointment. It consists of 14 modules covering foundational knowledge for supervisors, such as staffing procedures, labor relations, team leadership, and basic rules of procurement. VA is developing a replacement course for VA-wide implementation in 2014, and VHA will maintain a supplement to address the unique aspects of supervising in a health care environment.

VHA's implementation of the above training programs was significantly curtailed in FY 2013 as a direct result of budgetary constraints and challenges in transitioning to VA's new conference and training event oversight policies. Some programs were unable to launch a 2013 class, such as HCEF and HCLDP, while others had individual training events delayed or cancelled. The increased cost of approval and lack of flexibility brought about by the training event policies led to a significant increase in the use of alternative modalities to achieve required professional accredited training requirements and a decrease in total face-to-face training events, and

impacted the content of training to lean towards offering basic skills training rather than higher order or advanced skills training that would typically be offered by travel to face-to-face events. Some professional accredited training requirements cannot be completed using non-traditional training methods and other leadership development programs are significantly degraded without some face-to-face component. VHA took numerous steps to overcome the challenges. There has been a surge in the use of virtual training technologies, such as vTel, webinars, and live meetings, as alternatives to face-to-face training and as expansions of existing training program content. SharePoint, the VA Leadership Development Portal, and other collaborative tools are being leveraged to share training materials, hold topical discussions, and provide students access to a broad range of learning resources. Programs such as HCEF and HCLDP are under review to identify creative ways to conduct them more cost efficiently, while simultaneously increasing their effectiveness at preparing ethical, forward-looking VHA leaders.

VHA is actively participating in a number of initiatives at the Department level that hold the potential to positively affect VHA's employee development efforts and its ability to meet its workforce succession challenges. These initiatives relate to assessing skill gaps, training opportunities, delivery methods, training resources, and evaluation with the goal of developing a robust portfolio of programs that dovetail seamlessly to produce competent employees for each successive level of leadership and skill development.

Chapter 3 – Workforce Planning Process Refresh

Over the years, the process for workforce planning has undergone fairly significant modifications and improvements that have enabled VHA to enhance its ability to gather input and analyze its workforce. However, recent changes in the organizational structure and the release of the VA's Concept of Operations for a new corporate workforce planning capability presented an opportunity to review the VHA process to ensure its relevance in light of existing realities.

To assist in addressing these emerging situations, the Healthcare Talent Management (HTM) Office's Workforce Succession Planning (WFSP) Team received approval to temporarily suspend efforts to produce a full, printed version of the 2014 VHA Workforce and Succession Strategic Plan. In the interim, WFSP facilitated focusing the efforts of the traditional "Rollup Team" towards reviewing and identifying existing planning process constraints and opportunities with the ultimate goal of enhancing the existing workforce planning process.

Under the guidance of the HTM WFSP, the 2013 Rollup Team was chartered with the basic aim of reviewing the current capability. During April through July, 2013, the national Rollup Team met with the charge of conducting a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the current workforce planning process. As a result of this process, the Rollup Team identified the need to develop strategies, infrastructure, and processes to improve the alignment and integration of workforce planning with core strategic and budget planning processes and to strengthen or establish support for workforce planning through existing governance structures. A full list of the goals and strategies identified is included in the Workforce Planning Process Implementation Plan <http://vaww.succession.va.gov/2014implementationplan>. These goals will be periodically reviewed and refreshed by the HTM WFSP Team and/or the Succession and Workforce Planning and Analysis Subcommittee (SWAPS) as new priorities and objectives emerge through the activities conducted during each phase of implementation.

The most significant changes to the process include the creation of the SWAPS, a new subcommittee of the SWDMS. The SWAPS will enhance the strategic alignment and deployment of initiatives identified through the workforce planning process within VHA. SWAPS will also assist the HTM WFSP Team in the development of the annual VHA Workforce and Succession Strategic Plan.

Through the SWDMS, SWAPS will take direction from the Under Secretary for Health, the National Leadership Council, and the Workforce Committee and will actively monitor national, governmentwide, and VHA-wide guidance and workforce trends to interpret them for workforce and succession planning purposes. SWAPS will identify and prioritize key issues through environmental scans, select topics for conducting issue-focused analysis and perform ongoing review and oversight of VHA Program Office and field-based workforce planning activities.

Facility, VISN and Program Office planners will continue to produce annual workforce succession strategic plans. The HTM WFSP Team will continue to issue annual guidance, but will provide planners with a prioritized list of issues of national importance that resulted from the SWAPS/SWDMS environmental scanning process. Future workforce planners' training will

emphasize the importance of ensuring that local planners also utilize the concepts of environmental scanning and SWOT analysis to identify the issues of highest impact to the Facility, VISN, or Program Office. In addition, planners at these levels will also be asked to provide quarterly updates on the status of all workforce planning initiatives, both local and national. The changes to the process will be implemented in phases:

- ▶ Phase 1 – Design and Testing (2014):
 - ▶ Create a newly designed workforce planning process model.
 - ▶ Perform an environmental scan to identify a limited scope of issues that will be included in the FY 2014 planning cycle guidance.
 - ▶ Collaborate with internal and external stakeholders to gather feedback and approval for the new process.
 - ▶ Launch the SWAPS Subcommittee.
 - ▶ Create a communication and training plan, and process evaluation strategy.
- ▶ Phase 2 – Evaluate and Gather Feedback (2015-2016):
 - ▶ Work with the SWAPS to evaluate the results of Phase I and incorporate feedback gathered during the phase into a refined process model.
 - ▶ Introduce new objectives and strategies will be introduced as appropriate.
 - ▶ Evaluation and feedback from stakeholders will continue at the end of each planning cycle.
- ▶ Phase 3 – Full Implementation and Continuous Evaluation (2017 and beyond):
 - ▶ Roll out the remaining portions of the implementation plan to include full annual and quarterly environmental scans.
 - ▶ Support final enhancements to the model’s capability to include continuous improvement and updates of tools and training.
 - ▶ Continue to work with stakeholders to further understand their needs and customize tools and requirements for the future.

Human Capital Lifecycle Model (HCLM)

The establishment of the Office of the ADUSH for Workforce Services and the vision of the HCLM reinforced collaborative efforts between the offices of Workforce Management and Consulting, Employee Education Service, National Center for Organizational Development and Office of Academic Affiliations will ensure fully integrated partnerships to respond comprehensively to VHA’s workforce needs.

The core elements of the model include:

- ▶ *Plan* – All activities that establish the requirement for VHA human capital (employees, students, residents, volunteers, contractors, partnerships, affiliations, etc.) *Plan* links people, strategy and performance to achieve the goals and objectives of the VA and VHA Strategic Plans.
- ▶ *Prepare* – Focuses on VA’s statutory missions “to train for VA and the Nation”. This is primarily accomplished in conjunction with VA’s academic affiliates. Together, VA and its affiliates share a mission for education and research and VA trainees provide an important component of the pipeline for future recruitment.
- ▶ *Hire* – The acquisition of human capital both internal and external to VHA. *Hire* establishes policy that facilitates the recruitment and hiring process.
- ▶ *Develop* – Focuses on empowering the VHA workforce with technical, leadership, and management competencies. *Develop* enables VHA staff to further refine the skills necessary to accomplish their jobs, and to advance in their careers. This includes all aspects of learning: formal education, training, and ancillary/On Job Training (OJT).
- ▶ *Compensate* – Remuneration of the VHA workforce consistent with their contribution to the VHA mission. Aligns with *Plan* and *Hire* to support human capital targets for recruiting, retention, and forecasting through use of incentives.
- ▶ *Sustain* – Ensures support for a stable workforce. In conjunction with the other core elements of the HLCM, *Sustain* also drives career progression for VHA employees through human capital requirements, progression models, individual employee development and transition.
- ▶ *Transition* – Movement of employees between internal positions, and departure of employees from VHA.



Figure 32 - VHA Human Capital Lifecycle Model

Chapter 4 - VHA Workforce and Succession Planning 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 categories of initiatives and strategies are needed to strengthen existing programs and efforts.

Table 5: VHA Workforce and Succession Planning Initiatives

Initiatives	Strategies
<p>Recruitment – Recruitment initiatives will attract a wide range of skilled professionals to provide the highest quality care to our nation’s Veterans.</p>	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 and implement physician recruitment incentives utilizing current authorities.
<p>Engagement and Retention – Retention initiatives include programs, flexibilities, and developmental opportunities designed to keep highly qualified professionals growing and engaged within VHA.</p>	Implement Veteran Hiring Initiative to increase the number of Veterans in the workforce.
	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 e-mail 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.

Initiatives	Strategies
	Develop and implement a variety of innovative strategies to recognize and retain nurses in clinical and administrative roles.
<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.
	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.
	Assure all VHA Leadership Development Programs are consistent with VA I CARE values.
<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>	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.
	Implement phased retirement to utilize skills of retirement eligible staff for knowledge transfer and leadership development.
	Retaining nurses at the bedside.
<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>	Develop skills and competencies for effective facility-based workforce planners by enhancing the content of and access to workforce and succession planning training opportunities through modalities such as web-based courses and other virtual modalities.
	VHA National Workforce Planning Team will administer VA Workforce Planner Certification Program to market and implement VA workforce planner competencies.

Initiatives	Strategies
	Launch the Succession and Workforce Analysis and Planning Subcommittee (SWAPS).
	Implement and report on the status of the newly designed workforce and succession strategic planning process.
	Complete a gap analysis on Servant Leadership characteristics in VHA to develop program content for leadership development.
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.	Develop strategies for employees to embrace movement to a Personalized, Proactive, Patient Driven Health Care system.
	E-Performance- Partner with the Department to create an electronic performance management system.
Deployment – Workforce deployment initiatives facilitate the implementation of an integrated approach to workforce planning and workforce management operations.	Roll out automated Organizational and Position Management tool.
	Develop charter template for taskforces.

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Appendix A: List of Acronyms

Acronym	Title
AAMC	Association of American Medical Colleges
ACA	Affordable Care Act
AES	All Employee Survey
ATS	Applicant Tracking System
BLS	Bureau of Labor Statistics
CHCO	Chief Human Capital Officers
CNL	Clinical Nurse Leader
CVT	Clinical Video Telehealth
DoD	Department of Defense
DRRTP	Domiciliary Residential Rehabilitation Treatment Programs
eConsults	Electronic Consultations
EDRP	Education Debt Reduction Program
EEO	Equal Employment Opportunity
EHCPM	Enrollee Healthcare Projection Model
EISP	Employee Incentive Scholarship Program
eOPF	Electronic Official Personnel Folder
FEVS	Federal Employee Viewpoint Survey
FTC	Facility Telehealth Coordinators
FY	Fiscal Year
GMH	General Mental Health
HBOC	Hospital Based Outpatient Clinic
HCEF	Health Care Executive Fellowship
HCLDP	Health Care Leadership Development Program
HLCM	Human Capital Lifecycle Model
HMPDS	Health Manpower Personnel Data System
HPDM	High Performance Development Model
HPSP	Health Professional Scholarship Program
HR	Human Resources
HRM	Human Resources Management

HRMO	Health Recruitment & Marketing Office
HT	Home Telehealth
HTM	Healthcare Talent Management
I CARE	Integrity, Commitment, Advocacy, Respect, and Excellence
IDP	Individual Development Plan
IOC	Independent Outpatient Clinic
JOLTS	Job Openings and Labor Turnover Survey
LDP	Leadership Development Portal
LDSTF	Leadership Development System Task Force
LEAD	Leadership, Effectiveness, Accountability and Development
mHealth	Mobile Health
MHOC	Mental Health Outpatient Clinical
MOC	Mobile Outpatient Clinic
NCA	National Cemetery Administration
NHSC	Nurse Managed Health Clinics
NMHC	Nurse Managed Health Clinics
NEEI	National Nurse Education Initiative
NRP	National Recruitment Program
ODI	Office of Diversity and Inclusion
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
OPCC&CT	Office of Patient Centered Care and Cultural Transformation
OPM	Office of Personnel Management
PA	Physician Assistant
PACT	Patient Aligned Care Team
PCMHI	Primary Care Mental Health Integration
PP	Percentage Point
PPBE	Planning, Programming, Budgeting, and Execution
RCLF	Relevant Civilian Labor Force
RMA	Recruitment Marketing and Advertising

RN	Registered Nurse
SCAN-ECHO	Specialty Care Access Network and Extension for Community Healthcare
SECVA	Secretary VA
SES	Senior Executive Service
SFT	Store and Forward Telehealth
SLRP	Student Loan Repayment Program
SMH	Specialty Mental Health
SUD	Substance use Disorder
SWAPS	Succession and Workforce Analysis and Planning Subcommittee
SWOT	Strengths, Weaknesses, Opportunities, and Threats
SWDMS	Succession and Workforce Development Management Subcommittee
TCF	Technical Career Field
TCT	Telehealth Clinical Technicians
TMS	Talent Management System
VA	Veterans Affairs
VACO	VA Central Office's
VALU	VA Learning University
VANEEP	VA National Employee Education Program
VBA	Veterans Benefits Administration's
VEC	Veteran Experience Committee
VEOA	Veteran Equal Opportunity Act Authority
VHA	Veterans Health Administration
VHACO	Veterans Health Administration Central Office
VIOMPSP	Visual Impairment & Orientation & Mobility Professionals Scholarship Program
VISN	Veteran Integrated Service Network
VOW	Veterans Opportunity to Work
VRA	Veterans Readjustment Authority
WFSP	Workforce Succession Planning