Healthcare Leadership Talent Institute

Workforce Services

VETERANS HEALTH ADMINISTRATION

VHA Workforce and Succession Strategic Plan 2016

At the Veterans Health Administration (VHA), we know our employees are our most valuable resource.

Every day, over 315,000 committed and dedicated VHA employees provide essential health care services to over four million of our nation's Veterans. Having the right employees with the right skills is critical to successfully delivering high quality, patient-centered health care in the largest integrated health care system in the United States.

This 2016 VHA Workforce and Succession Strategic Plan identifies VHA's unique workforce challenges, gaps, solutions, and strategies to ensure the best workforce is in place at VHA. This national data driven plan is the culmination of input from VHA Medical Centers, Veterans Integrated Service Networks, and VHA program offices and is anchored to the VHA Strategic Goals, and my top five priorities:

- Improved Access
- Increased Employee Engagement
- Building a High Performing Network
- Consistency of Best Practices
- Rebuilding the Trust of the American Public

I encourage VHA staff to read this plan, become familiar with its contents, and use it to help guide local strategic planning and decision making. An electronic version is available on the VHA Succession Planning SharePoint at http://go.va.gov/jm3j.

Utilizing this plan as a roadmap will help us to identify ways we can work together to build, develop and support our talented staff, improve our culture and employee engagement, and creatively address workforce challenges to ensure we continue to improve the Veteran experience.

David J. Shulkin, M.D.

Under Secretary for Health

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Executive Summary

Effective workforce and succession planning ensures an ample pool of talent with the right skills, experiences, and competencies is recruited, developed, and retained to meet the challenges of the future. The 2016 Veterans Health Administration (VHA) Workforce and Succession Strategic Plan utilizes the latest workforce planning data from medical centers and Veterans Integrated Service Network (VISN) as well as strategic guidance and analysis of key issues to present workforce planning needs and recommend actions toVHA leaders. Leaders at every level play a key role in ensuring that the resources needed to address the critical elements of the plan are provided and that responsible parties are held accountable for implementing the actions outlined in the plan.

Contents and Key Findings

Chapter 1, Strategic Direction, defines the strategic goals, major initiatives, and legislation that will impact the workforce as described below.

- MyVA Integrated Plan: empowers employees to be effective and to integrate operations across business lines and organizations for improved service delivery and maximized efficiency;
- Veterans Access, Choice and Accountability Act (VACAA) of 2014: provides new authorities, funding, and tools to help support and reform VA, improve access to care, and expand capacity through increased health care staffing and revised personnel procedures and authorities;
- VHA Blueprint for Excellence: goals include improving performance, promoting a positive culture of service, advancing health care innovation for Veterans and the country, and increasing operational effectiveness and accountability;
- Under Secretary of Health's Five Priorities: improved access, increased employee engagement, building a high-performing network, consistency of best practices, and rebuilding the trust of the American public;
- VHA Modernization Report: modernization efforts impact the workforce through improved Veteran health and well-being, increased Veteran satisfaction, and increased cost effectiveness;
- Projecting Veteran Demand for VA Health Care: Enrollee Health Care Projection Model (EHCPM) predicts Veteran enrollment growth through FY 2025 due to high enrollment of OEF/OIF/OND Veterans and dynamic enrollment priority;
- New Models of Care: models of care pursued by VHA such as Patient Centered Care, Patient Aligned Care Teams, VA Voices, Telehealth, Connected Health, Veterans Crisis Line, Peer Support, and Home Based Care may require new skill sets or increased numbers of employees.

Chapter 2, Workforce Planning Priorities, provides an overview of several workforce planning priorities identified through environmental scanning, analysis and prioritization. The chapter narratives describe the background, challenges, and planned or recommended actions being taken in relation to these priorities.

- Recruitment and Retention in Key Health Care Service Areas Identified in the Choice Act (Mental Health, Primary Care, Gastroenterology, and Women's Health): cross cutting challenges include care coordination, ability to analyze data for the workforce by clinical service line, and gaps in compensation.

- Recruitment, Retention, and Training of Clinic Schedulers (i.e., Medical Support Assistants): challenges include turnover, lack of succession planning, standardized training, and a standard organizational structure.

- VHA Leadership Vacancies and Succession Planning: VHA is currently experiencing a critical number of vacancies in medical center senior leadership positions, for which a long-term strategy to identify, develop, and leverage VHA's emerging leaders is needed.

- Analysis and Use of Results from VHA Organizational Health Surveys: The youngest VHA new hire respondents to the VA Entrance Survey cite career and advancement opportunities as their top reason for choosing VA; mid-career respondents cite VHA career/advancement, but also benefits; and older respondents equally cite career/advancement and benefits, but also mission to serve Veterans. Among the VA exit survey respondents , non-Veterans leave equally for other federal agencies (16.0%) or the private sector (19.0%), while Veterans leave largely for other federal agencies (28.0% vs. private sector 12.0%). Most VHA employees who responded to the All Employee Survey seem to agree that they experience moderate psychological safety within their workgroup and higher psychological safety with their direct supervisor. When comparing VHA results with other governmentwide tools used to assess employee engagement, employees in VHA are as similarly engaged as most of their colleagues in other agencies of the federal government.

- Use of VHA Recruitment, Retention, and Development Tools: challenges include burdensome onboarding and recruitment processes; inability for some to recruit and retain the right number of Human Resource staff; delegated local management of scholarship and education programs; and increased awareness and demand for Education Debt Reduction Program (EDRP) for which national program funding must continue to keep pace.

- Recruitment and Retention of Trainees: lack of a trainee tracking system makes it challenging to find and offer permanent positions to trainees that rotate through the VA system each year.

Chapter 3, Workforce Analysis, provides an overview of key workforce demographics.

Section 1, Workforce Trend and Rate Analysis: VHA has seen continued growth in onboard since FY 2011 and a trend of increasing loss rates, particularly quits. Projections indicate approximately 29% growth in onboard by FY 2022. The senior executive workforce is experiencing high vacancy rates and high projected retirements.

Section 2, Workforce Diversity and Inclusion: The average age of VHA onboard employees is 48 years. VHA has experienced increases in the rate of employees with targeted disabilities from 1.6% in FY 2011 to 2.2% in FY 2015, and increases in the percentage of Veterans in the VHA workforce from 30.8% in FY 2011 to 31.2% in FY 2015.

Section 3, Mission Critical Occupations: input from VISN workforce plans identified the VHA national top ten occupations.

Mission Critical Occupations	
1. Medical Officer (Physician)	6. Psychology
2. Nurse	7. Medical Technologist
3. Human Resource Management	8. Occupational Therapist
4. Physical Therapist	9. Diagnostic Radiologic Technologist
5. Physician Assistant	10. Pharmacist

Overarching Mission Critical Occupation (MCO) challenges include:

- Gaps between supply and demand;
- Inability to compete for specialists in each occupation due to salary disparities when compared to the private sector;
- Budgetary restraints that prevent medical centers from offering retention incentives;
- Hiring practices that do not always attract qualified applicants;
- Lags between date of acceptance of an applicant and onboarding;
- Entry/junior level positions in some occupations such as physical therapy, physician assistant, occupational therapy, medical technologist, diagnostic radiologic technologist, and pharmacy that offer limited promotions or leadership opportunities and hinders retention efforts;
- Lack of job control and poor organization public image leads to declines in morale and employee satisfaction and may deter potential candidates.

FY 2015 was an unprecedented year of change in VHA and this plan reflects increased efforts by leadership and staff to define workforce actions and strategies. Through these efforts, VHA desires to institute continuous improvements in the workforce planning process over the next four years to achieve the following:

- Incorporate the results of clinical staffing models into workforce and succession planning assessments of staffing needs that will improve access to care and the Veteran experience.
- Integrate and align staffing projections for more effective planning, programming, budgeting, and execution of strategic priorities.

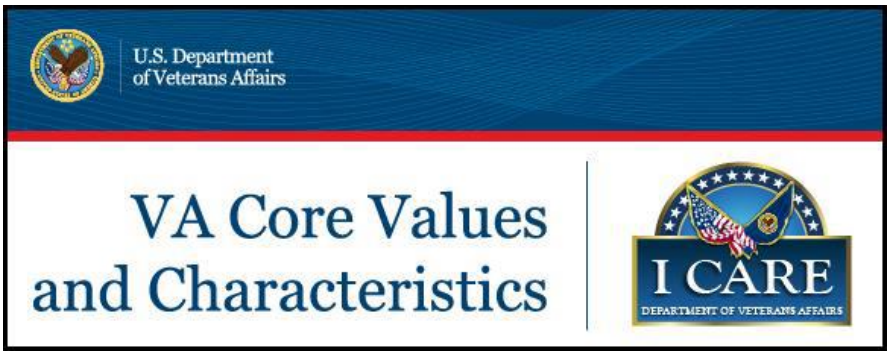
Chapter 1: Strategic Direction

The need for effective workforce and succession planning in Veterans Health Administration (VHA) is compelling. Sweeping changes in health care in the United States (U.S.) have brought about an increased demand for medical care in an environment of widespread shortages in and increased competition for skilled and experienced health care talent. In addition, tightening federal budgets, and an aging workforce and patient population make it imperative that VHA continues to predict and plan for its workforce needs.

Two separate, but complementary processes provide the mechanism for VHA's future success. Workforce planning systematically identifies and addresses the gaps between the workforce of today and the human capital needs of tomorrow. Succession planning identifies and develops leaders at all levels within the organization. Together these processes lay the groundwork for deploying actions to ensure an ample pool of talent with the right skills, experiences, and competencies is recruited, developed, and retained to meet the challenges of the future.

The VHA Workforce and Succession Strategic Plan guides VHA by providing the latest strategic guidance, as well as analysis and summary of key issues to define workforce planning needs and recommend actions for VHA leaders. This chapter provides the foundation for workforce planning by outlining the mission, vision, strategic goals and major initiatives that impact workforce planning.

VA Strategic Outlook



VA Mission and Values

Department of Veterans Affairs mission is to fulfill President Lincoln's promise to care for those "who shall have borne the battle," and for their families and their survivors 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 our internal and external stakeholders interact with each other and with the Veterans and we serve. These underscore our moral obligation to Veterans, their families, and beneficiaries. Our core values are: Integrity, Commitment, Advocacy, Respect, and Excellence ("ICARE"). According to the Fiscal Year (FY) 2014 – 2020 VA Strategic Plan, our

characteristics describe "what we stand for" and help guide how we will perform our mission.[1] They shape our strategy, guide the execution of our mission, and influence key decisions made within VA. VA's core characteristics are Trustworthy, Accessible, Quality, Agile, Innovative, and Integrated. Our core values and characteristics are an integral part of VA's Priority and 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

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

My VA

VA is undergoing a radical transformation to improve our relationship with our Veterans called MyVA. The MyVA vision is to provide a seamless, unified Veteran Experience across the entire organization and throughout the country. Because Veteran and employee relationships are inextricably linked, this transformation will also have a significant effect on the VA workforce.

The MyVA Integrated Plan

The MyVA Integrated Plan outlines the approach VA will take to guide our transformation, describing this as an employee-driven transformation, with VA employees playing a critical part in identifying challenges, crafting solutions, and delivering world-class services to Veterans.[2] VA will accomplish this by empowering employees to be as effective as possible and integrating operations across business lines and organizations to improve service delivery and maximize efficiencies.

MyVA Priorities for the Workforce

- Improving the employee experience
- Achieving support services excellence
- Establishing a culture of continuous performance improvement

[1] *http://www.va.gov/op3/docs/StrategicPlanning/FY2014_2020_Strategic_Plan.pdf*
[2] *http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf*

The Employee Experience (EE)

The most important outcome for employees is to feel engaged and empowered to create the highest level of impact every day. Each employee must have meaningful work and clear view of its benefit to Veterans. Indicators of progress in this area include:

- Ranking in the Governmentwide Federal Employee Viewpoint Survey (FEVS)
- Employee turnover (retention of one year)
- Employee ratings of leadership effectiveness via the All Employee Survey
- Hiring rates

The MyVA Integrated Plan (MIP) also describes the importance of rebalancing the relationship between headquarters and field operations, and striking the right balance between standardization and autonomy. Balancing efficiency and effectiveness will result in excellent customer service to employees.

The MIP states, "Improving the Employee Experience (EE) also requires reducing vacancies and developing streamlined standards for workforce planning, recruiting, and hiring processes so that VA attracts, hires, and retains high-performing candidates. Doing so enables VA to fill mission critical positions and ensure succession planning is in place." Furthermore, the plan outlines the need to provide continuous learning opportunities, linked to key competencies and competency gaps. This will require VA to utilize a consistent method for developing competency models, defining career paths, and identifying career development opportunities that will ensure employees have the right skills to perform their jobs and are engaged by their leaders to innovate and improve.

Highlights of specific Department-level EE initiatives and actions include:

- **Developing Leadership Excellence.** Refining the Senior Executive Service (SES) Candidate Development Program for General Schedule (GS) 14/15 employees through FY 2016; expanding the 4-week Leadership VA program for GS 13 and above in FY 2016; expanding enrollment in the Aspiring Leaders Program for GS 9-12 in FY 2016; and expanding the Corporate Employee Development Board program for GS 13-15 in FY 2017 with the Federal Executive Institute, George Washington University, Harvard University, University of Maryland, and Graduate School USA.

- **Engage Employees and Improve VA Culture.** Expand Corporate Senior Executive Management Office Connect, a collaborative website created exclusively for the Senior Executive Community; institutionalize the Secretary's Honors Awards Program in FY 2016; institutionalize the President and Secretary, Veterans Affairs Customer Service Awards in FY 2016; strengthen Union Partnerships by expanding the number of viable Labor Management Forums in FY 2016; implement performance measures to cascade VA enterprise-wide goals and objectives by FY 2016; and strengthen VA Leadership Training Programs.

- **Attract and Retain High Performing Candidates.** Continue implementation of HR SMART in FY 2016; increase the number of Veteran Employment Specialists in VA Districts; continue to implement an Automated Performance Management System in FY 2016; expand the Pathways program to hire interns and recent college graduates in FY 2016; and continue the pursuit of creative hiring/retention procedures within statute/regulatory requirements. Progress will be tracked in the Performance Management System, HRStat, Human Resources (HR) Dashboard, and Monthly Performance Reviews.

- **Develop Employees.** Improve customer service training by FY 2016; continue to certify HR professionals at the HR Academy; establish a Veteran Retention Working Group to develop and implement a retention strategy by FY 2016; expand the use of MyCareer@VA during FY 2016 and 2017.

Support Services Excellence (SSE)

The SSE priority addresses VA's internal operations: the mission support functions provided internally, especially to VA employees who directly serve Veterans and their beneficiaries. The cornerstones of SSE are better support to employees for services such as HR, information technology (IT), legal services, public affairs, congressional affairs, finance, purchasing, and logistics.

A Support Service Governance Council will determine the functions and services to be provided using a shared services approach and to oversee their delivery and operation. The Governance Council will review all the support services provided at VA and determine which are best provided using a shared services model.

Performance Improvement (PI)

The PI team will partner across VA to support improvement efforts, while establishing an enterprise-wide Lean strategy and network that enables a culture of continuous process and outcome improvement. These efforts will allow employees to be empowered to streamline daily processes, leverage solutions, and remove barriers in order to provide excellent customer service. VA has set a target of having 10% of employees trained in Lean techniques by the end of FY 2016.

Regionalization

One of the first MyVA Task Force activities was to set up a Regionalization Task Force to develop recommendations for a single regional framework for the Department. The Task Force worked with each Administration to develop a plan to guide the realignments into a five-district model. See Figure 1 below. The district offices will be established in a phased approach, beginning with the North Atlantic and Southeast Districts, and then moving to the Midwest, Continental, and Pacific Districts.

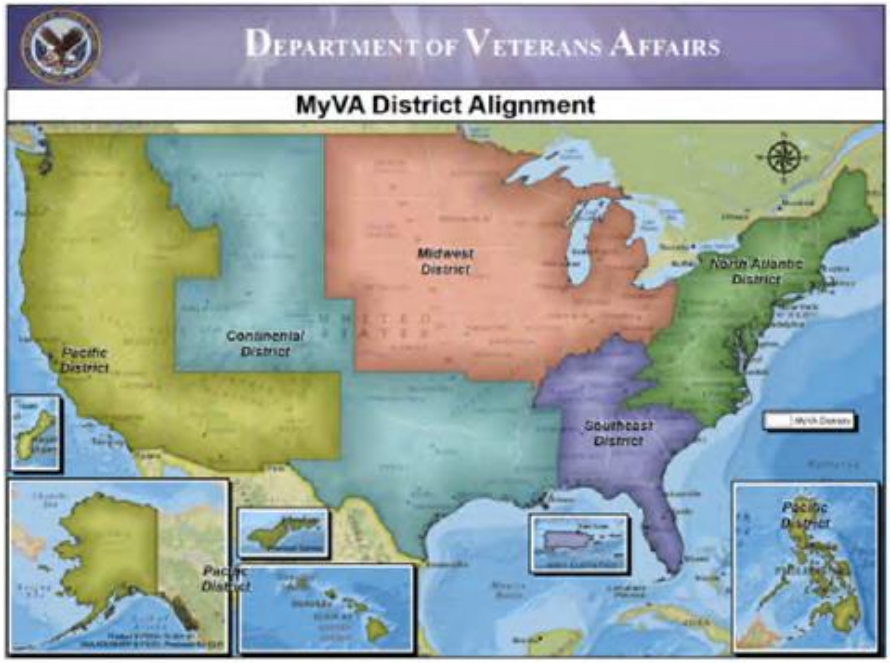


Figure 1: MyVA District Framework

The intent of moving to five districts is more effective and efficient internal operations that will result in better service to Veterans because they will provide a single point of access to all VA service. The district framework will set the conditions for the rollout of the Veteran Experience office that will be responsible for facilitating enhanced customer service capabilities across the Department.

VHA's phased approach for the realignment of Veteran Integrated Service Networks (VISN) began at the start of FY 2016. The realignment results in all VISNs being fully aligned within the state-based boundaries of the district framework. This realignment results in a decrease from the current 21 VISNs to 18 VISNs.

Veterans Access, Choice and Accountability Act

The Veterans Access, Choice and Accountability Act of 2014 (VACAA or "Choice Act") provides new authorities, funding, and other tools to help support and reform VA. According to a fact sheet issued by VA[3], the Choice Act includes measures to improve access to care, and expand capacity and processes, as well as measures that pertain to or directly impact the workforce:

Health Care Staffing

- New Residency Positions: Over a five-year period, the legislation directs the VA to increase its number of Graduate Medical Education (GME) residency positions by up to 1,500. An emphasis will be placed on creating residency positions that improve Veterans' access to primary care, mental health, and other specialties the Secretary

[3] *http://www.va.gov/opa/choiceact/documents/Choice-Act-Summary.pdf*

deems appropriate. It will be important for VA facilities to aggressively recruit the new graduates of these programs in order to ensure sufficient workforce for Veterans' needs.

- VHA Staffing Requirements: The VA Office of Inspector General (OIG) annually identifies the top five occupations with the largest staffing shortages. An initial report was published on February 3, 2015, with a subsequent annual report published on September 30, 2015. The top staffing shortage occupations identified in the September 30th report mirrored the top (i.e., highest ranking) clinical occupations identified by VHA, which includes: Medical Officer; Nurse; Physical Therapist; Physician Assistant; and Psychology. The Secretary will have the authority to recruit and directly appoint qualified personnel to serve in these specific occupations. Because of the Act's requirement for VA to provide access to full-time primary care providers within 40 miles of a patient's residence, the recruitment and retention of Primary Care physicians will become even more critical.

- Training and Education: The law extends the VA's existing Health Professionals Education Assistance Program from December 31, 2014 to December 31, 2019. The Act also increases the maximum reimbursement ceiling for the Education Debt Reduction Program (EDRP) from $60,000 to $120,000. In order to meet this requirement, sustained funding beyond that provided by the Choice Act will be required.
- Employee Performance Plans: VA will ensure that scheduling and wait-time metrics or goals are not included as factors in employee performance evaluations or when calculating whether to pay performance awards, but will instead ensure the metrics are tied to health outcomes and improved health.

Reviewing and Expanding Capacity and Processes

- Technology Task Force: A Technology Task Force reviewed VA's patient scheduling processes and supporting software. The task force proposed specific actions VA might take to improve patient scheduling and submitted their recommendations to the Secretary and to Congress. Several of the recommendations related to analyzing the scheduler workforce. VA will implement the recommendations of the task force that the Secretary considers feasible, advisable, and cost effective.

Departmental Personnel Authorities and Related Procedures

- Employee Disciplinary Procedures: VA will revise HR policies to include penalties for employees who knowingly falsify or require another employee to falsify data regarding access to care or quality measures.

- Employee Awards and Bonuses: VA will limit the amount of awards and bonuses paid to VA employees each year for fiscal year 2015 to fiscal year 2024.

- Removal of Senior Executives: The Choice Act provides new authority for VA to seek removal or transfer Senior Executives based on poor performance or misconduct, with an abbreviated process for an expedited appeal.

VHA Strategic Outlook

VHA's mission, vision, principles, and new priorities and strategic goals have been carefully aligned to the VA priority and strategic goals, and include 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

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.

Under Secretary for Health (USH) Five Priorities

To ensure that VHA remains aligned with MyVA and the Blueprint for Excellence, the Under Secretary for Health identified five top priorities:

- Improved Access
- Increased Employee Engagement
- Building a High-Performing Network
- Consistency of Best Practices
- Rebuilding the Trust of the American Public

STRATEGIC DIRECTION

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

Blueprint for Excellence

In September 2014, VHA issued the Blueprint for Excellence. Its intent was to frame four themes and ten essential strategies within a set of activities that simultaneously address improving the performance of VHA health care, developing a positive service culture, transitioning from "sick care" to "health care" in the broadest sense, and developing agile business systems and management processes that are efficient, transparent, and accountable.

The Blueprint for Excellence contemplates what is necessary for VHA to become the system that Veterans deserve by:

- Improving performance,
- Promoting a positive culture of service,
- Advancing health care innovation for Veterans and the country, and
- Increasing operational effectiveness and accountability.

The strategies articulated in the Blueprint intersect directly with annual strategic planning, program development, budget execution, and performance reporting and help us achieve the Under Secretary for Health's Five Priorities. As such, it offers a common framework for action, based on a number of touchstones, including the VA Strategic Plan, My VA, the Under Secretary for Health Five Priorities, the VHA Strategic Plan, the VA Health Care Modernization Study, and the Choice Act.

Within Theme 2, Promote a Positive Culture of Service, are the strategies that directly relate to the workforce:

- Strategy Four: Grow an organizational culture, rooted in VA's core values and mission, that prioritizes the Veteran first; engaging and inspiring employees to their highest possible level of performance and conduct.
- Strategy Five: Foster an environment of continuous learning, responsible risk-taking, and personal accountability.

VHA Modernization Report

The VA Health Care Modernization Report identifies ways to improve Veteran health and well-being, Veteran satisfaction, and cost-effectiveness of services. It includes a current state assessment of each area of study, best practices and emerging trends in those areas, recommendations for VA's desired future state, gaps and challenges, benefits of modernization, the complexity of implementing the recommendations, and considerations for implementation. The Modernization Report recommendations align with and support VA and VHA Goals and Objectives.

Through modernization, VHA seeks to advance achievement of three outcomes:

- Improved Veteran Health and Well-being
- Increased Veteran Satisfaction
- Increased Cost-Effectiveness

To achieve the desired outcomes for modernization, VHA has identified and defined nine recommendations. These nine recommendations are organized into four themes:

Table 1: VHA Modernization Report Recommendations by Theme

Theme	Recommendation
Improve Quality of Care	Provide personalized, proactive, patient-driven whole person care.
	Enhance coordination of care for Veterans with the most complex medical conditions.
	Share intramural research opportunities between VA, Health and Human Services (HHS), and Department of Defense (DoD).
Increase Access to Care	Expand virtual medical modalities to enhance access and satisfaction.
	Coordinate VA Care with Non-VA Providers.
Improve the Veteran Experience	Build a system of immediate Veteran feedback.
Increase Efficiency	Plan and design health care delivery systems based on evolving Veteran demographics and health care delivery modalities.
	Develop standard designs for physical health care delivery structures.
	Use a variety of techniques and technology to modernize VA's supply chain for greater efficiency.

The Work We Do

Projecting Veteran Demand for VA Health Care

VHA uses the VA Enrollee Health Care Projection Model (EHCPM) to project enrollment, utilization, and expenditures for the enrolled Veteran population for over 90 categories of health care services for 20 years into the future. First, VA uses the EHCPM to determine how many Veterans will be enrolled each year and their age, gender, priority, and geographic location.

Next, VA uses the Model to project the total health care services needed by those enrollees and then estimates the portion of that care that VA will provide. Projections include all care that VA provides to enrolled Veterans whether provided in VA facilities or purchased in the community.

Veteran enrollment in VHA is projected to grow from FY 2015 to FY 2025 even though the Veteran population is declining (see Figure 2). This growth is largely due to the high enrollment rates for Gulf War and Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans. After FY 2025, enrollment is projected to decline slightly as the impact of mortality in the enrollee population begins to outweigh new enrollment.

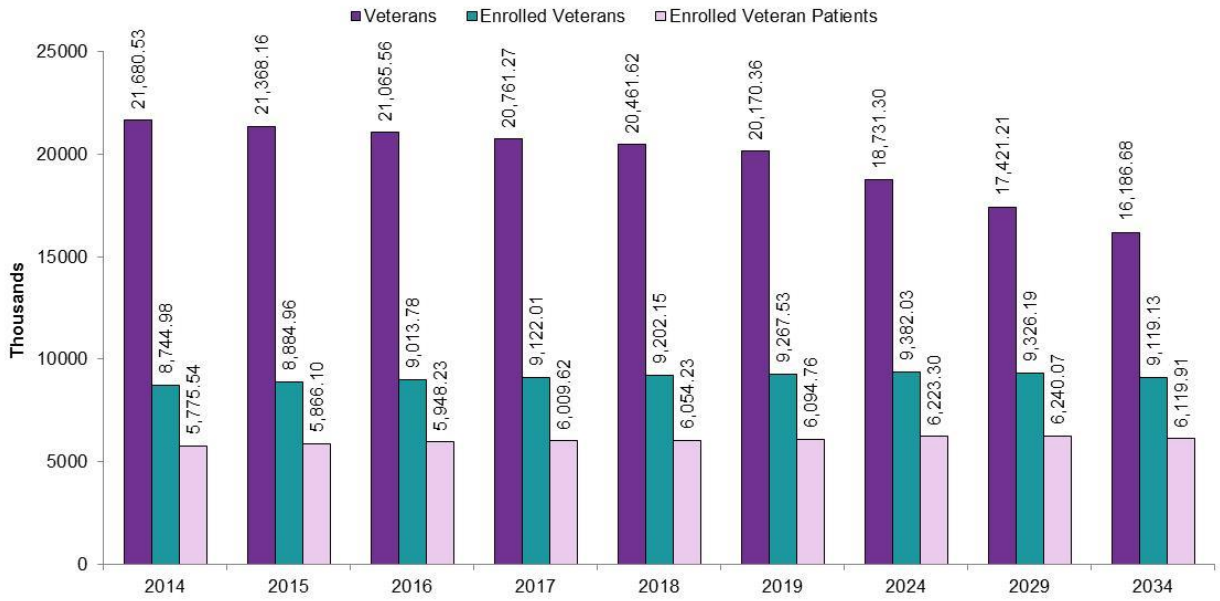


Figure 2: Veteran Demand for VHA Health Care Projections

An enrollee's enrollment priority is dynamic. In recent experience, approximately 40% of new enrollees transitioned to a new priority level within three years of enrolling. Enrollees transition between Priorities 5, 7, and 8 due to changes in income. Enrollees also transition into Priorities 1, 2, and 3 as a result of adjudication for service-connected disabilities by the Veteran Benefits Administration.

The EHCPM accounts for the unique demographic characteristics of the enrolled Veteran population, OEF/OIF/OND and other enrollee cohorts, as well as other factors that impact a Veteran's decision to enroll in VA and use VA health care services, such as:

- Enrollee age, gender, income, travel distance to VA facilities, and geographic migration patterns;
- Significant co-morbidity of the enrolled Veteran population, particularly for mental health services;
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) and the long-term downward trend in labor force participation, particularly for high school educated males;

- Enrollee transition between enrollment priorities as a result of movement into service-connected priorities or changes in income;
- Enrollee reliance on VA health care versus other health care options available to them (e.g., Medicare, Medicaid, TRICARE, and commercial insurance);
- Unique health care utilization patterns of OEF/OIF/OND, women, and new enrollees, and other enrollee cohorts with unique utilization patterns for particular services;
- New policies, regulations, and legislation, such as the implementation of the Medicare drug benefit;
- VA health care initiatives, such as the mental health capacity improvement initiative;
- A continually evolving VA health care system (e.g., quality and efficiency initiatives); and
- Changes in health care practice and technology such as new diagnostics, drugs, and treatments.

Projected Veteran demand for VA health care services will grow or decline as a result of all these factors. The EHCPM projections are integrated into planning processes that address the components required to meet the projected demand:

- VA Health Care Budget – securing the resources required to meet Veteran demand
- Health Care Planning Model – market based planning to address imbalances between current capacity and projected utilization growth or decline
- Strategic Capital Investment Planning – facility footprint planning
- Specialty Productivity Access Report and Quadrant tool (SPARQ) – links wait times, full time employee equivalent (FTEE) levels, EHCPM projections, and other relevant data to assess productivity and staffing requirements.

Enrollees have many other public (e.g., Medicare, Medicaid, DoD, and TRICARE) and private health care options available to them, and, therefore, most do not use VA as their primary health care provider. On average, enrollees rely on VA for only 34% of their health care needs.

VA's capacity to provide health care reflects medical staffing levels and the required support staff and infrastructure, the productivity of current staff, resources available for purchasing care in the community, and the availability of care for purchase in the community.

The Veteran Experience and New Models of Care

VHA continues its focus on providing personalized, proactive, patient centered care to our Veterans, and developing or enhancing new models of care.

Patient Centered Care

Established in 2010, the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) catalyzes the cultural transformation towards Patient Centered Care (PCC). Its role is to help clearly define the future state of health care, provide employees with the tools and support needed to make it happen, and identify and remove barriers to successful implementation of a patient centered health care system. The OPCC&CT is providing training to VHA clinicians through a whole health curriculum to support greater awareness and understanding of the personalized, proactive, patient-driven model of care. 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 members and support local efforts to develop and implement new and innovative strategies to transform the practice of whole health and to enhance the experience of health 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 Health for Life site and the new OPCC&CT Internet site.[4,5] The OPCC&CT Resource Guide provides additional resources.[6]

VHA employs several models of care to enhance the provision of patient centered care. Each has implications for the workforce that supports them. These include Patient Aligned Care Teams (PACT), VA Voices, Telehealth, Veterans Crisis Line (VCL), Connected Health, Peer Support, Home Based Care, and the new Veterans Choice Program (VCP).

Patient Aligned Care Teams

In 2010, VHA implemented a new model of health care delivery that is a patient-driven, team-based approach branded as PACT. PACT care is based on principles that promote effective, efficient, comprehensive care through continuous communication and improved coordination of services throughout the health care system. The goal of PACT is to improve the patient experience, clinical quality, safety, and efficiency by ensuring that VHA is a national leader in the delivery of health care services. PACT is a partnership between the Veteran and the health care team with an emphasis on prevention, health promotion, and self-management. Veterans are the center of the care team that also includes family members, caregivers, and health care professionals. PACT provides comprehensive primary care to over 5.4 million Veterans annually.

PACTs offer improved ways to access health care. In addition to personal visits with their own primary health care provider, Veterans may schedule visits with other members of the PACT team or may select group clinic appointments and/or educational classes. Veterans may also access health care using virtual modalities such as the telephone, secure messaging, or telehealth technology. Veterans may access a personal health vault, selected portions of their electronic health record, and a wealth of health information using My HealtheVet.

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[4] *http://healthforlife.vacloud.us/*
[5] *http://www.va.gov/patientcenteredcare*
[6] *http://vaww.infoshare.va.gov/sites/OPCC/Shared Documents/Brochures/091014 Resource Guide.pdf*

VA Voices

VA Voices teaches participants to discover methods of productive conversations, become aware of their impact on others, connect personal values with their role at work, and understand the power of being present with themselves and others.

The focus of VA Voices is to:

- Further support the patient-provider relationships and Veteran activation in their health and well-being goals fostered through PACT;
- Promote leadership-driven change, which is relationship-based, values oriented, interactive, team enhancing, and promotes relationship building with each other and Veterans through shared experience that develops trust and connection among staff.

The program is designed for all VA employees with the goal to build connections and to develop the interpersonal focus and skills required to operate effectively in a health care system that utilizes a team-based care delivery model. Implementation began with five facilities in the FY 2014 pilot starting with facility leadership actively participating in the VA Voices experience, then phased expansion throughout all levels of the facility. This model was expanded to ten additional pilot sites in FY 2015 and 10-20 pilot sites projected for FY 2016 with anticipated phased expansion across all VHA in the out years.

Telehealth

Telehealth increases access to high quality health services by utilizing information and telecommunication technologies to provide health care services when the patient and practitioner are separated by geographical distance. VHA is the largest provider of Telehealth services in the United States. The VHA Telehealth Services program office supports VISNs to develop Telehealth services. It works to support the following modalities of Telehealth services:

- Clinical Video Telehealth is the use of real-time interactive video conferencing, sometimes with supportive peripheral technologies, to assess, treat, and provide care to a patient remotely.
- Home Telehealth is a program that applies care and case management principles to coordinate care using health informatics, disease management and technologies such as in-home and mobile monitoring, message and/or video technologies.
- Store and Forward Telehealth is the use of technologies to asynchronously acquire and store clinical information that is then forwarded to or retrieved by a provider at another location.

The workforce that manages Telehealth programs are employed in each VISN and include more than 1,000 Telehealth clinical technicians, 900 Teleretinal imagers, 800 home Telehealth care coordinators, 150 facility telehealth coordinators, and many additional staff who 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.

Telehealth programs 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 to provide systematic training for each of the modalities of telehealth. 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 Telehealth curricula is provided virtually 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.

Connected Health

The Connected Health Office (CHO), part of the VHA Office of Informatics and Analytics, leverages technology and innovation to transform the delivery of care. Connected Health technologies empower patients by providing tools to help with self-care, to access personal health data, and to communicate with health care teams extending the reach of VA care beyond VA facilities. Through the use of Connected Health technologies, VA is better equipped to deliver care remotely wherever patients live and reside. To make access easier for Veterans, VA is working to better align and integrate virtual care technologies including My HealtheVet, VA's online patient portal, web and mobile applications (apps), telehealth services, and point of care kiosks. Additionally, CHO is working with the VistA Evolution Program Office to evolve the existing VistA Electronic Health Record into a single, standard interface to enhance delivery of patient care.

CHO is working closely with VA programs offices to deliver technologies that will assist patients in the following ways:

- Provide patient access to their health record using VA Blue Button and/or the Mobile Blue Button app;
- Enable patient and VA health care team communication using My HealtheVet and/or the Secure Messaging app
- Allow patients to refill and track prescriptions using My HealtheVet and/or the RxRefill app
- Allow for patient self-care and health reminders using Annie, VA's text messaging system
- Enable patients and VA staff to schedule and cancel primary care and mental health appointments using the Veteran Appointment Request app

CHO supports activities from concept development (innovations) through application development and implementation. The office comprises nearly 100 VA employees ranging from VA health care providers and technologists to project managers and administrative support staff. The office depends on and solicits input from VHA leaders, clinicians, and clinical and IT

support staff to participate in developing technologies for patients and VA staff to improve routine care delivery. The VA workforce plays an essential role in all CHO efforts, including assisting with developing, testing, evaluating, and implementing VA digital tools to improve Veteran health.

Veterans Crisis Line

VA implemented the Veterans Crisis Line (VCL) with the passage of the Joshua Omvig Veterans Suicide Prevention Act of 2007. The VCL's priority is to provide 24/7/365 coverage of critical suicide prevention and crisis intervention services for Veterans, Military Servicemembers, and their supportive others. The responders at VCL help callers modify immediate stress, identify options, and get connected to the appropriate VA or community resources nearest their homes. Since its launch, the VCL has answered nearly two million calls and initiated the dispatch of emergency services to callers in imminent crisis over 53,000 times. The addition of chat services in 2009 and text services in 2011 further increased VCL's outreach to Veterans in need. As a result, VCL has provided over 320,000 referrals to local VA medical facility Suicide Prevention Coordinators, ensuring Veterans are connected to care in their community.

VCL responders are required to have a bachelor's degree in a related field such as mental health or social services, and the majority of responders have a great deal of mental health experience. Some responder staff members are licensed as clinical social workers or professional mental health counselors and about 25% are Veterans. All are trained in advanced Crisis Intervention techniques and are given up to six weeks of new employee orientation classroom training as well as one-to-one precepting. New staff must perform satisfactorily when monitored by supervisors before they are cleared to work on the crisis line alone.

The success of VA's marketing of VCL and its partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) has resulted in tremendous growth in demand for services, and thus for additional responders; however, VCL's hiring attempts have not kept pace. In recent years, the Office of Mental Health Operations (OMHO) has worked with VCL to develop a more rigorous, analytic approach to making staffing determinations beyond the use of call volume reports and traditional schedules and shifts. The approved FY 2015 FTE plan was based on observed operational conditions, analysis of current and projected demand for services, and service level targets. The plan includes critical positions that will ensure a long-term, comprehensive, and strategic approach to providing consistent, timely, and high quality VCL services. In addition, new HR processes such as identifying a larger pool of initial applicants, providing targeted recruitment and staffing services to expedite hiring, and offering varied work schedules from which applicants can choose have been implemented to improve recruitment and retention.

Due to VCL's growth, ensuring adequate space for the number of staff needed to maintain services has been a challenge. Since its inception, the VCL has moved into new physical space three times. Currently there is a phased plan to quickly renovate temporary space to accommodate all staff and then expand to another building at the Canandaigua VA Medical Center that will encompass two floors. The long-term plan aims to provide adequate space for both frontline and administrative staff to appropriately support all call center functions by FY 2017.

Peer Support

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful; it is a process dedicated to promoting empowerment and self-determination in the service of recovery. These skills are acquired during the experience of having a mental health condition.

A Peer Support Provider in VHA is a person with a mental health and /or co-occurring disorder, who has been trained to help others with these disorders identify and achieve specific life and recovery goals. Peer Support Providers must complete VA Central Office (VACO) approved training and pass a rigorous competency assessment to perform their peer support roles, which includes communication skills, knowledge of recovery, crisis management and many others. They are actively engaged in their own recovery and hired to provide peer support services to others engaged in mental health treatment. VHA has approximately 1,100 Peer Specialists who help Veterans by:

- Providing opportunities for Veterans to take control of their own recovery;
- Teaching and supporting the learning of skills needed to facilitate one's recovery;
- Making Veterans aware of available services and choices;
- Helping Veterans develop a sense of wellness and self-worth; and
- Bringing a unique perspective to the treatment teams on which they work.

Peer Support Providers serve as role models by sharing their personal recovery stories, showing that recovery from mental illness is possible. They teach goal setting, problem solving, symptom management skills and a variety of recovery tools. They empower by helping others identify their strengths, supports, resources, and skills. They advocate by working to eliminate the stigma of mental illness. They act as community liaisons by identifying social supports in the community and encouraging the expansion of local community resources.

Studies have demonstrated the positive impact peer support makes to the recovery of people with serious mental health conditions: improves social functioning and quality of life; lessens the sense of loneliness, rejection, and discrimination; fosters independence; improves ability to deal with mental illness; increases access to resources beyond the VA; improves skills necessary to recover; improves communication with providers; improves employment outcomes; provides comfort and support; results in fewer hospitalizations; causes them to use fewer crisis services; and improves the effectiveness of the mental health delivery system.

There are currently efforts to expand peer support services from mental health into primary care and community settings through new pilot programs.

Home Based Care

Home Based Primary Care (HBPC) Special Population PACT is a VA home care program that provides comprehensive, interdisciplinary, primary care in the homes of Veterans with serious medical, social, and behavioral conditions for whom routine clinic-based care is not effective. In contrast to other systems such as Medicare home care that target patients with short-term remediable needs and provide episodic, time-limited and focused skilled services, HBPC Special Population PACT serves Veterans as they face the challenges of disability, aging and chronic disease by providing comprehensive longitudinal home care.

The HBPC workforce nationally exceeds 3,000 employees with a full complement of professional clinicians including physicians, nurse practitioners (NP), physician assistants, social workers, registered nurses, licensed practical nurses, pharmacists, dietitians, occupational therapists, physical therapists, kinesiotherapists, psychiatrists, and psychologists. Clinicians travel to Veterans' homes to provide clinical assessments and services. These health care professionals are generally experienced at the full performance level of their discipline, function independently in the field and support training and mentoring of students, residents and fellows in all of the professional fields. In addition, these clinicians require ongoing specialized training and clinical competencies in the areas of geriatrics and extended care, case management, chronic illness and disease management, and end of life care.

Veterans Choice Program

The VA Budget and Choice Improvement Act calls for improving Veteran access to community care by consolidating community programs into one new, streamlined VCP. Leading industry practices, feedback from Veterans, employees and stakeholders, and alignment with VA's future vision for health care will inform the design of the new VCP. The new program will standardize Veteran eligibility, authorization, provider networks, care coordination, claims management, and the integration of current activities into one VCP.

The design of the VCP aligns with VA's vision for the future of health care delivery, which aims to provide Veterans the highest quality care, both inside and outside VA. The transformation will be implemented in a phased approach beginning in FY 2017. This will help VA meet its access needs in the near term and enable Veterans to receive the best care with the right provider for any and all services in the long term.

Comparison Data

VHA competes directly with the private sector for all categories of health care occupations.

The two primary sources of benchmarking data or information on industry standards on the health care workforce are the US Department of Labor's Bureau of Labor Statistics (BLS), and the Health and Human Services, Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHPR).

BLS publishes a large amount of information by occupation, including career information, employment levels and projections, and various types of data on earning and working conditions.

The BHPR provides estimates of supply and demand for the health care workforce. The vast majority of occupations identified in the HRSA health workforce are employed in the "health sector", which includes settings such as hospitals, clinics, physician offices, and nursing homes. Individuals in health occupations may also work outside the health sector in settings such as local governments, schools, or insurance companies. Between 2008 and 2010, BHPR identified that the largest occupations in the health sector were registered nurses; nursing, psychiatric, and home health aides; personal care aides; physicians; medical assistants and other health care support occupations; and licensed practical and licensed vocational nurses.[7]

BHPR predicts growth in non-primary care fields of practice through 2025, although there are considerable variations both by profession and specialty area. Overall, the supply of non-primary care physicians is expected to increase by 2025, but may decline for surgical fields. In addition, the supply of physicians in critical non-primary care specialty service areas, such as psychiatry and general surgery, may not keep up with population growth. However, rapid growth in the advanced practice nurse and physician assistant workforce is projected to be sufficient to raise the supply of non-primary care specialty providers across all fields.[8]

BHPR projects a shortage of 20,400 primary care physicians, alleviated only by more reliance on primary care NP and physician assistants. Shortages may be more prominent in some regions. Overall demand for primary care services is projected to increase through 2020, mostly due to population, aging, and growth, and also due to expanded insurance coverage offered by the Affordable Care Act (ACA).[9]

Refer to the MCO section of Chapter 3 for more information and strategies about specific occupations in VHA's MCO list.

Workforce Demographics and Clinical Modeling

As of the end of FY 2014, VHA had over 298,000 employees. Since then, the number has grown to more than 310,000 (as of September, 2015). VHA continues to be the second largest civilian employer in the federal government, after the DoD, and one of the largest health care providers in the world. Additionally, VHA has one of the most complex workforces with over 300 job series classifications, encompassing professional, technical, administrative, clerical, and trade occupations, covered by three personnel systems established by Title 5, Title 38 and hybrid Title 38 statutes.

Recruiting and retaining highly skilled and dedicated employees is critical for VHA to ensure it maintains an adequate succession pipeline to meet current and future patient care needs. VHA must contend within an environment of widespread shortages and increased competition for health care professionals in hard-to-fill occupations such as physicians, nurses, physician assistants, physical and occupational therapists, medical and diagnostic radiologic technologists, pharmacists, and mental health professionals. Other challenges include rapidly changing technologies requiring new skills and continued increases in percentages of employees eligible

[7] http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/chartbook/chartbookbrief.pdf
[8] http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/clinicalspecialties/clinicalspecialties.pdf
[9] http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/index.html

for retirement, particularly in leadership positions. A complete analysis of the total workforce, supervisors, senior leaders, and top MCOs is provided in Chapter 3.

The broad array of services to be provided and the diverse population of Veterans seeking care mandate distinct approaches to clinical human resource planning. To that end, clinical modeling, both for VHA and for other health care systems, is a constantly evolving activity, where emerging best practices are identified from continuous review of data and processes. Data sources and information technology themselves likewise evolve, further refining the ability of models to project requirements. VHA has made noteworthy progress in some aspects of clinical staffing models and methods:

- Developed a prototype staffing model for general mental health and additional criteria to guide staffing of specialty mental health;
- Piloted a team-based general mental health staffing model, entitled Behavioral Health Interdisciplinary Program (BHIP), in general mental health outpatient settings;
- Established maximum panel sizes for all Primary Care Practitioners and Associated Practitioners. The panel consists of "active patients" for whom the provider delivers primary care. Parameters in determining panel size include support staff, space considerations, and patient intensity, acuity.
- Established Women's Health staffing requirements for Women's Health PACT teamlets, and gynecology specialist and support staff;
- Maintained the Physician Productivity Cube that provides information about staffing levels for each medical center and calculates the productivity of our physician workforce utilizing a standard health care measure of relative value units (RVUs) per physician clinical FTEE. RVUs consider the time and intensity of the medical services delivered and has been utilized by Medicare since the early 1990's.
- Developed the SPARQ tool that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians.[10]
- Defined productivity and staffing standards for all VHA specialty physicians.[11]

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[10] http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fOPES%2fSPARQ%2fSpecialtyQuadrant&rs:Command=Render

[11] http://reports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/OPES/SpecialtyProductivityReport/Prod_Stats&rs:Command=Render

Workforce Planning Approach

With an aging workforce, anticipated increases in turnover and retirements, growing Veteran need for health care, and possible federal budget cutbacks it becomes more essential than ever that VHA plan—and act—strategically about its workforce.

Current VHA Workforce Planning Process and Governance Structure

Workforce planners at the VISNs and facilities ensure the issues affecting the workforce at the ground level are brought to national attention. To accomplish this, VISNs and facilities work together to ensure completion of an annual workforce plan, guided by requirements distributed by the National Workforce Planning Team and approved by local and VISN leadership.

The various components of VHA's workforce and succession planning activities are developed under the auspices of the Workforce Development and Leadership Succession Subcommittee, a subcommittee of the Workforce Committee. The Workforce Committee reports directly to the National Leadership Council. This framework of governance ensures the plan includes the most relevant and up-to-date information possible.

Chapter 2: Workforce Planning Priorities

This year, several workforce planning priorities in VHA were identified and selected for further consideration in this workforce plan. They were defined through a process of environmental scanning to identify issues, analysis to understand the issues, and prioritization to define the issues of highest impact to the workforce:

- Recruitment and retention of staff in key health care service areas identified in the Choice Act
  - Mental Health Care Services
  - Primary Care Health Care Services
  - Gastroenterology Services
  - Women's Health Care Services
- Recruitment and retention of clinic schedulers (i.e. medical support assistants)
- VHA leadership vacancies and succession planning
- Analysis and use of results from VHA organizational health surveys
- Use of VHA recruitment, retention, and development tools
- Recruitment and retention of trainees

VISN and facility workforce planners were asked to identify the challenges (e.g., recruitment and retention barriers) associated with these priority issues, and subject matter experts reviewed that input to provide further insight and analysis of these issues from the national perspective. This chapter provides a summary of those analyses and defines resulting recommendations or actions.

Analysis of Key Health Care Service Areas

Four key VHA health care service areas were identified for in-depth analysis due to their inclusion in the Choice Act: Mental Health, Primary Care, Gastroenterology, and Women's Health. Three challenges appear to be cross-cutting for most of the VHA health care service areas:

- **Care Coordination:** The increased need for care coordination of purchased and community care is presenting new and additional challenges throughout VHA. Care coordination influences communications across departments and facilities and affects quality of care for patients. Providers and staff must coordinate appointments between the Veterans and outside facilities; track patient care, treatment decisions, and lab results; maintain VHA records to show care received at every facility; and serve as liaisons with other providers for additional orders and consults. Numerous providers report not operating at the top of their license because they spend considerable time gathering results and charts, contacting patients, and doing other administrative work.

This is largely caused by an increase in demand for coordinated care and shortages or turnover of support staff in some clinics.

- **Workforce Data:** The inability to properly and easily determine and track workforce data for clinical support staff via their health care service line continues to present challenges. This is largely due to data coding and mapping challenges between national HR and health care staffing, productivity, and management databases. The inability to cross-analyze data between these systems makes it difficult to determine current and future retirement, retention, and vacancy trends and projections by clinic.

- **Compensation:** Gaps in compensation between the private sector and VHA, in part fueled by national workforce shortages and increased competition, continue to present challenges across some VHA service lines.

Mental Health Care Services

Overview

VA offers a comprehensive continuum of coordinated mental health care, including mental health services in Primary Care clinics, general and specialized outpatient mental health clinics, residential treatment programs, intensive inpatient treatment programs, and a Veterans Crisis Line. Services include individual and group therapy, evidence-based pharmacotherapy, care coordination, and resources that address needs in the areas of housing, employment, and the justice system. In FY 2015, VHA treated over 1.6 million mental health patients, compared to six million total Veterans treated in VHA, and the number is projected to increase to nearly 1.8 million Veterans annually by FY 2021.

VHA outpatient mental health is organized into three levels of care, Primary Care Mental Health Integration (PCMHI), General Mental Health (GMH), and Specialty Mental Health (SMH). PCMHI works with patients in primary care to address mental health concerns that require low intensity treatment and to provide maintenance treatment to stabilized patients with chronic mental health conditions. GMH provides interdisciplinary recovery-oriented care for patients in need of standard care, including assessment, medication management/pharmacotherapy, case management/care coordination, psycho-education, and common psychotherapies for mental health conditions (e.g., evidence-based therapies including cognitive behavioral therapy for depression). SMH provides time-limited or diagnosis-specific specialty care for patients including intensive Substance Use Disorder and Post Traumatic Stress Disorder (PTSD) treatment, mental health intensive case management, psychosocial rehab and recovery programs, methadone maintenance, and other mental health care that is typically delivered by a mental health sub-specialist.

VHA mental health programs include providers from the following disciplines: psychiatrists, psychologists, social workers, registered nurses (RN), licensed practical nurses (LPN), licensed professional mental health counselors (LPMHC), marriage and family therapists (MFT), addiction therapists, occupational therapists (OT) and recreational therapists, clinical pharmacists, peer specialists, clinical nurse specialist, NP, physician assistants (PA), and “front-line” support positions (e.g., schedulers, clerks, etc.).

Outpatient Mental Health Staffing Model

Analyses examining relationships between VHA outpatient staffing levels and mental health treatment access and quality found that outpatient staff to patient ratio was significantly related to measures of population access, timeliness, continuity of care, and mental health provider and Veteran satisfaction. Based upon extensive internal reviews, and upon OIG reports, VHA launched the Mental Health Hiring Initiative in April 2012, bolstering provider staff at facilities with access concerns. In April 2012, immediately prior to the start of the Mental Health Hiring Initiative, the national mean ratio of onboard outpatient clinical mental health full-time equivalent (FTE) per 1,000 mental health patients was 7.72. The initial goal for new hiring was based on bringing all facilities up to a minimum of the facility average staff to patient ratio in April 2012 (i.e., 7.72 FTE/1,000 patients), with plans to continue monitoring and analysis to determine a more optimal staffing ratio. Given continued rapid growth in the number of mental health patients, on-going hiring is required to reach that goal. Many VHA facilities are still working on reaching or maintaining the goal of having at least 7.72 onboard outpatient clinical mental health FTE for each 1,000 mental health patients treated at the facility, and facilities were advised to pursue this 7.72 goal using funds for hiring provided by the Choice Act. On-going analyses have continued to support associations between this overall outpatient mental health staff to patient ratio and better access to, quality of, and satisfaction with mental health services.

Workforce Data

The VHA national average for the combined quit and retirement rates for all occupations from FY 2010-2015 ranged from 6-7%. On average, combined quit and retirement rates for VHA mental health providers and staff are on par with other occupations in VHA with two notable exceptions. First, VHA psychiatrists have significantly higher combined quit and retirement rates than other VHA employees, ranging between 7.5-9% since FY 2010. Second, VHA psychologists have significantly lower combined quit and retirement rates than other VHA employees, ranging between 3.5-5% since FY 2010.[12]

According to the most recent figures from the BLS (2014)[13], VHA mental health providers and staff are compensated 7-28% higher than their counterparts in the private sector. Specifically, VHA psychologist salaries are 23% higher, VHA marriage and family therapist salaries are 18% higher, VHA mental health counselor salaries are 29% higher, VHA peer support staff salaries are 11% higher, and VHA psychiatrist salaries are 7% higher than their counterparts.[14]

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[12] *VHA PAID data, June 2015*

[13] *Bureau of Labor Service, May 2014 National Occupational Employment and Wage Estimates, http://www.bls.gov/oes/current/oes_nat.htm*

[14] *These salary averages include both annual salary and special pay received throughout the year.*

Workforce Analysis

VHA's OMHO modeled outpatient mental health staffing needs for the next six years by facility and year. Based on the VHA Office of Policy and EHCPM, strategic planning projections and our outpatient clinical mental health staffing models, 3,712 additional outpatient clinical mental health FTE will be needed by FY 2021 to address existing and projected mental health staffing gaps.

Unfortunately, growth in demand for care exceeds supply of mental health professionals in some areas of the country. In order to appropriately match staffing to demand, it is likely that VHA will need to use Choice Act flexibilities, contracting, community care, telemental health, and enhanced recruitment and retention methods. For example, the demand for care in an area of provider shortage could potentially be met by hiring in easy-to-hire markets and using telemental health.

Anticipated Workforce Challenges

Staff Morale and Satisfaction

The VHA Mental Health (MH) Provider Survey directly assesses workgroup functioning and staff satisfaction. The 2014 survey was completed by about a quarter of mental health providers nationwide.[15] Respondents generally reported effective workgroup functioning, supervision and high job satisfaction. However, the number of respondents reporting high job satisfaction decreased from 71% in the 2013 survey to 67% in the 2014 survey.[16] Furthermore, 30% of the respondents disagreed or strongly disagreed that their workload was reasonable, an increase of 4% from the 2013 survey, and 24% reported job burnout, a 3% increase over 2013 results, and an additional 13% reported persistent symptoms of burnout. Between 2013 and 2015, results from the All Employee Survey (AES) had similar changes among mental health staff. AES showed MH providers experienced increased commitment to helping Veterans and satisfaction with their work group. Although their sense of personal accomplishment was stable, scores increased on emotional exhaustion and depersonalization. There was also some increase in the desire and intention to leave their jobs.

Shortages of Mental Health Providers

Regional shortages of psychiatrists, psychologists and other licensed mental health professionals, and/or greater demand than supply of mental health professionals in the community mean that some locations may have more difficulty recruiting mental health

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[15] *VHA Office of Mental Health Operations and National Center for Organization Development, 2014 Mental Health Survey Results for All VHA,* *https://spsites.dwh.cdw.portal.va.gov/sites/OMHO_MHMP/_layouts/ReportServer/RSViewerPage.aspx?rv:RelativeReportUrl=/sites/OMHO_MHMP/AnalyticsReports/MHPS_agg14.rdl&Source=https%3A%2F%2Fspsites%2Edwh%2Ecdw%2Eportal%2Eva%2Egov%2Fsites%2FOMHO%5FMHMP%2FAnalyticsReports%2FForms%2FAllItems%2Easpx%3FInitialTabId%3DRibbon%252EDocument%26VisibilityContext%3DWSSTabPersistence&DefaultItemOpen=1*

[16] *VHA Office of Mental Health Operations 2013 Mental Health Survey Results for All VHA,* *http://www.mentalhealth.va.gov/docs/Mental_Health_Transparency_Report_11-24-14.pdf*

professionals. Solutions being considered include utilizing telehealth or regional telehealth hubs to address regional staffing shortages.

Adequacy of Clerical and Program Support Staff

Provider surveys and management discussions have highlighted common gaps in ensuring the adequacy and consistency of clerical and program support staffing for mental health clinics. These staff members are key to the efficient organization and flow of clinical care, and allow clinical providers to work at the top of their license. At many facilities, these staff members are centrally managed for all clinics and may rotate through clinical programs, limiting the ability of program support staff to assist with care coordination, panel management, and other practices that improve quality of care and the efficiency and effectiveness of clinical providers. VHA currently has no way of tracking data on clerks and other program support staff working in mental health clinics, and thus it is difficult to identify and address local gaps in staffing for these positions.

Education and Training Programs

The Office of Academic Affiliation (OAA) provides a wide range of training opportunities for multiple mental health professions. Roughly 60% of psychiatrists and 70% of psychologists who work for VA completed some of their training at a VHA facility.[17] VHA's clinical training programs are a vital tool for recruitment and retention. However, there are some deficiencies in training and supporting mid-level and facility mental health managers and supervisors in the skills they need for their jobs. There are not enough opportunities or resources available for clinicians and managers. Training for clinicians and managers in general needs a major revision in the manner in which it is delivered, moving from a reliance on in-person training to virtual training. The uncertainty of education and training has been acutely felt and it may leave providers feeling neglected and undervalued.

Psychiatrists

VISNs and facilities are responsible for attaining and maintaining sufficient psychiatry staffing, and may need to consider alternatives to standard recruitment and retention approaches such as delivery of care via telemental health from other sites; community care; and delivery of care by advanced practice nurses, physician's assistants, and/or clinically-trained pharmacists. These alternative options can be particularly useful in sites where the available professional population in the area is very small and difficult to recruit. VISN and facility leaders need to fully utilize available incentive strategies such as EDRP, geographic pay, and scarce specialty pay. Because retention of psychiatrists is generally more effective and less costly than recruitment of new psychiatrists, it is important that VISN and facility leaders ensure that pay for currently employed VA psychiatrists be in parity with salaries offered to new recruits, given that recent increases in authorized pay for new recruits have not been uniformly applied to the existing psychiatric workforce.

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[17] *VA Fact Sheet- 2014 Statistics: Health Professions Trainees, http://www.va.gov/OAA/docs/OAA_Statistics.pdf*

Psychologists

Psychologists remain on the VHA MCO list due to the vital role they play in the implementation and sustainability of VHA Mental Health, as well as their projected need, difficulty recruiting, and market shortages. Additional discussion of the issues surrounding psychologists can be found in Chapter 3, MCOs section of this plan. During FY 2015, the VA average number of vacant psychology positions was over 700 positions nationally, reflecting a vacancy rate of 15.2% to include existing and new Choice Act positions.[18] Several strategies to address vacancies and promote an increased number of psychologists include: ensuring continued, robust psychology training programs; revising psychology qualification standards to ensure a greater number of qualified applicants for open positions (e.g., providing a pathway for psychologists who completed an internship that was not American Psychological Association (APA)-accredited or who re-specialized in clinical or counseling psychology and allowing psychologists who trained in doctoral programs and internships accredited by the Canadian Psychological Association to meet the educational standards); implementing stronger recruitment, marketing and incentives (e.g., Student Loan Repayment Program [SLRP] and EDRP); and developing locally customized recruitment and retention programs to mitigate the limitations identified by VISNs (e.g., rural locations, candidate pool scarcity, high demand of specialized services, limitations in pay; staff recognition/awards, and space and work environment).

Planned Actions

Staffing Models

VHA mental health service's staffing models will be refined as more data are analyzed over time. VHA mental health leadership will work to develop standards for hours of evidence-based care delivery and standards for the availability of psychiatrists who can prescribe medications for treatment of opioid dependence and provide other specialized services. Updates in such standards can be expected within the next two to five-years.

Process Improvements in Workforce Tracking

VHA's OMHO tracks onboard outpatient mental health FTE and has plans to begin tracking inpatient, residential, and homeless program FTE. This tracking is accomplished by working with the mental health leadership and administrative staff at the facility and local program level to improve coding practices, including labor mapping, encounter capture, and clinical and scheduling set-up (stop codes), where needed to improve validity and completeness of source data. Additionally, VHA is exploring the validity of capturing additional onboard staffing breakouts by sub-specialty program, such as specialty substance use disorder and Primary Care Mental Health Integration. This will improve tracking of staffing for these subspecialty programs, which previously relied on self-reported survey data. Additionally, VHA is working with facilities to improve use of the Primary Care Management Module (PCMM) package to assign patients to general mental health BHIP teams.

[18] *VHA Office of Mental Health Operations (OMHO) Staffing and Vacancy Results Surveys*

Mental Health Management System Dashboard

During FY 2015, in response to a request by leadership to develop a strategy to minimize the heterogeneity of access, services, and outcomes in the VHA mental health system, the Mental Health Management System Dashboard was created as a tool to guide conversations with VISN and facility mental health leadership focused on improving access, care delivery, and the experience of care. The dashboard is organized by facility, and it currently includes key metrics related to Veteran and provider satisfaction, resources (e.g., staffing), processes (e.g., telemental health), and environmental factors (e.g. growth in demand).

Primary Care Health Care Services

Overview

The provision of primary care health care services in VHA relies upon the Patient Aligned Care Team (PACT). The PACT staffing model consists of the PACT teamlet and the Expanded (or Interdisciplinary) PACT. The PACT teamlet is comprised of four staff members: primary care provider (physician, NP or physician assistant), RN care manager, clinical associate (LPN/Licensed Vocational Nurse, health care technician, or medical assistant), and administrative associate (clerk). The teamlet works with the Veteran to identify health care goals and patient preferences, to provide basic health care services and education, to develop a care plan, and to coordinate care. The PACT teamlet manages the comprehensive primary care needs for an assigned panel of patients (~ 1200). When more specialized services are needed, other members of the Expanded PACT, such as pharmacists, dieticians, social workers and behavioral specialists, step in to assist the Veteran and the PACT teamlet. The Expanded PACT provides services to multiple PACT panels, with recommended staffing per each panel as follows: 0.3 FTE clinical pharmacy specialist, 0.2 FTE anticoagulation pharmacist, 0.5 FTE social worker, and 0.2 FTE dietician. Together, the entire PACT is focused on helping the patient meet his/her health care goals.

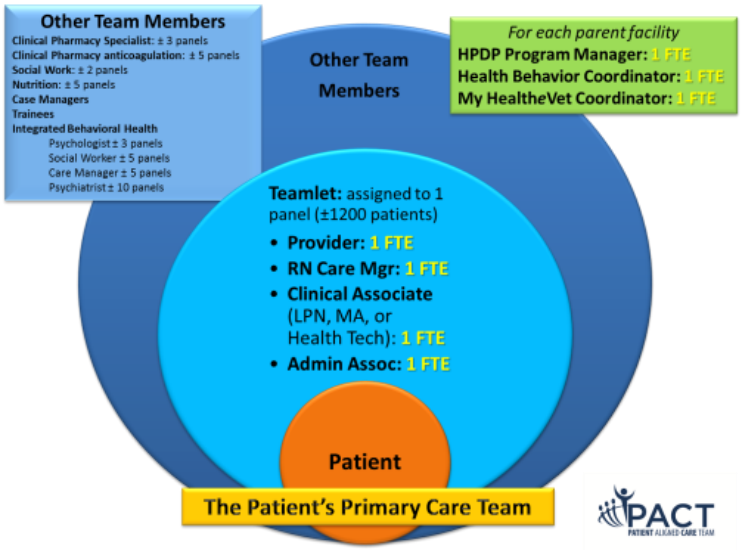

Figure 3: VHA PACT Staffing Model

Primary Care Demand and Utilization Projections

Primary Care utilization is projected to increase 26% between FY 2013 (baseline) and FY 2025 and will reach 32% by FY 2033 (Figure 4).[19] Projections of Medicare Equivalent Cost per Unit also demonstrate significant increases and are projected to double over the next 20 years. Indeed, the number of patients treated in primary care has already increased 13% since 2010 (Figure 5) when the PACT model was implemented.[20] Projections for PACT staffing and delivery determinations will be driven by projections of Veteran utilization and demand using VHA's EHCPM.

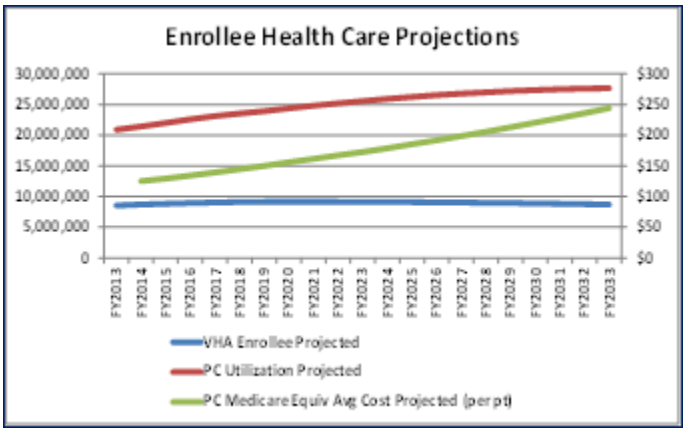

Figure 4: VHA Enrollee Health Care Projections

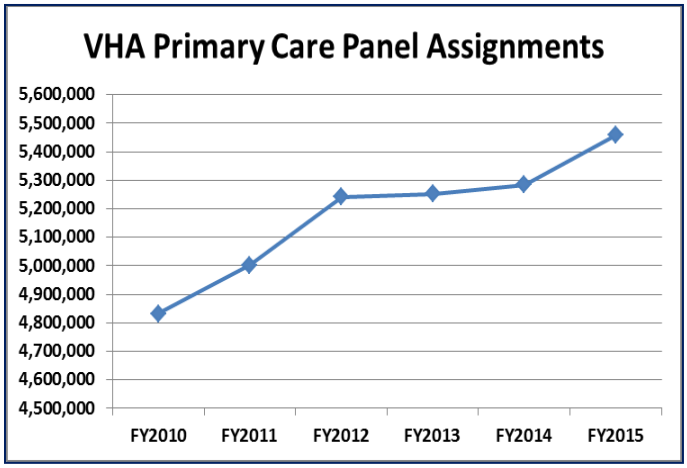

Figure 5: VHA Primary Care Patients

[19] *VSSC Projected Enrollee HC Cost for Primary Care; PC utilization and enrollment, https://bioffice.pa.cdw.va.gov/default.aspx?bookid=A784E1E8-774C-4883-A831-6D550C4FC0F6|ispasFalse|report29BE1181-6BFD-433E-808C-EA8D98CFB85F|ws1|wsb0|isDisabledAnalyticsFalse|isDashboardPanelOnTrue*

[20] *VHA PACT Compass, https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fPC%2fPACTCompassCubeSSRS%2fMainMenu&rs:Command=Render*

PACT Wait Times

The PACT Compass displays wait access metrics for teams including number of new and established patients, average days to third next available appointment (a widely accepted industry standard that is used as a means to measure clinic access) and same day access to the assigned primary care provider. FY 2015 data demonstrate that new primary care patients are able to obtain an appointment in 8.04 days and established patients are able to be seen in 3.98 days. The VHA goal for Primary Care new patient access is within 30 days. The average days to third next available appointment in VHA Primary Care clinics is 13.87 days. These measures are mediated (both positively and negatively) by the number of onboard PACT staff and losses, factors causing disruption to continuity of care. The end result may be untimely access to the PACT.

Workforce Data

The VHA national average for the combined quit and retirement rates for all occupations from FY 2010-2015 ranged from 6-7%. On average, VHA primary care physicians and physician assistants have higher combined quit and retirement rates than other VHA employees, ranging between 6.9-8.8% and 8.3-12.3% since FY 2010 respectively. In addition, VHA primary care nurses and NP have higher combined quit and retirement rates than other VHA employees, ranging between 6.2-10.9% since FY 2010.[21]

According to the most recent figures from the BLS (2014)[22], VHA primary care providers and nurses are compensated on par with the average for their counterparts in the private sector. Specifically, VHA primary care physician salaries are 2% lower, VHA primary care physician assistant salaries are 1% lower, and VHA primary care nurse salaries are 5% higher than their counterparts.[23]

According to a report prepared for the Association of American Medical Colleges in March 2015, the projected shortfall of primary care physicians across the U.S. will range from 12,500-31,000 by 2025.[24]

Workforce Analysis

VHA continues to experience a shortage in primary care physicians which is consistent with the private sector. In addition, station-to-station transfers of VHA primary care providers and movement from primary care to specialty care after gaining experience and knowledge is common in VHA and the private sector.

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[21] *VHA PAID data, June 2015*

[22] *Bureau of Labor Service, May 2014 National Occupational Employment and Wage Estimates, http://www.bls.gov/oes/current/oes_nat.htm*

[23] *These salary averages include both annual salary and special pay received throughout the year.*

[24] *HIS, Inc, The Complexities of Physician Supply and Demand: Projections from 2013 to 2025- Final Report https://www.aamc.org/download/426242/data/ihsreportdownload.pdf*

The number of onboard PACT teamlet staff is monitored via the VHA Support Service Center (VSSC) PACT Compass using facility self-reported data from the PCMM software program. The Compass metric, PACT 18-PACT Staffing Ratio, reflects the percent of divisions within an administrative parent facility that have a primary care staffing ratio of greater than or equal to 3.0 FTE staff to 1.0 FTE provider, which is the recommended level. By the end of FY 2015, 65% of VHA divisions had achieved the recommended staffing level. Trended data indicate a 14% overall increase in staffing ratios since October FY 2014. Adequate staffing is a critical component associated with improved access, clinical quality, staff morale, and Veteran satisfaction.

The VHA AES and PACT Personnel Survey data indicate that primary care providers demonstrate the highest burnout rates when compared to VHA staff in other clinical areas. Additional analyses conducted by VHA Office of Analytics and Business Intelligence using the PACT Implementation Progress Index, indicate that sites with higher PACT implementation scores have better clinical quality based on External Peer Review Program (EPRP) results, higher provider ratings by Veterans on the Survey of Healthcare Experiences of Patient, less staff burnout, and decreased patient visits to emergency departments.[25] Primary care physicians are one of VHA's largest physician groups and per the AES are clearly the least satisfied. In addition to burnout, the greatest challenges reported by primary care physicians in the AES are amount of work, workload, and limited job control and innovation.

Anticipated Workforce Challenges

Turnover is a substantial problem for PACTs. Recent VHA studies suggest that turnover of any PACT staff member, not just the primary care provider but also a nurse care manager, clinical associate, or administrative assistant, can significantly disrupt teamlet workflows and their ability to care for Veterans. Further analyses may elucidate potential contributing factors related to recruitment and retention.

Planned Actions

The VHA Interim Staffing Program (ISP) is an important part of primary care contingency planning for provider extended absence as well as losses, and continues to be an excellent recruitment source for primary care providers at VHA sites. An internal, VACO-based enterprise solution, the ISP strives to optimize the national availability of a highly-trained cadre of mobile VA employed physicians, nurses, psychologists, and other health care professionals for rapid, short-term deployment to VHA facilities. ISP supplies temporary health care professional staffing services to subscribing VHA entities on a fee-for-service basis. The ISP's current 146 health care participants, including 36 in the hiring process, serve 99 VHA health care systems and medical centers and their constituent community-based outpatient clinics via Memoranda of Agreement. ISP works closely with VA HR to expedite recruitment and onboarding of qualified candidates.

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[25] *Nelson, et al., Implementation of the Patient-Centered Medical Home in the Veterans Health Administration,* http://archinte.jamanetwork.com/article.aspx?articleid=1881931&resultClick=3

As an internal VA program, the ISP is not a contract locum tenens operation. Further, the ISP promotes internal care, as opposed to community care. Since ISP health care professionals may elect to transfer, without cost or penalty to the receiving facility, to permanent positions at subscribing facilities, ISP supports both urgent, temporary staffing needs, and also VA's effort to recruit new permanent hires. Existing service areas include primary care, geriatrics, home-based primary care, compensation and pension, and the broad spectrum of direct-care nursing. In the future, VHA plans to build on recent accomplishments in the ISP by increasing existing services to associate directors for patient care services, hospitalists, emergency medicine, psychiatry specialties, dermatology, pain management, endocrinology, and telemedicine.

Gastroenterology Services

Overview

Gastroenterology (GI) is a medical subspecialty dealing with disorders of the digestive system, including the esophagus, stomach, small intestine, large intestine (colon), liver and pancreas. The field includes the medical diagnosis and treatment of a wide variety of conditions, such as abdominal pain, reflux (heartburn), gastrointestinal bleeding, inflammatory bowel disease, hepatitis, cirrhosis, pancreatitis and nutritional disorders. GI clinics are also involved in the screening, diagnosis, and treatment of a variety of cancers, such as colorectal, esophageal, pancreatic, gastric, and liver cancer. GI clinics perform a variety of diagnostic and therapeutic procedures, including gastrointestinal endoscopy, colonoscopy, liver biopsy, and feeding tube placement.

VHA GI services are delivered in a variety of settings, including Outpatient GI Clinic, Outpatient Hepatology Clinic, Gastrointestinal Endoscopy Clinic and Inpatient settings. Increasingly, VA facilities are employing the use of telephone, telemedicine, e-consults and other non-face-to-face modalities.

Staff in the VHA GI Clinics include: gastroenterologists, hepatologists, NP, RN case managers, physician assistants, RNs, LPNs, and medical technicians. Some clinics also include surgeons and generalist physicians who may perform gastrointestinal endoscopy, especially in areas where gastroenterologists are in short supply. GI is recognized as a nursing clinical specialty. There has been considerable utilization of non-VA GI care through fee-basis authorization and locum tenens. Some of this purchased care is provided in VHA facilities and others in non-VA settings.

VHA is a training institution and is relied on by the academic community to provide in-depth training on GI services.

The provision of comprehensive and timely GI services across VHA has been challenging due to difficulty in fully staffing VHA facilities with gastroenterologists and support staff. Nevertheless, FY 2014 productivity reporting revealed VHA gastroenterologists generate over 80% of comparable private sector mean RVU's (7,022/8,879) and 79% of academic community RVU's (7,134/9,138).

Workforce Data

The VHA national average for the combined quit and retirement rates for all occupations from FY 2010 to FY 2014 ranged from 6-7%. On average, combined quit and retirement rates for gastroenterologists have fluctuated over the past four years, ranging from 6.9% to 12.0%. For FY 2014, the gastroenterologists combined quit and retirement rates were on par with VHA averages.[26]

According to the 2015 Review of Physician and Advanced Practitioner Recruiting Incentives by Merritt Hawkins[27], gastroenterologists in the private sector are one of the top three highest compensated physicians in the nation. Two leading national physician compensation analysis organizations, Sullivan Cotter[28] and Medical Group Management Association[29], reported an average of $439,000 and $554,000 respectively for private sector gastroenterologist salaries in 2014. Per the Association of American Medical Colleges[30], academic GI salaries in 2014 averaged $297,000 for assistant professors, $348,000 for associate professors, $370,000 for professors, and $441,000 for GI division chiefs. Annual compensation increases of 7% are typical among the GI career field in the private sector. It is important to note that competition, physician density, location, and employment setting play a role in gastroenterologist salaries. Furthermore, personal professional expenses, such as medical liability or malpractice insurance, of private sector physicians are higher than VHA physicians and must be taken into account when comparing overall compensation.

The average VHA gastroenterologist salary in FY 2014 was $247,938 per year, which is 44-56% lower than their counterparts in the private sector. In many regions of the nation, private sector salaries greatly exceed the maximum VHA gastroenterologist salary allowed on the VHA tier 3 pay table ($320,000).[31] Pay exceptions can be requested by medical centers to go above the maximum salary allowed on the VHA tier 3 pay table.

Workforce Analysis

The ability to provide timely, high quality GI screenings and treatment is reliant on a good supply of GI staff formally trained to provide these services. However, due to the addition of no cost and low cost preventative GI-related screening measures in the ACA and an aging and growing population in the U.S., GI services are in high demand and staffing is short in both VHA and the private sector. According to a 2009 study conducted by the Lewin Group, there will be a

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[26] *VHA PAID data, June 2015*

[27] *Hawkins, M., 2105 Review of Physician and Advanced Practitioner Recruiting Incentives, http://www.merritthawkins.com/physician-compensation-and-recruiting.aspx*

[28] *Cotter, S., 2015 Physician Compensation and Productivity Survey, https://www.sullivancotter.com/surveys/physician-compensation-and-productivity-survey/*

[29] *Medical Group Management Association, 2014 Physician Compensation and Production Report, http://www.mgma.com/industry-data/survey-reports/physician-compensation-and-production-survey*

[30] *Association of American Medical Colleges , AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers (2015) and Report on Medical School Faculty Salaries 2013-2014, https://www.aamc.org/*

[31] *These salary averages include both annual salary and special pay received throughout the year.*

shortfall of 1,050-1,550 gastroenterologists across the U.S. by 2020.[32] With the supply of available GI staff projected to remain low compared to the demand for services, an increase of competition for staff is expected for the foreseeable future. In particular, competition over salaries is expected to create significant challenges for recruitment and retention of high quality gastroenterologists across VHA.

Anticipated Workforce Challenges

GI medical officers are hard to recruit and retain in VHA, in part due to the salary differences with the private sector and increasingly demanding workloads. This shortage of GI staff has resulted in changes to VHA health care modalities, such as the use of surgeons and their support staff to perform some GI services and the sustained reliance on fee-basis and contract GI services.

Because non-GI staff perform some GI services, HR databases do not accurately capture all staff performing GI services. This makes it difficult to track current and project future staffing needs. In addition, HR databases do not easily distinguish advanced GI medical officers and hepatologists.

The demand for new Hepatitis C services and medications by Veterans has increased dramatically with the recent FDA approval of highly effective antiviral therapy for Hepatitis C infection. These new treatments are highly sought after by Veterans, a group with a high prevalence of this deadly infection. As these treatments have risk and substantial costs, considerable care coordination is required by VHA staff.

Given the tremendous demand for VHA GI services, a considerable proportion of basic endoscopic services are now outsourced for community care, leading to challenges in continuity of care and increased need for care coordination by VHA staff.

Planned Actions

The VHA GI program office is working to create and disseminate training programs to ensure high quality endoscopies throughout the system. This training will help to ensure that both endoscopy unit staff and non-GI staff (e.g., surgeons) that are involved in GI procedures are able to provide optimum care.

The VHA GI program office is working towards development or acquisition of a national endoscopy software tool to allow for optimal endoscopic procedure data collection and reporting on workload, quality, etc. Not only will this improve patient care through better documentation of care, but it may assist with right-sizing staff for specific GI services throughout the system via analytics on efficiency and throughput associated with staffing models and health care modalities.

The VHA GI program office will regularly gather and analyze private sector salary comparison data to inform leadership of gaps between VHA GI medical officer salaries and those in the

[32] *Olympus America, Inc., The Impact of Improved Colorectal Cancer Screening on Adequacy of Future Supply of Gastroenterologists,* http://www.crcawareness.com/files/lewin-gastroenterologist-report.pdf

private sector. The VHA GI program office is currently recommending a higher pay table for GI medical officers across the nation.

Women's Health Care Services

Overview

The number of women Veterans who use VHA health care services has nearly doubled in the past decade and is projected to continue to increase from 8% in 2015 to 20% of the patients treated in VHA facilities by 2030. In FY 2014, 672,000 women were enrolled in VA care and 418,000 actually used VA care. VA health care for women has increased over 30% in just the past two years and over 100% in the last ten years. We expect the number of women seeking care from VHA to rise dramatically in the next three years.

VHA strives to ensure that women Veterans experience timely, high quality comprehensive care in a sensitive and safe environment at all points of care. VHA's commitment to the health of women Veterans requires a practice focused upon the specific needs of women as a population distinct from male Veterans. Women's health must not only incorporate gender-specific clinical practices such as gynecology, but also care for non-gender specific conditions that are either unique to women, more common in women or have unique manifestations in women.

Additionally, mental health services must be available and tailored to meet the needs of women Veterans at all points of care. Comprehensive primary care for women Veterans is collaborative-team-based care that includes not only trained and proficient women's health providers, but also nurses, health-technologists, support staff to serve as chaperones during exams, and co-location of mental health.

Primary Care for women in VA uses the PACT model, which is a team based approach to care. Each Women's Health (WH) PACT is made up of the Designated Women's Health Primary Care Provider (DWHPCP), an RN, two health technologists or LPNs, and a clerk. Extended team members for the WH PACT include social worker, clinical pharmacist, gynecologist, dietician, military sexual trauma coordinator, mental health provider, and an RN Pap/Mammogram/Maternity Care Coordinator.

All women Veterans eligible for VA care must have access to a full range of gynecologic services. Basic gynecologic care, such as contraception, cervical cancer screening, menopausal care, etc. is usually provided by the DWHPCP. When women require referral for specialty gynecologic care, including gynecologic surgery, it may be provided on site or through community care.

Emergency Departments also must be prepared to provide emergency gynecologic care for such things as acute vaginal bleeding, pelvic pain, and pregnancy complications.

In addition, Women Veteran Program Manager (WVPM) and Women's Health Medical Director are critical to ensure successful Women's Health Programs (WHP) within VHA facilities.

Workforce Data

The current number of DWHPCPs across VHA is 2,168 as of the end of FY 2014.[33]

According to the most recent figures from the BLS (2014), on average for the entire nation, VHA designated women's health care physician salaries are 5% lower and VHA gynecology physician salaries are 1% higher than their counterparts in the private sector.[34] Furthermore, on average for the entire nation, VHA designated women's health care physicians are compensated slightly lower (3%) than other VHA primary care physicians.[35]

Turnover rates for VHA WVPMs average 27% for the past three years, up from 22% four years ago. In FY 2014, 18 WVPMs retired, 14 moved to another job inside VA, and six left VA. In FY 2015, eight WVPMs retired, eleven moved to another job inside VA, and four left VA.[36]

Workforce Analysis

DWHPCPs and their Women's Health PACT teams may practice in any of three models of care:

- Model 1 is a gender integrated primary care clinic. Within this model women are preferentially assigned to DWHPCPs but they practice within a "usual" primary care clinic setting.
- Model 3 is a women's only clinic arrangement, known as a Comprehensive Women's Clinic. In this model, DWHPCPs practice in a separate clinic for women, including a separate entrance and separate waiting room. In addition to primary care, Comprehensive Women's Clinics incorporate gynecologic care, mental health care, social work and other services for women Veterans. As of the end of FY 2014, there were 77 Model 3 clinics in VHA.
- Model 2 falls between Models 1 and 3 and is known as "Separate but Shared Space." This describes a model of care where DWHPCPs are practicing in a clinic setting that may be a section or area of a gender neutral primary care clinic that is just for women, or another clinic area that is reserved for women at certain times. This model often works well in smaller sites that choose to have a separate women's clinic, but don't have a large enough population of women to support a fully staffed Comprehensive Women's Clinic. As of the end of FY 2014, there were 99 Model 2 clinics in VHA.

The target is for every VHA site of primary care to have a sufficient number of DWHPCPs to provide support for the local women Veteran population, to include redundancy when a given

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[33] *VA Women's Health Evaluation Initiative (WHEI) and VHA Women's Health Services, February 2014, Women Veterans in the Veterans Health Administration, Volume 3: Sociodemographics, Utilizations, Costs of Care, and Health Profile*

[34] *Bureau of Labor Statistics, May 2014 National Occupational Employment and Wage Estimates, http://www.bls.gov/oes/current/oes_nat.htm*

[35] *These salary averages include both annual salary and special pay received throughout the year.*

[36] *VA Women's Health Evaluation Initiative (WHEI) and VHA Women's Health Services, February 2014, Women Veterans in the Veterans Health Administration, Volume 3: Sociodemographics, Utilizations, Costs of Care, and Health Profile*

provider may be on leave or otherwise unavailable. Ideally at each site of care in VHA, including medical centers and Community Based Outpatient Clinics (CBOC), there would be approximately 1.0 FTEE DWHPCP for each 1,000 woman Veterans receiving care. To that end, VHA Women's Health Service data indicate that VHA needs to train, certify, and/or recruit an additional 675 DWHPCPs to meet the current demand. Within the next fiscal year, accounting for the VHA primary care provider turnover rate and a projected 10% increase in the number of women Veterans, it is estimated that an additional 521 primary care providers will be needed; bringing the total near-term need to 1,196 DWHPCPs across VHA.

Data indicates that VHA Comprehensive Women's Clinics are understaffed in comparison to VHA PACT clinics in general. The PACT policy recommendation for staffing is 3.0 FTEE staff (nurse, LPN, health technician or clerk) for all PACT and 4.0 FTEE staff for DWHPCPs, to account for the added need for chaperones. In reality the staffing actually reported is far less for DWHPCPs, with fewer than 75% having a 3:1 staffing ratio. Of the VHA Comprehensive Women's Clinics, 20% have no nurse assigned, approximately 25% have no LPN, and 35% have no assigned clerk.

Currently, 104 of 144 VAMCs have on-site gynecology.[37] All medium to large complexity VHA facilities should have on-site gynecology services. Smaller, less complex, or highly rural VHA facilities typically provide care through on-site part-time services, off-site community care, or another VHA facility within 40 miles of the Veteran's home.

It is important to note that female Veterans are referred for care outside the VHA system more than their male counterparts. In FY 2014, 80% of women Veterans were sent outside VHA at least once that year for such services as mammograms, gynecology, oncology, and pregnancy care. This dual care (a.k.a. coordinated care) with non-VHA providers greatly impacts workloads in VHA Comprehensive Women's Clinics as staff are expected to oversee outside care of Veterans even if they are not currently seeing the patient in an appointment. This high demand for community care affects productivity models inside women's health clinics.

Anticipated Workforce Challenges

Designated Women's Health Primary Care Providers (DWHPCP)

According to data from the VHA Women's Health Service, VHA must train and certify or recruit almost 1,200 new DWHPCPs within the next fiscal year to meet current and projected women's health care capacity needs.

While VHA provides 2 ½ day Women's Health Mini-Residencies and virtual training through VA's Talent Management System and My Veterans E-Health University Campus to update primary care providers in gender specific health care for women Veterans, additional ongoing educational programming and resources are needed in order to meet training needs.

Per the 2015 VA-Center for Applied Systems Engineering (VA-CASE) review at VHA facilities, participants reported that many of their VHA peers who were not currently DWHPCPs appeared

[37] *http://planning.vssc.med.va.gov/VAST/Documents/QES_4thQtr_FY15_Final.pdf*

to be unwilling to receive training in women's health and/or decided not to work in VHA WHP because they believed that Comprehensive Women's Clinic patients took more appointment time, required more appointments, and/or were too needy.[38] These views on women's health, coupled with the understaffing of Comprehensive Women's Clinics and the 5% pay disparity between DWHPCP's and other VHA primary care providers, negatively impacts DWHPCP recruiting, retention, and development.

Gynecology Staff

At VHA sites without on-site gynecology, increased staff and resources are needed for care management and care coordination of women Veterans receiving purchased, community care. Furthermore, as noted in a 2015 study of VHA's gynecology services, recruitment of gynecologists, particularly in smaller communities, was noted as a significant challenge. The fact that pay is similar to non-VA providers but care is significantly more complex does not provide an incentive to work for VA. Care is more complex because women Veterans who use VA have worse health, fewer socioeconomic resources, higher rates of homelessness and unemployment, and are more likely to smoke then civilian women.

Care Coordination Demands for Women's Health

In 2015, the VHA Women's Health Service and VA-CASE analyzed the process for delivery of primary care to women. The following are the three main findings from their study:[39]

- Women Veterans require a higher number of community care consults as compared to male Veterans resulting in greater need for care coordination.
- The complex co-morbidities of women Veterans combined with high use of community care placed a high burden of care coordination responsibilities on women's health teams.
- Mammography represents one of the biggest challenges and opportunities for care coordination.

In FY 2014, the community care referral rate was on average 37% higher in absolute terms for female Veterans compared to male Veterans (80% vs 43%). (Note this data is prior to the introduction of the Choice Act requirements for care within 40 miles or access beyond 30 days. As such, FY 2015 numbers are expected to be even higher.) While sending female Veterans outside VHA for specialized care increases access to care, the care coordination demands create a significant time burden for VHA staff. Coordinating community care continues to be a unique challenge due to the complexity of arranging and tracking care and the lack of nurses and support staff in Comprehensive Women's Clinics.

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[38] *VA Center for Applied Systems Engineering and VHA Office of Informatics and Analytics, Women's Health Workforce Assessment (WHWA), https://vaww.visn11.portal.va.gov/sites/verc/VA-CASE/SitePages/Home.aspx*

[39] *VA Center for Applied Systems Engineering and VHA Office of Informatics and Analytics, Women's Health Workforce Assessment (WHWA), https://vaww.visn11.portal.va.gov/sites/verc/VA-CASE/SitePages/Home.aspx*

Sub-Specialty Medical and Surgical Care

Because women Veterans have been and are still a minority population in VHA some specialty providers have seen few women in their practices. This may result in a lack of knowledge or up-to-date skills in treating conditions that are unique to or more common in women, or those that have gender specific manifestations such as fibromyalgia, migraine headaches, or cardiovascular disease. Each site must ensure that they have specialty providers on site who are trained and proficient in the specialty care of women Veterans. Additionally, specialty care clinics must ensure that they have adequate support staff to provide chaperones for any physical exams or procedures that require exposure of breasts or genital areas. Providers must also be attuned to needs of women Veterans including sensitivity to needs of women with sexual trauma histories, and privacy and security of the health care environment.

Women Veteran Program Managers (WVPM)

Per VHA Handbook 1300.02, the facility WVPM position must be a full-time health care professional without collateral assignments who is directly supervised and reports to the facility director or chief of staff. Annual reviews conducted by VHA Women's Health Service continue to reveal that many WVPM's are not working within the recommended 1.0 FTEE, but instead have been assigned several collateral positions such as Mammogram Coordinator, Maternity Care Coordinator, or coordinator for other special populations. This has caused retention challenges among many facility WVPMs. In addition, many VAMC's have no coverage for when the WVPM is out of the office on leave or at training. A lack of facility-level succession planning has caused new WVPMs to face training deficiencies and other challenges in this demanding position. Furthermore, a facility WVPM should not serve as the VISN Lead WVPM. Every effort should be made for the VISN Lead WVPM position to be directly supervised and report to the network director or chief medical officer. VHA will need to better plan for the recruitment, retention, and succession planning of facility WVPMs and VISN Lead WVPMs.

Planned Actions

Staffing Gaps in DWHPCP's and Gynecologists

- VHA will continue to provide large scale trainings, with two conferences planned in FY 2016, and provide support and travel funds for VISNs to train DWHPCPs. These trainings will add approximately 450-475 DWHPCPs.
- VHA Women's Health Service will coordinate with VHA Workforce Management and Consulting (WMC) on the review of compensation for DWHPCPs as additional specialty training and ongoing learning is required for this designation. The review will include pay table definitions, use of Pay for Performance, and enhanced use of retention incentives for DWHPCPs.
- VHA Women's Health Service will coordinate with VHA WMC on utilizing enhanced national recruiting efforts for DWHPCPs, including women's health NP and gynecologists, to address current and projected staffing gaps.

- VHA will track and report on the use of Choice Act funds to hire DWHPCPs and gynecologists for FY 2015-2016. Facilities are encouraged to utilize Choice Act funding to address gaps in women's health staffing.

Staffing Gaps Affecting Care Coordination

- VAMCs and VISNs will report current PACT and Comprehensive Women's Clinic staffing and develop plans to address basic staffing levels to ensure compliance with PACT policy.

- Aggressive new staffing plans for women's health must be implemented immediately to assist with care coordination, especially now that the Choice Act has resulted in a significant increase in purchased, community care. These new staffing plans must include clinical nurse-based care coordination, administrative health technician positions to schedule appointments and recover test results, and managerial oversight in PACT and in the Chief Business Office.

Retention of WVPMs

- VISN and VAMC leadership and human resource officers will review and update job descriptions and assignments so that facility WVPMs are limited to the duties of 1.0 FTEE without collateral assignments and reports to the Director or Chief of Staff.

- Each VAMC will establish a written succession plan, cross-training, and coverage plans for the position of the WVPM.

- VISN leadership will consider restoring the Lead WVPM position to a minimum of 0.5 FTEE to focus on the growing population needs of women Veterans.

Tracking Workforce Data

Improving clinical staffing models and workforce projections for women's health rests upon refining the flow of relevant information throughout the VHA. To that end, VHA is pursuing the following initiatives:

- Workforce Capacity System Process Map/Modeling: This effort includes development of a system-wide tool to support analysis of the current and future population to identify resources needed to provide a coordinated continuum of care for women Veterans. This tool will detail the number and types of clinical personnel needed for each aspect of women's health care. With this tool, VAMCs and VISNs can better forecast the cost of providing selected health care for female Veterans.

- Qualitative Assessment and Feedback: Qualitative analysis will be conducted to identify the areas of greatest concern for VHA's women's health workforce. The analysis will use on-site discussions, interviews, and analysis to obtain perspectives regarding gaps and barriers. Sites selected will represent the various VAMC facility tiers; will address/assess resources available versus patient load and access; and will represent one of the Comprehensive Primary Care Clinic Models.

- DWHPCP Assessment of Workforce Capacity: The WVPM at each VAMC will identify all local DWHPCPs within their health care systems, including VAMCs and CBOCs. In addition to identifying names of providers, information is collected to identify the "capacity" of the site to provide primary care to women Veterans. VHA is working to assess provider women's health training and experience by documenting attendance at Continuing Medical Education (including Women's Health Mini-Residency) or prior experience working in a practice that is at least 50% female. Data from these assessments will be analyzed and incorporated into practices across VHA.

- Women's Assessment Tool for Comprehensive Health: The Women's Assessment Tool for Comprehensive Health initiative is an annual online self-assessment of WHP in VHA. The assessment identifies the current capabilities of each WHP and identifies local and national opportunities for improvement. Topics of interest include WHP workforce and strategic planning development, women's health care services, outreach, communication, collaboration, patient centered health care delivery, PACT implementation and women's health education and training. The assessment also reviews the models of care available for comprehensive primary care delivery in each VAMC and CBOC.

- Site Visit Assessments: To date, VHA has completed 120 comprehensive evaluations of WHPs across the country. The assessment teams use a Capability Review Tool that addresses five essential WHP domains or "components:" 1) program features; 2) health care services; 3) outreach, communication, and collaboration; 4) PCC/ PACTs; and 5) education and training. The remaining site surveys are scheduled to be completed in FY 2016, and the results will be incorporated into VHA women's health policy and planning over the next 1-2 years.

Analysis of Clinic Schedulers (i.e. Medical Support Assistants)

Background

Veterans interact with VA on average over five times a year to make appointments. Clinic schedulers are the first contact for most Veterans and therefore have a prime opportunity to make the Veteran's Experience more predictable, consistent, and easy in accordance with MyVA goals and the Under Secretary for Health's top five priorities.

Vacant scheduler positions can cause appointments to become uncoordinated, scheduled in error, prone to failure, and delayed. In addition, scheduler vacancies may mean increased delays and inefficiencies in the provision of care -- phones may not be answered, and clinicians may use their time to schedule appointments.

Section 203 of the Choice Act mandated a review of VA's scheduling software and system. The review was conducted by the Northern Virginia Technology Council (NVTC) through site visits and interviews at two VAMC in 2014. NVTC's report of findings included 39 core recommendations broken out into four broad categories – people, process, technology, and performance. People comprised 19 of the recommendations and focused on a number of issues

pertinent to scheduler positions including retention rates, long vacancy durations, and high turnover. These findings prompted calls for an analysis of the 0679 Medical Support Assistant (MSA) occupational series.

Although the role of MSAs within VHA may vary from site to site and clinic to clinic, approximately 19,000 MSAs schedule the majority of clinic appointments. An analysis conducted in December 2014 revealed MSAs are the third largest occupation in VHA. The occupation more than tripled in onboard strength over the last nine years, growing from 5,341 in FY 2006 to 19,510 in FY 2015. The highest onboard percentage change (34.5%) occurred at the end of FY 2012. This growth was largely due to the conversion of the 3,000 employees in the 0303 Miscellaneous Clerk and Assistant occupation to the Hybrid Title 38 MSA occupation. The total loss rate for MSAs in FY 2015 was 10.5% as compared to 9.3% for the total workforce. In addition, an analysis performed in FY 2014 indicated that approximately 8.3% (1,321 employees) left the occupation in FY 2014 to transfer to the 0303 miscellaneous clerk, 0640 health aid and technician, 0301 miscellaneous administration and program, and 0318 secretary occupations, however, approximately the same number of employees leave those same occupations to become MSAs each year, so the flow is bi-directional and does not contribute to higher losses from the occupation. As with the total workforce, the majority of losses are due to quits. The rate of quits increased from 4.9% in FY 2012 and 2013 to 6.3% in FY 2015. Retirements ranged from 2.9% - 3.0% between FY 2013 and FY 2015.

Following the conversion of the occupation from Title 5 to Hybrid Title 38 in FY 2012, the majority of MSAs were Grade 5. However, during the first two months of FY 2015, 3,544 promotions were processed as part of the one-time review of the PACT positions initiated in September 2014. Now, the majority of MSAs are Grade 6 (53.4%), with 33.9% at Grade 5. Approximately 6.5%% of employees are in Grade 7 (see Table 2 below).

Table 2: FY 2015 Number of MSAs by Grade

MSA Grades (Occ Code 0679)	How Many in the Grade	Percent by Grade (Rounded)
3	79	0.4%
4	731	3.7%
5	6,394	32.8%
6	10,640	54.5%
7	1,311	6.7%
8	319	1.6%
9-12	36	0.2%

Challenges

Input from local workforce plans indicated that turnover of MSAs due to low grades and lack of promotion opportunities results in loss of experienced employees with the required specialized knowledge. In addition, job stress, lack of succession planning, lack of standardized training and dedicated training resources, and lack of a standard organizational structure pose significant barriers to retention.

The vast majority of planners indicated little difficulty recruiting for MSAs. However, local plans indicated that the most significant barriers to recruitment included a lengthy boarding process, difficulty boarding at the GS-7 and GS-8 (lead and supervisor) positions due to the

requirement for a year of specialized experience, and lack of quality applicants. Some planners indicated it can be difficult to entice quality candidates to apply due to the nature of the job, which sometimes requires coverage on off-tours.

In their review and analysis of current business processes, the NVTC team identified a number of critical challenges that are corroborated by planner input, including slow hiring processes, high turnover, and issues with delivery of needed training. In addition, however, the NVTC also found lack of space, "role creep" (i.e., clerks performing functions that may be beyond their job descriptions), and inefficiencies in the legacy scheduling package as barriers to appropriate scheduling activities.

Planned Actions

In 2016, VHA will utilize feedback from the 2015 facility workforce plans and additional on-site interviews to conduct an MSA workforce analysis and HR strategy and build an implementation plan that will focus on:

- Identifying barriers to onboarding and reducing hiring cycle time for MSAs;
- Outlining career paths, including necessary knowledge, skills and abilities needed to advance in their careers;
- Improving job satisfaction and performance;
- Decreasing workforce turnover, increasing customer satisfaction and improving customer service;
- Developing tools and strategies that will allow facilities to predict and anticipate vacancies;
- Formalizing relationships with internal and external stakeholders so that job opportunities can be communicated; and
- Developing consistent sourcing, hiring, staffing, and retention best practices to be used across all 144 VAMCs.
- Developing a stronger partnership with Veteran Employment Service Office.
- Conducting a thorough review of recruitment and retention incentives.

Analysis of Leadership Vacancies and Succession Planning

Background

Leaders set the direction and tone for their organizations that coalesce employees around a common mission and vision, and define the operating principles that govern their behavior. The need for strong leaders to guide and direct the VHA has never been more evident. However, VHA is currently experiencing a critical number of vacancies in medical center senior leadership positions, including medical center directors. Executive vacancy rates above 20% and the large

number of VHA senior leaders who are retirement eligible accentuate the current insufficiency of the succession pipeline to meet the numerical demand for qualified and capable health care leaders.

The health care industry in general, and specifically within VHA, has grown more complex and is challenged to keep pace with rapid advancements in medical treatment and technology, evolving regulatory requirements, and changes in patient demographics and expectations. VHA leaders will need to be more agile in their thinking, collaborative in their internal and external partnerships, engaging of their workforces, and servant-oriented in their relationships.

An independent study commissioned through the Choice Act documented numerous challenges in previous VHA leadership practices and support systems. Among the seven overarching findings were that the VHA culture is "characterized by risk-aversion and distrust", the VHA workforce "appears to be steadily losing its motivation", and "the leadership pipeline is not robust enough to meet VHA's current and future needs, a function of both inadequate succession planning and unfocused leadership development efforts."[40]

In response to the "crisis in leadership", the VHA Healthcare Leadership Talent Institute (HLTI) was created in 2015 to establish an integrated system from the local to the national level that will enable VHA to better identify, develop, and strategically manage its health care leadership talent. The goal of HLTI is to create a strong and sustainable succession pipeline of ready, willing, and capable leaders to step into VHA's most demanding roles, particularly those associated with overseeing VA medical centers. During its first six months, the HLTI led several initiatives to address the immediate succession needs in VA medical center senior leadership positions.[41] These included:

- Identifying current medical center associate directors interested in and ready to pursue medical center director positions and increasing awareness of openings via the VHA Office of Executive Recruitment.
- Establishing a process for qualified VHA staff to volunteer for medical center senior leadership detail opportunities. A list of volunteers is now used by VHA Network Directors and HR Officers to fill short-term, detail executive positions.
- Reaching out to all medical center senior leaders below the director to gauge their interest and raise their awareness about serving in more senior leadership positions.
- Supporting efforts to streamline the executive recruiting and hiring processes.

In addition, VHA undertook a number of new initiatives to fill high-demand clinical and leadership positions, including a new national Medical Center Director recruitment effort, a revitalized National Recruitment Program (NRP) that broadened the number of venues VHA

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[40] *McKinsey & Company, Inc., Veterans Choice Act Independent Assessment (Section 201)- Assessment L (Leadership), http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf*

[41] *Medical center senior leadership positions include: Medical Center Director, Deputy Director, Associate Director, Assistant Director, Associate Director for Patient Care Services or Nurse Executive, and Chief of Staff.*

raises awareness about opportunities for physicians, nurses, and other hard-to-recruit professionals; personal outreach to potential candidates; and an increased presence at national conferences and in professional publications.

Planned Actions

- HLTI is in the process of outlining a long-term strategy to systematically identify, develop, and leverage VHA's emerging leaders. The system under development will be applicable and adaptable to all levels within VHA, with the initial focus on building a sustainable system to support the need for medical center senior leaders.

- An expanded definition of the requirements and expectations of VHA leaders needs to be finalized and adopted throughout VHA. VHA leadership positions have traditionally been defined by the education, technical skills, experience, and similar qualifiers for the role. This set of skills and experiences needs to be expanded to include personal attributes required of successful leaders, such as drive, resiliency, confidence and the ability to engage and motivate employees. These are many of the attributes the VA Secretary, independent consultants, and VHA senior leaders have noted as needed to be a successful leader. In addition, the HLTI will direct more focused workforce analyses of the succession pipeline to better understand the typical patterns for accession to executive leadership positions that build the requisite skills for those jobs. The HLTI will work to identify and disseminate specific attributes required in key positions within VA medical centers and suggested career or developmental steps to take to build those skills.

- Individual staff talent profiles are needed to more accurately assess and analyze VHA workforce needs and gaps. The HLTI will profile talent currently existing in VHA, particularly of those employees comprising the succession pool that supports targeted leadership positions. The content of the individual profiles will be related to leadership position requirements and the attributes of successful leaders. Profiles assist employees and supervisors with developmental discussions and action planning for employee growth and form the basis for determining the readiness of the succession pool for positions of greater responsibility. Possible profile data points include career histories, performance reports, perspectives from peers and subordinates, leadership competency measures, and statements of aspiration or motivation for advancement. VHA will develop a process and system for capturing and tracking this information about its employees.

- HLTI will create a process to conduct talent review panels of senior leaders. The panels will review individual talent profiles and make judgements about each person's readiness to assume a higher-level leadership position. The intent is to identify top performing employees with the potential for leading at the next level and encourage them to apply for open leadership positions. In addition, employees will receive recommendations for developmental steps to enhance their performance and potential.

- Facilities will create succession plans that address various developmental efforts and their utility for strengthening their leadership pipeline with ready, willing, and capable

leaders and to fill gaps between the workforce in place and the one needed to meet future requirements. This will include efforts to better align leader values, temperament, styles and behavior with those needed to successfully lead complex health care organizations.

- Facilities will assist in identifying talent and targeting developmental opportunities toward those with the highest potential to serve in positions of increased responsibility within their organizations.
- VHA will implement creative solutions to reduce the workload on executive recruitment teams and on individual applicants, while concurrently increasing the number of interested candidates for any one vacancy.

Analysis of Organizational Health Surveys

Background

There are several points across the *Human Capital Lifecycle* where VHA seeks feedback about employees' workplace experience: at hire, throughout work tenure, and upon leaving. This feedback is essential to ensuring VA is an environment where employees want to work, and Veterans want to receive services. Obtaining this workforce feedback is important in understanding VHA's health – what we are doing well and potential areas for improvement.

VHA links its workforce feedback with other organizational data to develop data-informed relationships and guide leadership decision-making. This data linking shows "all things connected" in the VHA workplace, where workplace culture, policies, or leadership actions can "spillover" to affect employee or customer experiences, and customer and employee actions can also impact workplace performance measures. The VHA organizational health chain illustrates this connectivity, but it is only supported when we have accessible data.

Figure 6: VA Organizational Health Chain

Data Sources and Metrics

VHA participates in several organizational health surveys as feedback tools directed to all VA employees and intended to capture different aspects of the human capital lifecycle. Additional feedback tools not explored here, but relevant, include the Integrated Employee Ethics Survey (IEES), VA Nursing Organizational Development Survey, and Learning Organization Survey (LOS), among others.

At Hire and Upon Leaving

Obtaining employee feedback at the point of hire (VA Entrance Survey) and the point of leaving (VA Exit Survey) lend insight into VA recruitment and retention efforts. These datasets are updated monthly with customized data pulls available through the VSSC Data Cube.

- VA Entrance Survey is a VA-wide survey managed by VA Office of Human Resources Management (OHRM). The survey audience is new employee hires with the assessment best offered during orientation or shortly thereafter. The VA Entrance Survey captures feedback on the hiring process and the reason(s) employees choose VA as their place of work. Data are available by fiscal quarter, facility, and select demographics.
    - Learn what hiring processes are working well and which need improvement.
    - Understand why new hires left their prior employer and what can be done to foster their retention in VA.
    - Discover why new hires choose VA and what can be done to reinforce this decision and recruit others.
- VA Exit Survey is also a VA-wide survey managed by VA OHRM. The survey audience is employees who choose to leave VA voluntarily for other private or public sectors or for retirement (i.e., not transferring within VA). The VA Exit Survey captures feedback on who is leaving VA, the reasons employees leave VA, any single incidents that contributed to employees leaving VA, and incentives/benefits that may have prevented employees from leaving. Data are available by fiscal quarter, facility, and select demographics.
    - Understand why staff choose to leave VA and how can we minimize unnecessary loss (e.g., due to supervisory/peer actions, workload, lack of advancement, etc.).
    - Learn where staff goes after VA and if to school, will they come back to VA; if to another agency or private sector, what could VA do better to retain them.

Throughout Tenure

VHA participates annually in two employee satisfaction/workforce perception surveys: Federal FEVS and VA AES. Both surveys capture comparative, yet distinct perspectives about the VA workplace.

Overlapping survey concepts offer bi-annual “pulse” snapshots (administered in the spring and fall) on employee satisfaction, general workplace perceptions, and supervisor and work group behaviors.

- FEVS is a federal-wide survey managed by the U.S. Office of Personnel Management (OPM). It uniquely measure issues of leadership behaviors, merit/recognition, engagement, performance evaluation, and Human Capital Assessment and Accountability Framework Indexes. Data are compared to other federal agencies. In VA, FEVS is a sample survey administered in the spring (May-June) with data reported at national, administration, regional, and office/facility levels. Limited workgroup data exist (i.e., VACO). Data reports are available within six months on the VSSC Pyramid Data Cube (i.e., time to receive raw data file from OPM).
    - Use the data to obtain unique insights on employee perceptions of merit and recognition, leadership actions, talent utilization, and development pathways.
    - See how VA perceptions compare to a related federal workforce (e.g., VHA police perceptions to the U.S. Department of Homeland Security).
    - Track the six key 'drivers' of workforce engagement in the organization: having constructive conversations around employee performance (Question [Q] 46), investing in employee career development (Q1), supporting work/life balance (Q42), fostering an inclusive workplace (Q55), involving staff in decisions affecting their work (Q63), and information-sharing from management (Q64).[42]
- VA AES is a VA-specific survey managed by the VHA National Center for Organization Development. It uniquely measures issues of workplace civility, psychological safety, customer satisfaction, burnout, managing risks, and data application. Data are compared to other VA entities (administration, region, site, workgroups, and demographic indicators). AES is a census survey administered in the fall of the year with data reported at all levels from the national level down through to the workgroup levels. Data reports are available within 45 days of survey close on the VA Workforce Surveys Portal, and through customized data pulls by using the VSSC Pyramid Data Cube.
    - Use the data to obtain unique insights on employee perceptions of workplace civility, psychological safety, customer satisfaction, and burnout, among others.
    - Recognize the business impact of learning from and acting on staff feedback.
        - Sites with greater *workplace civility* also experience lower turnover intentions, less sick leave use, fewer Equal Employment Opportunity complaints, and greater productivity and customer satisfaction.[43]

[42] *Government Accountability Office, Federal Workforce: Additional analyses and sharing of promising practices could improve employee engagement and performance.*

[43] *VHA National Center for Organization Development, ADVANCE Report 1: Creating a Healthier Organization. Available from vhancod@va.gov*

- Employees in *psychologically-safe* work environments are more willing to report errors. Managers/supervisors play a key role in fostering psychological safety through their expectations of and interactions with staff.[44]
- Greater *workforce engagement* is related to employee development opportunities, management seeking (and valuing) employee input, and supportive supervisory actions (communication, diversity, goal setting).[45]

Applying Data

Leaders play an important role in serving as active champions on how to use organizational health data as a learning tool inside VHA, where survey findings help inform areas of positive growth and those in need of further development. Data is beneficial because it provides an opportunity for learning and improvement – to truly understand how staff perceives the workplace and what can be done to effect change. This active learning role is critical to building employee trust and morale, improving employee engagement, and fostering a productive work environment. In fact, the "greatest good" a leader can impart with workforce survey results is to use them as a catalyst for meaningful (non-punitive) dialogue across all levels of the organization about what is working well and what improvements are needed. When leaders respond to survey results as part of organizational learning or feedback, it signals the importance of survey results (and survey participation), and communicates to employees that leaders are listening and that their feedback is valued.

Key Findings

Using organizational health data, commonalities emerge where VHA employees report favorable perceptions of their direct supervisor's actions, connection to the mission, access to safety and security resources, and work unit cooperation, communication, and competency. The following are key findings from this past year's organization health surveys:

- Among the staff that choose to come to VHA, the youngest new hires (less than 30 yrs.) cite VA career and advancement opportunities; mid-career hires (30-49 yrs.) cite VHA career/ advancement, but also benefits; and older hires (50 or more yrs.) equally cite career/advancement and benefits, but also mission to serve Veterans.
- Among the staff that choose to leave VHA, Non-Veterans leave equally for other federal agencies (16.0%) or the private sector (19.0%), while Veterans leave largely for other federal agencies (28.0% vs. private sector 12.0%).

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[44] *Derickson, R., Fishman, J., Osatuke, K., Teclaw, R., & Ramsel, D. Psychological safety and error reporting within Veterans Health Administration hospitals.*

[45] *VHA National Center for Organization Development, FEVS Measures and Drivers of Engagement , Available from vhancod@va.gov*

- Psychological safety is the degree to which employees trust that asking questions, sharing new ideas, raising concerns, disclosing honest mistakes and reporting violations will not be penalized or perceived negatively in the workplace (adapted from Edmondson, 2002). When the staff feels psychologically safe in the workplace, we can be confident that supervisors and managers are engaging in effective leadership behaviors. The AES measures psychological safety at the workgroup and supervisory level. Both groups are responsible for creating a work environment that facilitates learning and innovation, and encourages staff to seek help, admit mistakes, or raise concerns. Most VHA staff seem to agree that they experience moderate psychological safety within their workgroup and higher psychological safety with their direct supervisor.
    - 71% of VHA staff are comfortable talking with their supervisors
    - 61% of VHA staff are encouraged to speak-up if they disagree with a supervisory decision
    - 62% of VHA staff are able to bring up problems or issues in their workgroup
    - 56% of VHA staff feel safe to try something new in their workgroup
- Employee engagement is the degree to which employees think, feel, and act in ways that demonstrate high levels of commitment to the mission, goals and stakeholders of their organization. Increased levels of employee engagement can lead to better individual and organizational performance. Federal agencies use several tools to measure and improve employee engagement, including the Employee Engagement Index (EEI). Comparing the VHA's EEI of 61% with the federal Governmentwide EEI of 64%, it appears that VHA staff are as similarly engaged as most of their colleagues in other agencies of the federal government.
    - VHA's Employee Engagement Index (EEI) = 61%
        - 70% of VHA staff feel they have an Intrinsic Work Experience
        - 66% of VHA staff view Supervisors favorably and approve of their employee-supervisor relationship
        - 47% of VHA staff approve of the way Leaders Lead
    - New IQ (Inclusion Quotient) = 53%
        - Fair = 41%
        - Open = 52%
        - Cooperative = 48%
        - Supportive = 70%
        - Empowered = 55%
    - VHA Workgroup Satisfaction= 3.67
    - VHA Burnout = 2.16

Planned Actions

Areas for organizational health improvement from the VHA AES and FEVS surveys include pay, promotion, and merit/recognition systems, dealing with poor performers, and a desire for greater workforce motivation and concern from senior leaders.

The leader behaviors that drive psychological safety as well as those known to drive employee engagement are essentially the behaviors that align with the principles of servant leadership. Development efforts are underway to provide skill-building opportunities for supervisors and managers at all levels in VHA. These efforts will be piloted in the 4th quarter of FY 2016, and are planned to be available broadly in FY 2017. It is desired that servant leadership become the leadership model of choice among VA supervisors.

VHA has developed an objective metric known as the Servant Leadership (SL) Index by which leaders can monitor their movement toward a servant leadership framework. The SL Index score is a weighted composite of twelve AES items identified as being representative of servant leadership. VA organizations scoring high on the SL Index experience a workplace environment where innovation, learning, and speaking up are valued. Employees in these workplaces are also more satisfied with their supervisors and are more likely to have an effective working relationship with them. Supervisors in environments higher in SL provide clearer communication and give more recognition and praise. VHA plans to begin using this index widely over the next few years.

VHA leaders and facility directors will utilize the Employee Engagement Playbook to assist with meeting the changing needs of VHA employees and the dynamic environment in which they work.[46] Recommended actions include increasing opportunities for employees to provide feedback on their work environment, partnering more closely with local unions, empowering employees to be involved in decision-making, encouraging customer service skill building, creating valuable recognition programs, and being more transparent with staff on needs, desires, goals, and changes that are occurring.

VHA supervisors and leaders will focus on improving psychological safety by:

- Being accessible, approachable, and inclusive.
- Communicating clearly, directly, and honestly with staff.
- Expressing appreciation for mistakes made in good faith, and use error reports as opportunities for learning.
- Setting boundaries for behaviors that are acceptable and unacceptable, and hold people accountable when boundaries are crossed.

[46] *http://vaww.va.gov/ohrm/EmployeeEngagement/EES.asp*

Next Steps to Improve Organizational Health Surveys

VHA is working to limit survey fatigue through centralized survey management. In VHA, a centralized committee coordinates VHA-managed workforce data tools (e.g., AES, IEES, LOS, and VA Nursing Organizational Development Survey, among others) to balance their spacing, duration, and outreach (e.g., sample vs. census population). VHA is working with VA to mitigate VHA employee survey fatigue with VA-managed tools (e.g., FEVS, Organizational Health Instrument, and group-managed surveys such as Office of Information & Technology, Department of Defense (DoD) for Federal Health Care Center sites, etc.).

Low survey participation affects the utility and representativeness of workforce data, particularly at the local or site level, where action planning is most effective. VHA response rates for the VA Exit Survey have ranged from 27% to 32% between FY 2011 and FY 2015, while rates for the entrance survey have ranged from 44% to 50%, and AES rates have ranged from 55% to 63%. VHA plans to do more to increase staff participation by marketing the connectivity of workforce surveys for staff and leaders through emphasizing how the data are used to collectively inform the VA work experience and employee lifecycle: at hire, throughout tenure, and upon leaving. Local leadership and management will creatively encourage staff participation, include staff in data action planning, and value workforce data as a feedback tool from employees to leadership about the work environment - You Speak. VA Listens. Everyone Learns.

Improving cross-data utilization in VHA is key to improving the usefulness of surveys. VHA participates in a number of internal and external (VA/federal) surveys that share commonalities but lack common variables in the datasets. To improve cross-utilization in statistical analysis and benchmarking, VHA is working to have common embedded variables added to the datasets. Adopting a standardized metric as the common code will effectively link multiple data sources for better relational analyses. This will enable VHA to form a singular big picture and action plan by looking at cross-data trends.

Analysis of Recruitment, Retention, and Development Tools

Background

Effective staffing for VHA medical facilities is critical to meeting VHA's goal to ensure timely health care for Veterans. This, in part, is accomplished by successful and thriving recruitment and retention programs nationwide. VHA actively uses scholarships, student loan repayment and funded student programs to supplement recruitment and staffing for both health care professionals and non-clinical staff.

VHA utilizes a comprehensive approach to heightened marketplace competition for clinical and nonclinical health care personnel. This effort is led by WMC with the support and assistance of all levels of VHA, nationwide, including: national marketing and advertising resources, national health care recruitment consultants, field-level nurse recruiters, national recruitment offices (e.g. pharmacy, Veteran's employment, etc.), facility-level recruitment liaisons, trainee programs, and external recruitment vendors. This collaboration between many partners of VHA

helps the organization meet the current and future demands for professionals and continues to position VHA as an exemplary workplace.

Education Assistance and Scholarships

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. 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. EISP awards cover tuition and related expenses such as registration, fees, and books. The NNEI program is limited to funding registered nurses pursuing associate, baccalaureate, and advanced nursing degrees. VANEEP provides tuition and salary replacement dollars allowing scholarship participants to accelerate their degree completion by attending school full time. Participants incur a one to three year service obligation following completion of their academic program. The maximum tuition, books, and fee amounts of a scholarship that may be awarded to an employee enrolled in a full-time curriculum is $38,248 for the equivalent of three years of full-time coursework. As of September 30, 2015, VA has awarded 16,350 scholarships to EISP, NNEI, and VANEEP participants since the program started in 2000. Educational assistance awarded to date totals $247 million, which includes future obligations of $25 million through 2020.

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. Each scholarship recipient receives tuition (up to $15,000) for each year of a degree program (not to exceed a total of $45,000). VHA scholarships require service obligation as a Blind Rehabilitation Specialist enabling VHA to gain commitments for future employment following graduation and certification. In 2015, 15 primary candidates were selected during the initial application cycle for VIOMPSP. HPSP allows VA to provide tuition assistance, a monthly stipend, and other required education fees for students pursuing education/training that would lead to an appointment in one of the top five health professional shortage occupations. The Choice Act extended the HPSP sunset date until December 31, 2019. VA anticipates accepting applications for HPSP in January 2016.

VA Learning Opportunity Residency (VALOR) Program

VALOR provides opportunities for outstanding students to develop competencies in clinical nursing, pharmacy, and medical technology while at an approved VA health care facility. This program encounters students before they enter the VA workforce with hopes of positively impressing VA as a potential employer early on. Opportunities for learning include didactic or classroom experiences, and competency-based clinical practice with a qualified VHA preceptor. Students recruited for the program must have completed the final semester or quarter of the junior year of an approved nursing or medical technologist program or the second professional year in an accredited doctorate of pharmacy program that meets the VA standards

for employment in the occupational series. As of September 30, 2015, 4,594 students have participated in the VALOR program at VHA.

Education Debt and Loan Repayment

Education Debt Reduction Program (EDRP)

VHA has the authority to offer education debt reduction payments for employees who are in difficult to recruit or retain health care positions (typically Title 38 or Hybrid Title 38 employees). The EDRP is centrally funded by VHA. Local VHA facilities prioritize hard-to-recruit and -retain occupations based on facility needs via their facility workforce and succession planning process. Currently, at the conclusion of each 12-month service period, payments are made to EDRP participants equal to the student loan payments made by the participant during the service period not to exceed the award amount for that service period. Participants receive education debt reduction payments while they remain employed by VHA in the position that was approved for EDRP for up to five years, thereby acting as a significant retention incentive. As of September 30, 2015, VHA has awarded 11,756 EDRP awards totaling approximately $268 million since the program started in 2002.

The Choice Act and the Department of Veteran Affairs Expiring Authorities Act of 2014 (Public Law 113-175) increased the maximum incentive award from $60,000 to $120,000 for up to five years and authorizes VA to pay lending institutions directly on behalf of EDRP participants. Once direct lender payment processes are in place, it will allow for a more predictable distribution of funds and for more consistent use of program dollars, however, VHA has had difficulty implementing this using existing infrastructure and payment processes, and is exploring the option of shared service agreements with other government institutions as a possible means of implementation.

Student Loan Repayment Program (SLRP)

The SLRP is designed to serve as a recruitment/retention incentive via three-year service agreements for hard-to-fill positions and highly skilled employees. SLRP helps Title 5 and Hybrid Title 38 employees pay back their qualifying student loans. Participants may receive up to $10,000 per calendar year, with a lifetime maximum of $60,000. An employee receiving this benefit must sign a service agreement to remain in the service of the agency for a period of at least three years. Local facilities link program management to their recruitment, selection, and retention processes. Beginning in FY 2016, the SLRP funding will be decentralized and will need to come from VHA facility or program office local funds.

Challenges

- Current onboarding and recruitment processes at VHA are burdensome and can be detrimental in the hiring and retention of talented professionals wanting to assist our nation's Veterans.
- Local facility and VISN HR staff are integral to implementing successful recruitment and retention strategies. However, there is a challenge with recruitment and retention of HR specialists and managers that is negatively impacting the ability of local VA medical centers, VISNs, and VHA Central Office with performing necessary HR functions. This

directly impacts the ability of VHA to recruit and retain other staff throughout the VHA system. (See the MCO section in Chapter 3 for additional information on HR recruitment and retention challenges).

- Local management of recruitment and retention scholarship and education programs (including EDRP, SLRP, VANEEP, VALOR, etc.) can be burdensome for facilities that need to implement, monitor, and sustain each of them. Almost all programs are currently managed at the medical center and VISN-levels as a collateral duty for a local staff member. This often results in high turnover in the facility coordinator role. Increased frequency of training and availability of resources for new coordinators is needed.

- As a result of provisions in the Choice Act and greater marketing of the program by VA leadership, there is now an increased interest in the use of EDRP as a recruitment/retention tool among VHA employees. This is due, in part, to increases in the maximum loan amount from $60,000 to $120,000 over a five-year period. As a result of the increased awareness and demand, VHA supports additional funds to future EDRP awards in order to better meet access and patient care needs. Despite the additional funding, EDRP will continue to be a highly sought-after incentive and funding will need to continue to be increased in future years to meet the demands of the field.

Planned Actions

- VHA will continue to employ an aggressive, multi-faceted national marketing and outreach strategy to recruit and hire physicians, other health care occupations, and non-clinical staff including targeted efforts to challenging markets such as rural and highly rural, or clinical occupations/specialties (e.g., psychiatry, gastroenterology, etc.). This strategy is detailed in the *2015 VHA National Strategic Recruitment Plan*.[47]

- Collaboration and engagement between VHA program offices, medical center directors, chiefs of staff, and HR leadership is essential to overcome VHA's physician recruitment and onboarding challenges. To this end, VHA has published and distributed the *VHA Enhanced Physician Recruitment Model*[48] to senior leaders to provide direction for addressing challenges faced in prompt and efficient recruitment and onboarding of high-quality physicians.

- VHA developed the HR Restoration and Revitalization (HR3) program in response to a call for HR assistance at the Phoenix VA Healthcare System in Arizona. In the HR3 model, VHA's Workforce Management and Consulting (WMC) Office rapidly deploys HR and Staffing Services, NRP, and other VHA assets, as well as the temporary

[47] http://vaww.pdush.med.va.gov/filedownload.ashx?fid=9196

[48] *Workforce Management and Consulting Office, VA Enhanced Physician Recruitment and Onboarding,* http://vaww.hrro.wmc.va.gov/Recruiter_pilot/National%20Recruitment%20Plan/VA%20Physician%20Recruitment%20and%20Onboarding%20-%20DEPSEC%20May%202015.pdf.

reconfiguration of host facility HR Management Service resources. The goal of this effort is to establish a high-production work environment to develop and implement targeted recruitment strategies, quickly fill vacancies, and onboard new employees for the facility. This model is being incorporated into future planning and processes throughout WMC.

- VHA will continue to streamline and automate EDPR processes and systems. Efforts will focus on ensuring the use of EDRP for recruitment and retention of medical professionals where they are most needed as well as improve efficiency and standardization in field program operations. VHA is also actively engaged in securing additional future year program funding to enhance the overall program infrastructure and expedite, streamline, and standardize administration of this program. The desired enhancements include automation of the front-end application process and data migration as well as the ability to pay lenders directly. Furthermore, VHA has requested funding for expansion of EDRP in the FY 2017 draft President's Budget submission to OMB.

Analysis of Trainee Recruitment and Retention

Background

VA, through the OAA, collaborates with medical schools, universities, and colleges in its training programs, maintaining more than 7,200 individual affiliation agreements at more than 1,800 educational institutions. OAA now provides clinical education to more than 120,000 trainees in some 40 disciplines each year. The vast majority of trainees, such as medical students, are unpaid. Approximately one-quarter of VA trainees—those at more advanced levels of their clinical education who are able to deliver clinical care under the supervision of VA staff, such as physician residents, NP trainees, and psychology interns, receive stipends provided by VA for the time they work at a VA facility.

Investing in health professions trainees yields substantial return for VA and the Nation:

- Trainees powerfully augment the VA clinical workforce by providing substantial direct care to patients in a cost-effective manner.
- Trainees provide a pipeline of well-trained and VA-knowledgeable health care professionals to meet VA's ongoing clinical staffing needs, including the unique and specific health care needs of Veterans.
- The academic focus of VA attracts high-caliber clinicians who deliver state-of-the-art care to Veterans in VA facilities.
- The education mission imbues VA facilities with a sense of inquiry and an orientation toward continuous quality improvement.
- VA-trained clinicians serve the health care needs of the entire country—including caring for the many Veterans who receive part or their entire health care in non-VA settings.

Major Training Programs

Medical and Dental Education

Nearly two-thirds of all U.S. medical students train in VA facilities prior to their graduation.[49] Furthermore, 60% of VA physicians participated in VA training programs prior to employment.[50] Nearly 80% of VA physicians have faculty appointments at an educational institution.[51] VA's affiliations and the educational environment contribute to VA's mission by enabling the recruitment of high quality faculty members to VA staff. About 99% of the more than 2,300 VA graduate medical education programs are sponsored in the name of an affiliate, generally a medical school or teaching hospital. About one-third of VA's dental residency training programs are sponsored by VA, with 80% of these in general practice dentistry. The remaining two-thirds of the dental residency programs are sponsored by dental or medical schools, universities, or teaching hospitals.[52]

Associated Health Education

VA is a leader in the training of associated health professionals. Through affiliation agreements with more than 1,800 unique accredited college and university programs, training stipends are provided annually to over 4,600 trainees in fifteen disciplines. Funding is available for clinical pastoral education, dietetics, optometry, physician assistants, podiatry, as well as a range of mental health and rehabilitation professions. Over 25 training programs are administered, ranging from blind rehabilitation to marriage and family therapy to imaging tech to podiatry.[53] Nearly 70% of current VA optometrists and psychologists participated in VA training programs prior to their employment at VA.[54]

Nursing Education

VA maintains academic partnerships with nursing schools around the country to provide highly educated nurses to the VA and the Nation. Through these partnerships, VA provides opportunities for educational and practice innovations, expands faculty and professional development, implements faculty practice to increase Veteran access to care, and increases recruitment and retention of VA nurses. Major nursing education initiatives include the VA Nursing Academic Partnerships (VANAP) program, with both an Undergraduate and a Graduate focus; the Post-Baccalaureate Nurse Residency program; and the Psychiatric/Mental Health NP Residency program.

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[49] *FY 2014 OAA Annual Health Services Training Report. Generated from 2012-2013 Annual Association of American Medical Colleges Graduation Questionnaire.*

[50] *FY 2014 VA All Employee Survey, Demographic section.*

[51] *FY 2014 OAA Annual Health Services Residency Training Report.*

[52] *CY14-15 OAA Training Database.*
[53] *CY14-15 OAA Training Database.*
[54] *FY 2014 VA All Employee Survey, Demographic section.*

Advanced Fellowships

The VA Advanced Fellowships Program:

- Develops physician, dentist, and associated health clinical proficiency, academic scholarship, and leadership in emerging areas of health care important to VA.
- Contributes to a talented, well-trained staff recruitment pool for VA.
- Fosters an atmosphere of scientific inquiry and excellence within VA.

Advanced Fellowship program directors manage the fellowship programs at VA facilities. Working closely with their affiliates, program directors plan didactic experiences, clinical rotations, and research training for the fellows. Most fellowship sites are selected through a competitive process administered by OAA. Fellowship participants serve as trainees on a temporary, full-time employment basis at one of the fellowship sites for the duration of their appointment.

Advanced Fellowships include: Quality Scholars, Patient Safety, Robert Wood Johnson Clinical Scholars, Health Systems Engineering, Health Services Research, Medical Informatics, Clinical Simulation, Health Professions Education Evaluation, Mental Illness Research, Education and Clinical Center, Women's Health, Psychiatric Research, Advanced Geriatrics, Polytrauma/Traumatic Brain Injury, Spinal Cord Injury, Addiction Treatment, War-related Illness and Injury, Multiple Sclerosis, Parkinson's Disease Research, Education, and Clinical Centers, and Dental Research.

Challenges

Most trainees are not paid by VA, less than 10,000 of the 120,000 trainees in VA each year are entered in the Personnel and Accounting Integrated Data System (PAID) system, and therefore are not easily tracked. Instead, the majority of the trainees are either on Without Compensation (WOC) appointments or paid through disbursement agreements outside of the VA payroll system. This means that most trainees are not captured in a formal system of record at the national level and thus it is challenging for HR managers to find and offer permanent positions to the trainees.

Planned Actions

Expansion of Health Professions Education

The Choice Act authorizes VA to add 1,500 new physician resident positions over a five-year period through its GME portfolio. This initiative focuses on medical resident positions in primary care (family medicine, internal medicine, geriatrics) and mental health (psychiatry and subspecialties), those facilities in health professional shortage areas, areas having a documented shortage of physicians, or facilities with high concentrations of Veterans. This will bring residents, and therefore a workforce pipeline, into smaller and underserved communities and enables VA to build partnerships with new academic affiliates.

Clinical Trainee Registration and Tracking System

A clinical trainee registration and tracking system would allow trainees to pre-register into VA, download and fill out application forms, link them to the mandatory training for trainees, and begin the background screening/Personal Identification Verification badge processes. Field facilities would have the ability to review the processing of trainees through their own administrative portal, develop local reporting, and correspond with trainees through email. National offices would have access to the full database in order to run national reports, develop data concerning trainee to employee conversion, and maintain demographic and contact data on former trainees. This would enable active recruitment efforts directed at former trainees and can become a critical human resource system for VA. Negotiations are underway to determine if HR SMART or Identity Control and Management systems can be modified to enable the identified and necessary functionalities.

Consultative/Strategic Recruitment Approach

Selecting officials and HR are working to recognize current and former VA health professional trainees as a priority applicant pool for Title 38 and Hybrid Title 38 vacancies and create processes to expedite new hiring. Early consultation between HR and internal clinical service chiefs and training directors needs to occur to identify viable candidates before initiating recruitment.

Chapter 3: Workforce Analysis

Section 1: Workforce Trend and Rate Analysis

This section summarizes the analysis of workforce trends in VHA. It includes a summary of VHA historical workforce data, public and private sector comparisons, workforce projections, and results of surveys to assess employee engagement and job satisfaction.

Historical Workforce Trends

Onboard strength in VHA has increased by 17.7% since FY 2011 (+49,991 employees). Following the economic downturn in FY 2008, VHA experienced several years of declining growth rates, but with various hiring initiatives (Mental Health Hiring Initiative in FY 2013 and the recent Choice Act hiring initiative) the rate rebounded in FY 2015 to a 5-year high of 4.6% (Table 3). At the end of FY 2015, VHA's total onboard workforce including full- and part-time employees was 312,704, up from 269,908 in FY 2011.

During the same five years, VHA experienced losses of 123,104 employees. Nearly half (48.4%) of those losses were the result of resignations or transfers to other government agencies (i.e. quits), and 32.4% were from voluntary retirements. While the rate of retirements has remained stable, the rate of quits has rebounded since the economic downturn in FY 2008 to equal the FY 2007 rate of 4.6%.

To maintain and grow the workforce, a total of 171,389 new gains were required over this 5-year period, increasing from approximately 29,000 gains in FY 2011 to 41,000 gains in FY 2015. The percentage of clinical hires (defined as Title 38 and Hybrid Title 38 employees) increased from 58% of total hires in FY 2011 and 2012 to 62-66% in FY 2013-2015.

Table 3: VHA Total Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	269,908	277,152	288,828	298,764	312,704	N/A
Net Increase in Onboard	7,195	7,244	11,676	9,936	13,940	49,991
Onboard Percent Change at End of FY	2.7%	2.7%	4.2%	3.4%	4.7%	17.7%
Voluntary Retirement Rate	2.7%	2.8%	2.8%	2.9%	2.8%	2.8%
Quit Rate	3.8%	4.0%	4.1%	4.4%	4.6%	4.2%
Total Loss Rate	8.3%	8.6%	8.6%	9.0%	8.9%	8.6%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

Loss Rate Comparisons

Job Openings and Labor Turnover Survey (JOLTS)

The BLS Job Openings and Labor Turnover Survey (JOLTS) is a monthly survey that provides data on job openings, hires, and separations. Like VHA's workforce planning data, the JOLTS defines the number of employees as full- and part-time employees. However, unlike VHA data reported elsewhere in this document, it also includes intermittent employees. Quits, which JOLTS defines as employees who left voluntarily (excluding retirements and transfers to other locations), were much higher in the private sector, at 24.6% as compared to the federal government rate of 4.6%. Quit rates among the health care and social services industry were 18.8% in calendar year 2014 as compared to 4.2% for the VHA total workforce using the JOLTS criteria and calendar year timeline for an apples-to-apples comparison (Figure 7).

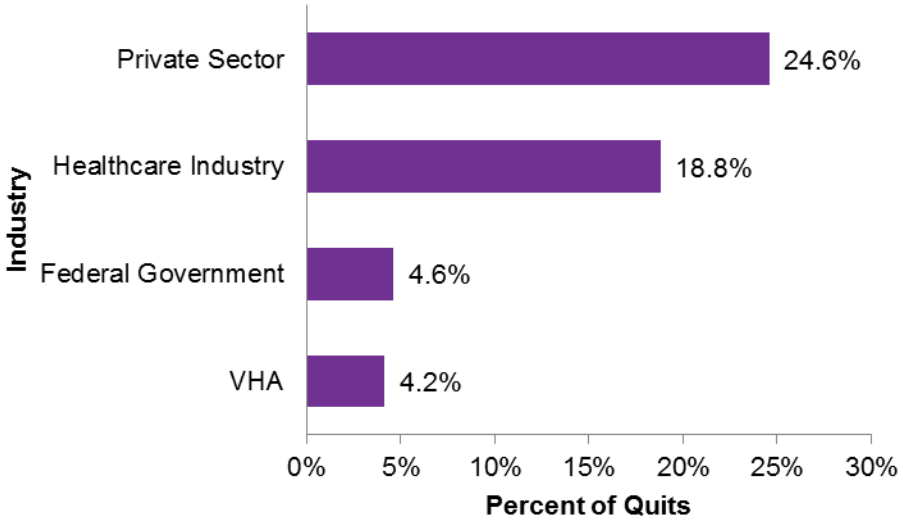

Figure 7: BLS Job Opening and Labor Turnover Survey (JOLTS) for Quits in CY 2014.

Note: Data retrieved from http://data.bls.gov/pdq/querytool.jsp?survey=jt in August 2015. JOLTS data (Private Sector, Healthcare, and Federal Government) and VHA are for Calendar Year 2014 Data are not seasonally adjusted.

Total losses (30.3%) were also much higher for the health care industry compared to the federal government (14.1%), and VHA (10.8%), as seen in Figure 8. NOTE: The criteria used to calculate the VHA loss rate for this comparison were modified to reflect the JOLTs criteria and unlike previous workforce data sets include intermittent, medical residents, and trainees. The VHA data were also modified to reflect calendar year rather than fiscal year.

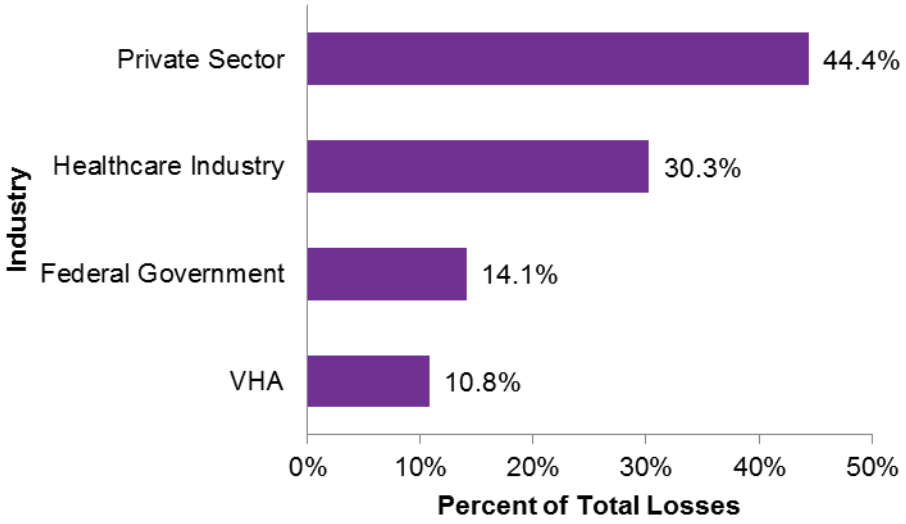

Figure 8: BLS Job Opening and Labor Turnover Survey (JOLTS) for Total Losses in CY 2014.

Note: Data retrieved from http://data.bls.gov/pdq/querytool.jsp?survey=jt in August 2015. JOLTS data (Private Sector, Healthcare, and Federal Government) and VHA are for Calendar Year 2014. Data are not seasonally adjusted.

Office of Personnel Management FedScope

Another source of comparison data is the OPM FedScope database, which combines personnel data submitted from 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 4.1% compares favorably with the average for all cabinet level agencies (3.6%), and the VHA total loss rate of 10.0% was the same as for all cabinet level agencies (10.0%) in FY 2014 (Table 4).

Table 4: OPM FedScope Percent of Losses by Department in 2014.

Agency	Quit	Retirement	Termination or Removal	Death	Other Separation	Separation from Federal Civil Service (Total Losses)
Department of the Air Force	3.4%	3.1%	2.7%	0.2%	0.0%	9.3%
Department of Agriculture	5.1%	3.1%	10.5%	0.2%	0.0%	18.8%
Department of the Army	4.1%	3.4%	2.8%	0.2%	0.0%	10.5%
Department of Commerce	4.8%	2.1%	2.4%	0.2%	0.0%	9.5%
Department of Defense	4.7%	4.1%	2.2%	0.2%	0.0%	11.3%
Department of Justice	1.9%	3.8%	0.4%	0.1%	0.0%	6.1%
Department of Labor	2.2%	3.7%	0.6%	0.2%	0.0%	6.8%
Department of Energy	2.4%	4.2%	0.8%	0.1%	0.0%	7.6%
Department of Education	3.1%	3.0%	1.4%	0.1%	0.0%	7.6%
Department of Health And Human Services	3.7%	2.3%	3.5%	0.1%	0.0%	9.7%
Department of Homeland Security	3.5%	2.2%	1.4%	0.1%	0.0%	7.2%
Department of Housing And Urban Development	1.9%	5.3%	0.6%	0.3%	0.0%	8.2%
Department of the Interior	5.0%	4.1%	12.9%	0.1%	0.0%	22.3%
Department of the Navy	2.4%	3.5%	0.8%	0.2%	0.0%	6.9%
Department of State	3.0%	2.6%	2.4%	0.2%	0.0%	8.3%
Department of Transportation	1.0%	4.4%	0.6%	0.1%	0.0%	6.1%
Department of the Treasury	4.4%	4.5%	2.2%	0.3%	0.0%	11.4%
Department of Veterans Affairs	3.9%	3.1%	2.4%	0.2%	0.0%	9.7%
Cabinet Level Agencies	3.6%	3.3%	2.9%	0.2%	0.0%	10.0%
Veterans Health Administration	4.1%	3.1%	2.6%	0.2%	0.0%	10.0%

Note: data retrieved from http://www.fedscope.opm.gov/index.asp in August 2015.

VHA Quits by Year of Employment

VHA performs an annual analysis that tracks quits among new hires for twelve full months after their date of hire, and repeats the analysis each year to analyze trends in new hire quits for five years. The most recent analysis conducted for employees hired between FY 2008 and FY 2014 concludes:

- On average, 26.9% of VHA new hires quit within the first five years of employment.
- The rate of new hire quits within the first two years of employment has increased from ble within the first year ranged from 10.0% to 11.1%, but increased to 12.2% in FY 2014.

Table 5: VHA Total Workforce Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	10.7%	16.0%	25.3%
FY 2009	10.0%	16.3%	27.0%
FY 2010	10.3%	17.3%	28.3%
FY 2011	10.7%	17.5%	
FY 2012	11.4%	18.0%	
FY 2013	11.1%	18.7%	
FY 2014	12.2%		
Average	10.9%	17.3%	26.9%

Workforce Projections

Onboard

In total, onboard strength will increase by 28.6% through FY 2022. These projections include consideration for additional hiring estimates as a result of the increased funding afforded by the Choice Act, as well as considerations of past trends in workforce growth.

Table 6: VHA Total Workforce - Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	312,704	325,212	336,920	349,049	361,615	374,633	388,120	402,092	N/A
Employees Eligible for Regular Retirement		51,709	53,657	55,452	57,422	59,731	59,558	59,115	56,663
Voluntary Retirements	2.8%	2.8%	2.8%	2.9%	2.9%	3.0%	3.0%	2.9%	2.9%
Quits	4.6%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
Total Losses	8.9%	8.6%	8.7%	8.7%	8.8%	8.8%	8.8%	8.8%	8.7%
Gains Needed		40,483	40,897	42,521	44,301	46,173	47,722	49,252	44,478

Note: Percent are calculated using the Employees Onboard at the End of FY for each year.

Supervisors

Historical Workforce Trends for Supervisors

The number of supervisors in VHA has increased by 19.1% over the last five years in comparison with the 17.7% increase in the workforce overall. Since FY 2011, loss rates have continued to climb, but remained steady in FY 2014 and 2015. Although voluntary retirements decreased in FY 2015 to a 5-year low of 4.1%, regrettable losses (i.e., quits) increased to a 5-year high of 2.9%, and overall losses remained high at 7.6%. This is significant because increased quits means that more and more supervisors are leaving VHA prior to retirement, which has not historically been the case.

Table 7: VHA Supervisor Workforce Trends

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	24,266	24,917	25,944	26,980	28,245	N/A
Net Increase in Onboard	837	651	1,027	1,036	1,265	4,816
Onboard Percent Change at End of FY	3.6%	2.7%	4.1%	4.0%	4.7%	19.1%
Voluntary Retirement Rate	4.4%	4.3%	4.4%	4.6%	4.1%	4.3%
Quit Rate	1.8%	2.0%	2.3%	2.4%	2.9%	2.3%
Total Loss Rate	6.8%	7.0%	7.1%	7.6%	7.6%	7.2%

Supervisors currently make up 9.0% of the total workforce (Table 8). VA has identified a best practice for the supervisor to workforce ratio of 1:15. VHA has maintained a ratio of approximately 1:11 for the last several years.

Table 8: VHA Total Workforce to Supervisor Ratio Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Supervisors	24,266	24,917	25,944	26,980	28,245
Total Employees	269,908	277,152	288,828	298,764	312,704
% of Workforce	9.0%	9.0%	9.0%	9.0%	9.0%

Projected Workforce Data for Supervisors

The number of supervisors is expected to continue to grow for a total increase of 28.1% over the next seven years with growth of 4.0% in FY 2016 and then leveling off to 3.6% each year through FY 2022. To replace losses and increases in onboard numbers of supervisors as projected, VHA will need to gain approximately 23,348 by the end of FY 2022, for an average of 3,335 per year.

Table 9: VHA Supervisor Workforce - Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	28,245	29,269	30,323	31,414	32,545	33,717	34,931	36,188	N/A
Employees Eligible for Regular Retirement		6,592	6,774	6,812	6,891	6,971	6,815	6,730	6,798
Voluntary Retirements	4.0%	3.7%	3.8%	3.8%	3.8%	3.9%	3.7%	3.6%	3.8%
Quits	2.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total Losses	7.5%	6.7%	6.8%	6.8%	6.8%	6.8%	6.7%	6.6%	6.7%
Gains Needed		2,990	3,115	3,219	3,346	3,477	3,547	3,653	3,335

Note: Percent are calculated using the Employees Onboard at the End of FY for each year.

Executive Leadership

Executive positions include quadrad level positions at the medical centers, VISN directors, deputy directors and chief medical officers, as well as VHA Central Office chief officers and other SES/SES equivalent positions. The vacancy rate for these positions was 21.7%. In addition, a large portion of employees in these positions will be retirement eligible over the next seven years. Chapter two outlines the VHA response to this leadership crisis.

Table 10: VHA Leadership - Vacancies and Retirement Projections

VHA Leadership	# of total positions	# of vacancies	% eligible for retirement in next 7 years
Medical Center Directors	140	28	74.3%
Medical Center Deputy Directors	14	5	55.6%
Medical Center Assistant Director	53	9	29.5%
Medical Center Associate Directors	143	17	51.6%
Medical Center Nurse Executives/ADPCS	141	17	75.8%
Medical Center Chiefs of Staff	140	19	90.1%
VISN Directors	21	9	100.0%
VISN Deputy Director	21	4	64.7%
VISN Chief Medical Officers	21	6	93.3%
Program Office Chief Officers	20	4	68.8%
Assistant Deputy Under Secretary for Health (ADUSH)	9	4	60.0%
Other SES/SES EQV	124	50	82.4%

Note: Number of positions was calculated based on onboard and vacancies. Data was compiled from Position Management Systems and PAID as of 9/30/2015.

Section 2: Workforce Analysis - Diversity

This section summarizes statistics on dimensions of the diversity of the VHA workforce. It includes data on age and generational makeup of the workforce; analysis of race and gender, disability, and Veteran employee representation; and a summary of supervisor, and executive leadership diversity measures.

Average Age and Generational Makeup

The average age of VHA employees has remained stable at 48 years of age for the last five years. During this time, the percentage of employees age 55 and over has remained consistent at approximately 33% of the workforce. The percentage of employees under age 35 has increased from 14.5% to 15.7% in that same time period (Figure 9).

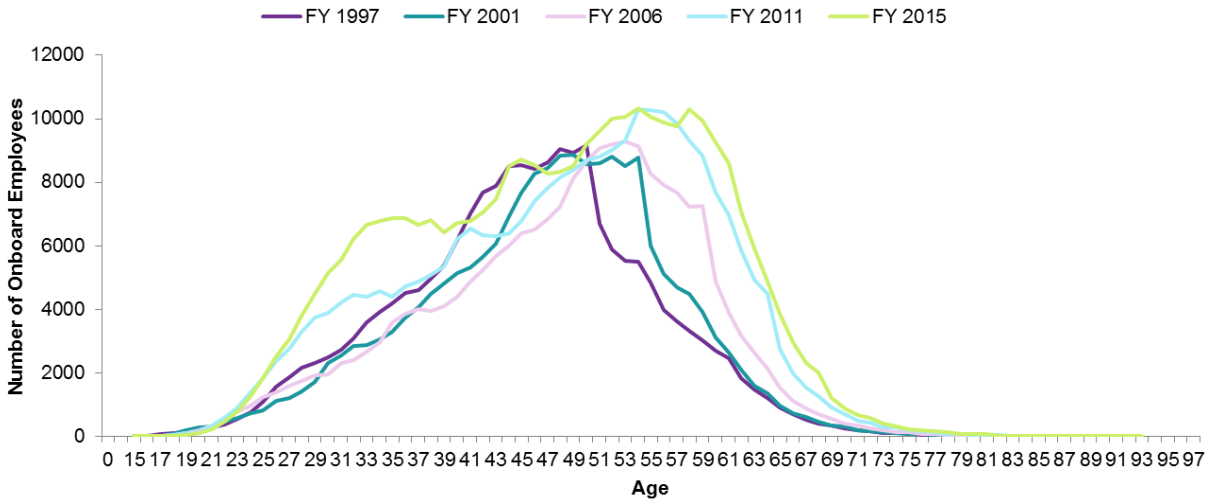

Figure 9: Age of VHA Employees

By generation, "Baby Boomers" continue to make up the majority (44.4%) of the VHA workforce, and they accounted for 49.1% of the losses in FY 2015. "Generation X" makes up the next largest group of VHA employees (36.8%), but a smaller percentage of VHA losses (26.0%). Millennials only make up 17.9% of the workforce, but 22.4% of VHA losses. This trend reflects retirements among "Baby Boomers" and a higher rate of turnover among "Millennials" that may be reflective of early career moves and generational differences in job stability, with "Generation X" having the lowest proportion of losses indicative of mid-career job stability (Figure 10).

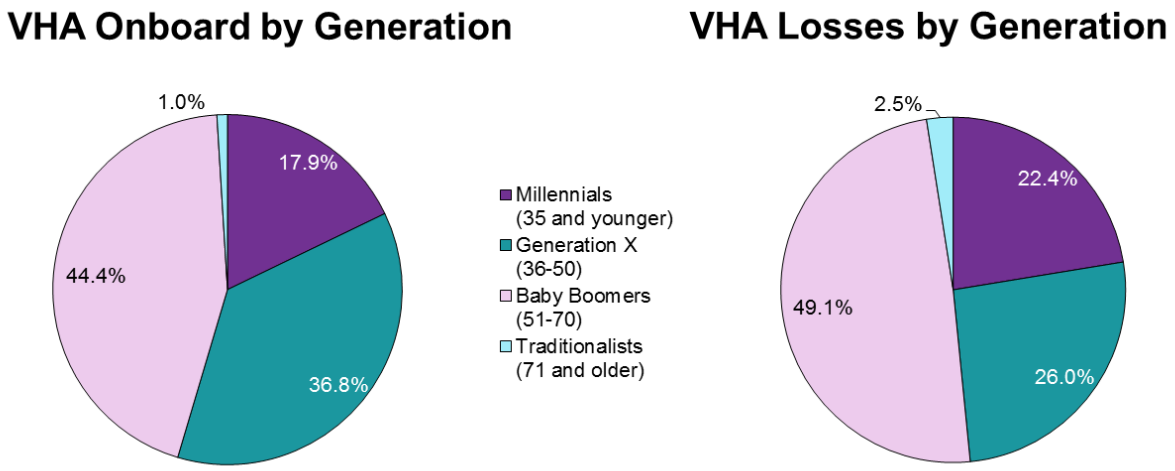

Figure 10: VHA FY 2015 Onboard and Losses by Generation

Diversity Analysis

Overall in FY 2015, VHA's workforce was 40.8% minority and 60.8% female. Hispanic females and males, representing 0.64% and 0.85% ratios, respectively, are the only minority groups, besides other/multiple race (0.67% and 0.88% ratios), that are below the Relevant Civilian Labor Force (RCLF) comparison statistics for those groups. The RCLF data are based on the 2010 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 (Figure 11). VHA continues to pursue national recruiting events that are aimed at diversity and minority outreach.

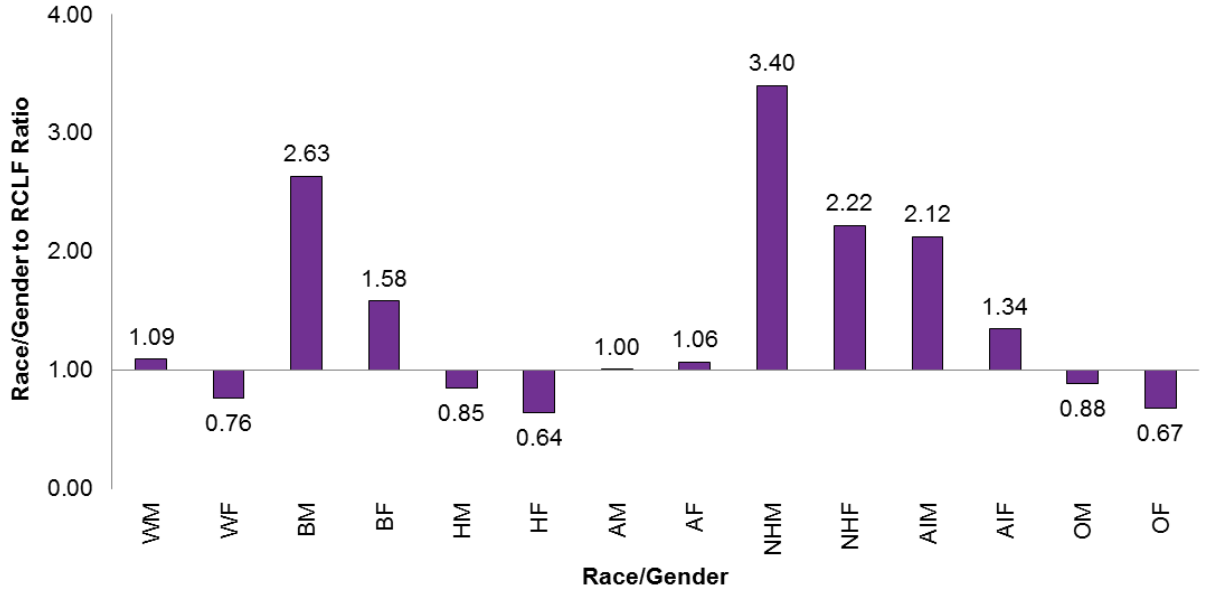

Figure 11: VHA Total Workforce Race/Gender to RCLF Ratio

The workforce distribution of individuals with non-targeted disabilities continued to increase to the current level of 11.6%, while individuals with targeted disabilities increased to 2.2% of the VHA workforce (Table 11). 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.

Table 11: Disability Representation for VHA Employees

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Non-Targeted Disability	8.7%	9.9%	10.5%	11.2%	11.6%
Targeted Disability	1.6%	1.9%	2.0%	2.1%	2.2%

At the end of FY 2015, the percentage of Veterans in the VHA workforce was 31.2%, reflecting an increase from the FY 2011 level of 30.8% (Table 12). In FY 2015, 36.1% of the total workforce new hires were Veterans (Table 12), but this represents a decrease over the peak in FY 2014 of 41.1%. VHA will continue to utilize special hiring authorities such as the Veterans Readjustment Authority, Veterans Employment Opportunity Act, 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 12: VHA Total Workforce Veteran Onboard and New Hires

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Veterans Onboard	30.8%	30.6%	30.8%	31.3%	31.2%
New Hire Veterans	32.7%	35.4%	36.3%	41.1%	36.1%

VHA continues to work towards accomplishing the Veteran hiring goal of 40%. While VACO, Veterans Benefits Administration, and National Cemetery Administration have exceeded the goal for Veteran representation, the goal continues to be difficult to attain for VHA due to the low percentages of qualified Veterans in clinical (Title 38 hybrid and non-hybrid) occupations. As of FY 2015, nearly two thirds of the VHA workforce is comprised of employees in clinical occupations; however, only 18.2% of Title 38 (hybrid and non-hybrid) clinical employees are Veterans.

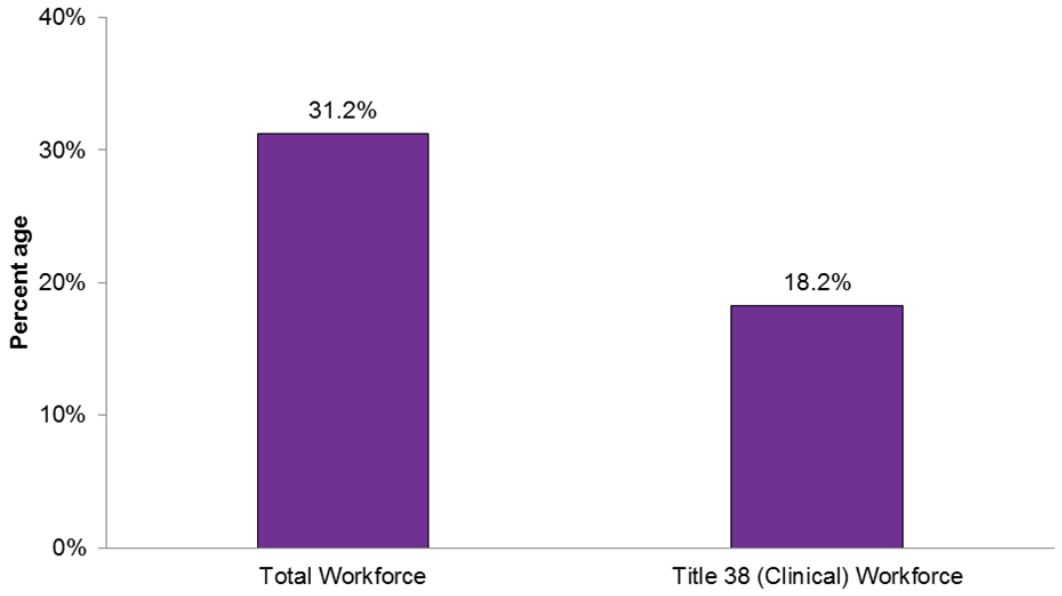

Figure 12: FY 2015 Veterans in Total VHA Workforce Compared to Clinical Workforce (Title 38 Hybrid and Non-Hybrid) Occupations

In addition, the total loss rate for Veterans is also higher than the total VHA workforce. Veteran employees' loss rates ranged from 10.0% to 11.9% between FY 2011 and FY 2015. In comparison, the total loss rate for the total workforce ranged from 8.3% to 9.2% between FY 2011 and FY 2015 (Figure 13). More than half (54.5%) of total losses among Veterans were due to quits in FY 2015, with quit rates among Veterans ranging from 4.3% to 6.5% between FY 2011 and FY 2015. In comparison, the total workforce quit rates ranged from 3.8% to 4.8% over the same timeframe.

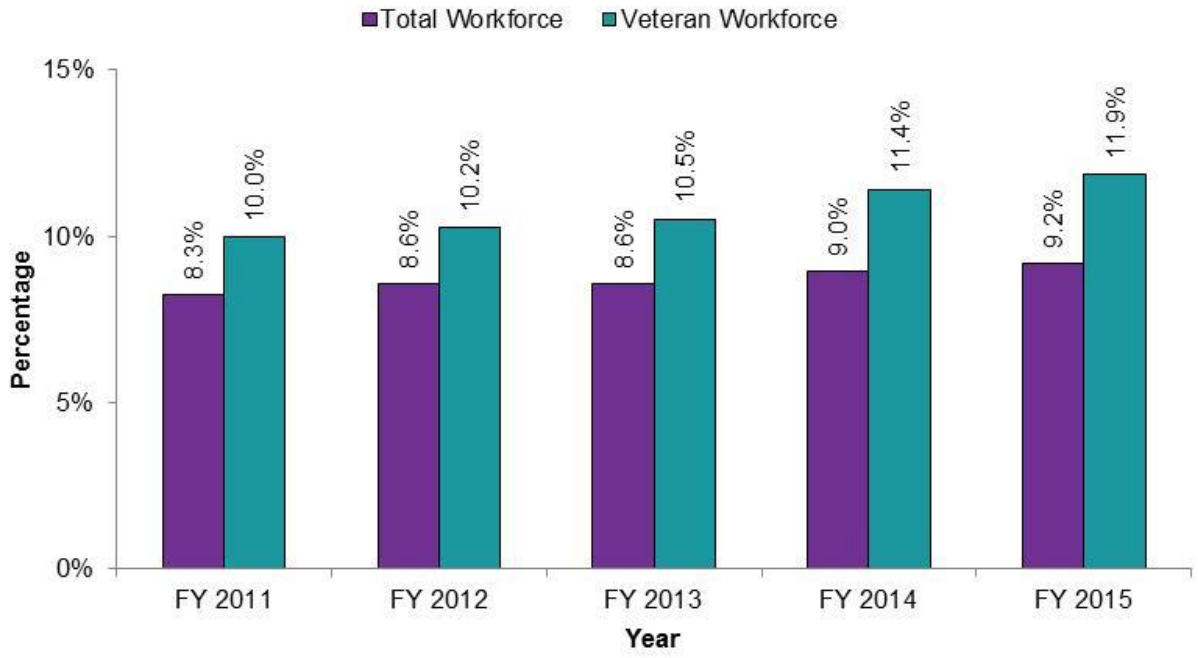

Figure 13: Total Loss Rate for Total VHA Workforce versus Veterans

Supervisor Diversity

Overall, the supervisory workforce is less diverse than the VHA total workforce. As of FY 2015, 32.7% of supervisors were minorities (8.1 pp below VHA overall) and 51.9% were female (8.9 pp below VHA; Figure 14Figure 14).

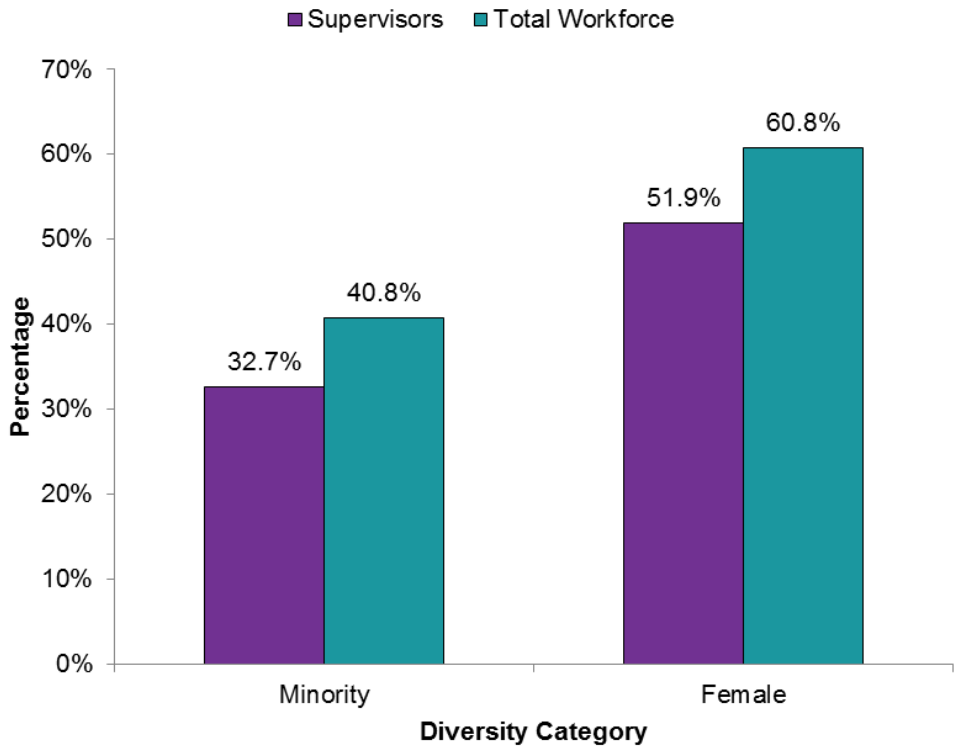

Figure 14: FY 2015 Minority and Female Representation Among Supervisors Compared to VHA Total Workforce

Compared with the total VHA workforce (Table 11), fewer VHA supervisors (Table 13) have targeted and non-targeted disabilities. However, representation of supervisors with disabilities has steadily increased since FY 2011. Of note, however, supervisors who are Veterans are represented at a greater percentage (33.9%) than Veterans in the total VHA workforce (31.2%).

Table 13: Disability and Veterans Representation for VHA Supervisors

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Non-Targeted Disability	7.9%	9.1%	9.3%	10.0%	10.0%
Targeted Disability	1.1%	1.2%	1.3%	1.3%	1.3%
Veterans	33.1%	33.1%	33.5%	33.8%	33.9%

Executive Leadership Diversity:

Table 14: FY 2015 VHA Leadership Race/Gender Data

Executive Title	% Male	% Female	% Minority Male	% Minority Female	% Minority
Medical Center Directors	62.8%	37.2%	8.0%	4.4%	12.4%
Medical Center Deputy Directors	55.6%	44.4%	11.1%	22.2%	33.3%
Medical Center Assistant Director	65.9%	34.1%	20.5%	6.8%	27.3%
Medical Center Associate Directors	61.9%	38.1%	11.9%	7.9%	19.8%
Medical Center Nurse Executives/ADPCS	16.1%	83.9%	0.8%	15.3%	16.1%
Medical Center Chief of Staffs	76.9%	23.1%	20.7%	4.1%	24.8%
VISN Directors	75.0%	25.0%	0.0%	0.0%	0.0%
VISN Deputy Director	52.9%	47.1%	23.5%	11.8%	35.3%
VISN Chief Medical Officers	66.7%	33.3%	26.7%	0.0%	26.7%
Program Office Chief Officers	50.0%	50.0%	12.5%	6.3%	18.8%
Assistant Deputy Under Secretary for Health (ADUSH)	40.0%	60.0%	0.0%	0.0%	0.0%
Other SES/SES EQV	59.5%	40.5%	6.8%	9.5%	16.2%

Section 3: Workforce Analysis - Mission Critical Occupations

Effective workforce planning segments the workforce to identify occupations with the most critical staffing needs. This process is necessary to determine challenges and identify strategies to improve recruitment and retention of staff in occupations that are critical to the mission. As a result, the annual VHA workforce planning guidance instructs facilities to identify their top ten Mission Critical Occupations (MCOs) for recruitment and retention. VISNs aggregate the input from facilities to define their VISN-wide top ten occupations. VISN aggregate rankings are used to build the VHA-wide list. The same process is used to determine the top five physician and nurse specialties.

VHA's criteria for determining MCOs at the local level include consideration of staffing shortages, number of vacancies or length of time vacancies have been open, mission critical nature of the position, high turnover and losses within the first year of employment, high number of anticipated hires in future years, and staff satisfaction issues.

This section includes a summary of analyses for these occupations.

Table 15: VHA's Mission Critical Occupations

Rank	Mission Critical Occupations	Projected Losses FY 2016 Through FY 2022	Projected Hires FY 2016 Through FY 2022
1	0602 Medical Officer (Physician)*	19,384	28,595
2	0610 Nurse (Registered Nurse - RN)*	39,256	62,800
3	0201 Human Resource Mgmt (HRM)	2,391	3,947
4	0633 Physical Therapist (PT)*	1,362	2,453
5	0603 Physician Assistant (PA)*	1,674	2,290
6	0180 Psychology*	4,076	8,041
7	0644 Medical Technologist (MT)	2,539	3,008
8	0631 Occupational Therapist (OT)	696	1,144
9	0647 Diagnostic Radiologic Technologist (DRT)	1,657	2,870
10	0660 Pharmacist	3,399	6,154
	Total	76,436	121,301

**Also designated by the OIG as one of the top five staffing shortage occupations in September, 2015 OIG Determination of VHA Occupational Staffing Shortages report.*[55]

[55] *Department of Veterans Affairs/Office of Inspector General. (2015). OIG determination of Veterans Health Administration's occupational staffing shortages. (Report No. 15-03063-511). Retrieved from* http://www.va.gov/oig/pubs/VAOIG-15-03063-511.pdf

Table 16: VHA Top Medical Officer and Nurse Specialties and Other Occupational Priorities

Top 5 Medical Officer (Physician)	Top 5 Nurse Specialties	Other Priorities (Ranked 11-15)
31 Psychiatry	88 Staff Nurse	0605 Nurse Anesthetist
P1 Primary Care	87 RN, Mgr/Head Nurse	0649 Medical Instrument Technician
25 Gastroenterology	75 Nurse Practitioner	0620 Practical Nurse
16 Emergency Medicine	Q2 RN/Staff-Mixed	0675 Medical Records Technician
07 Orthopedic Surgery	Q6 RN/Staff-Inp Clc	0640 Health Aid and Technician

Trend Analysis for MCO Group

Onboard Growth

At 5.9%, the FY 2015 MCO group average onboard growth rate is higher than the VHA total workforce rate of 4.7%. Physical therapist (9.7%), psychology (8.0%), occupational therapist (6.8%), physician assistant (6.4%), pharmacist (6.3%), and nurse (6.0%) had higher rates of growth than the MCO group average. See Figure 15 for the growth rate of all occupations.

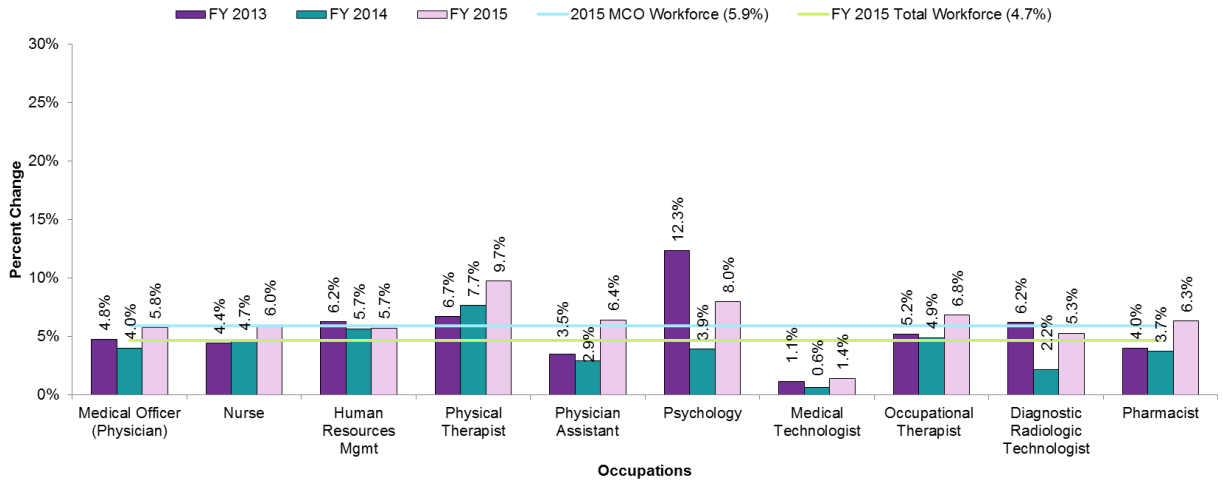

Figure 15: Percent Change in Onboard for VHA Mission Critical Occupations

Voluntary Retirements

The FY 2015 voluntary retirement rate (Figure 16) decreased by 0.1 pp in FY 2015 for the MCO group, but is equal to the total workforce rate (2.8%). Five of the MCOs had an increase in voluntary retirements (physician, human resource management, psychology, occupational therapist, and diagnostic radiologic technologist), while the other five had decreases. In addition, nurse (3.0%), HRM (3.4%), and medical technologist (3.9%) had rates higher than the MCO and total workforce average. HRM had the largest increase in retirement rate (+0.7 pp).

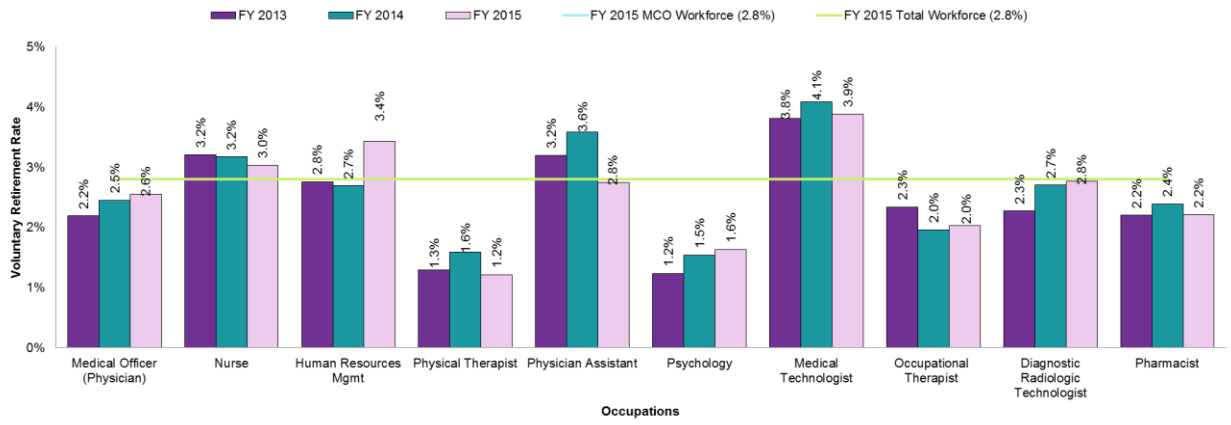

Figure 16: Voluntary Retirement Rate for VHA Mission Critical Occupations

Quits

The quit rate (Figure 17) for the MCO group remained the same (4.2%) in FY 2015 and is slightly lower than the VHA total workforce (4.6%). Five of the individual occupations' quit rates increased in FY 2015 (HR management, psychology, medical technologist, physical therapist, and occupational therapist). In addition, HR management (7.1%), medical officer (physician, 5.2%), and physician assistant (4.9%) had rates higher than the MCO average. HR management had the largest increase in quit rate (+1.3 pp), while DRT (-0.6 pp) had the largest decrease.

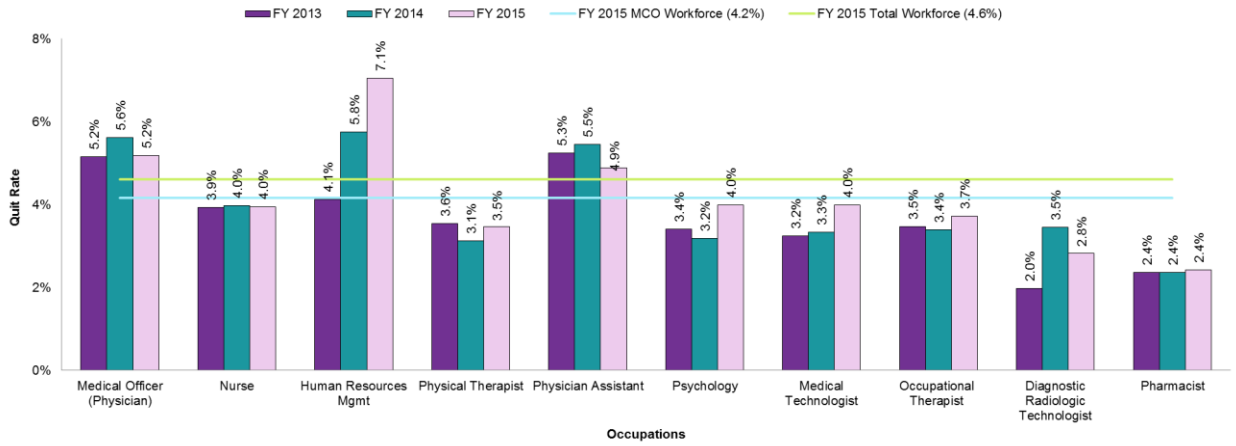

Figure 17: Quit Rate for VHA Mission Critical Occupations

Total Losses

The total loss rate (Figure 18) for the MCO group decreased by 0.2pp overall in FY 2015, and at 7.8% is lower than the total workforce (8.9%). Three of the occupations had an increase in total loss rates (HR management, occupational therapist, and medical technologist). In addition, HR management (11.4%), physician assistant (10.3%), physician (8.4%) and medical technologist (8.3%) all had rates higher than the MCO average. HR management had the largest increase of (+2.4 pp), while DRT (-1.0 pp) had the largest decrease.

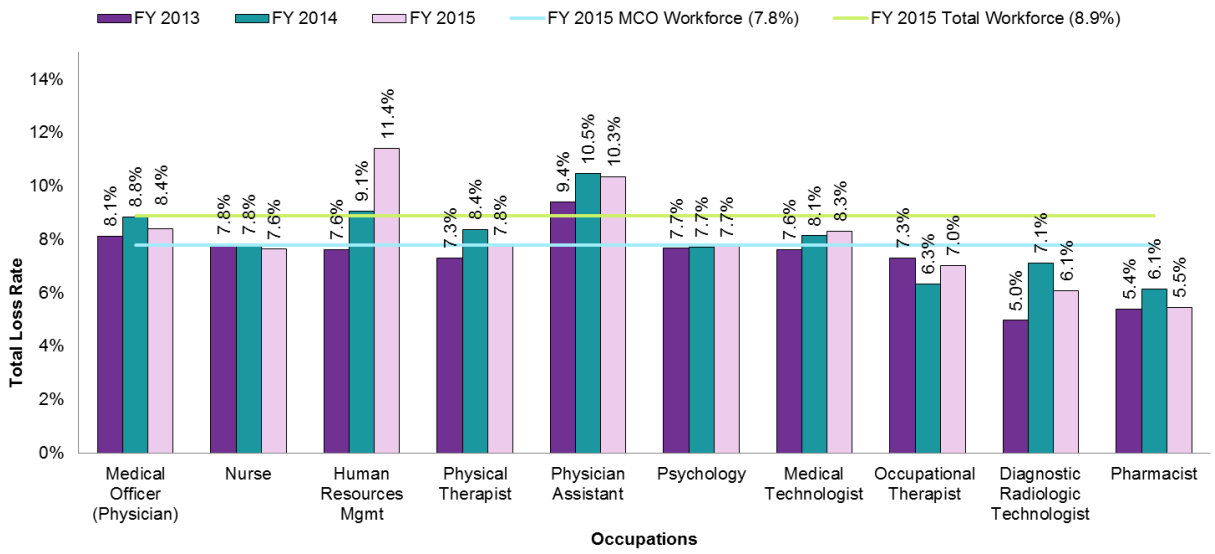

Figure 18: Total Loss Rate for VHA Mission Critical Occupations

Quits by Year of Employment

Between FY 2008 and FY 2014 a total of 76,252 employees were hired in the top ten MCOs (approximately 37.2%% of total VHA hires). The most recent analysis of quits among new hires in these occupations concludes:

- On average, 28.6% of new hire quits in the VHA MCO group occurred within the first five years of employment (-1.7 pp less than the workforce overall).
- The majority of MCO new hire quits occur in the first two years of employment. The rate of quits within the first two years has increased from 16.2% in FY 2008 to 18.7% in FY 2013 (+2.5pp). Similar to the total workforce, new hire quits within the first two years represent approximately two-thirds of the total quits in the first five years.
- Typically, 10-11% of MCO new hires quit within the first year of employment.

Table 17: VHA Mission Critical Occupation (MCO) Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	10.1%	16.2%	26.6%
FY 2009	9.8%	17.0%	28.7%
FY 2010	10.4%	18.7%	30.4%
FY 2011	10.7%	18.9%	
FY 2012	10.9%	18.4%	
FY 2013	10.7%	18.7%	
FY 2014	10.9%		
Average	10.5%	18.0%	28.6%

Diversity of Mission Critical Occupations

The percentage of minorities among the MCOs is generally lower than the total workforce. The MCO group percentage of minorities in FY 2015 was 35.1%, compared to the total workforce percentage of 40.8%. The occupations with the highest percentage of minorities were HRM (42.6%), medical technologist (38.5%), physician (37.6%), and nurse (37.0%). The occupations with the lowest percentage were psychology (15.4%) and PA (20.6%).

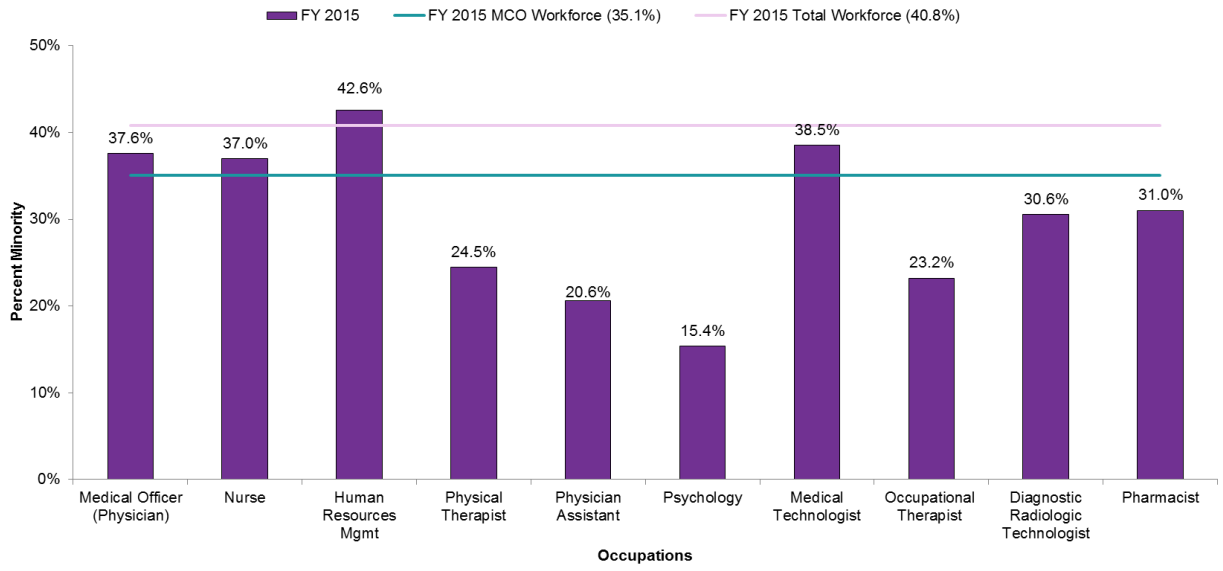

Figure 19: VHA Minority Representation by Occupation

Females represent 68.1% of the MCO group (Figure 20) as compared to 60.8% of the total workforce.

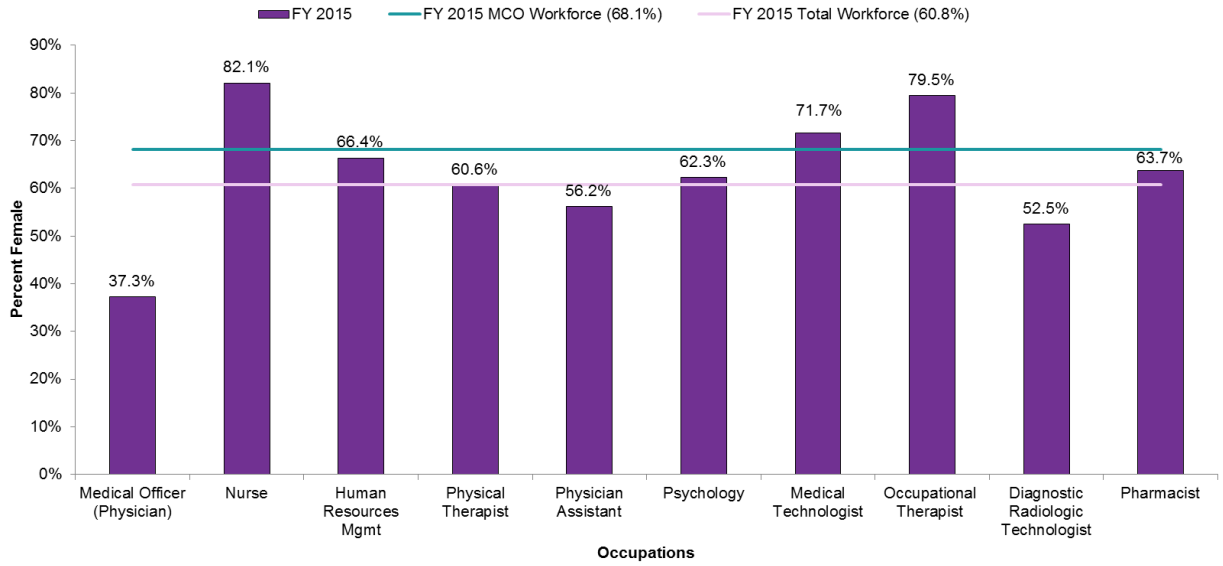

Figure 20: VHA Female Representation by Occupation

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 2015 percentage of Veterans among the MCO group (Figure 21) is much lower (14.7%) than the total workforce rate of 31.2%. HRM (45.8%) is the only occupation with a higher percentage of Veterans than the total workforce. At 7.1%, both pharmacist and psychology had the lowest percentage of Veterans.

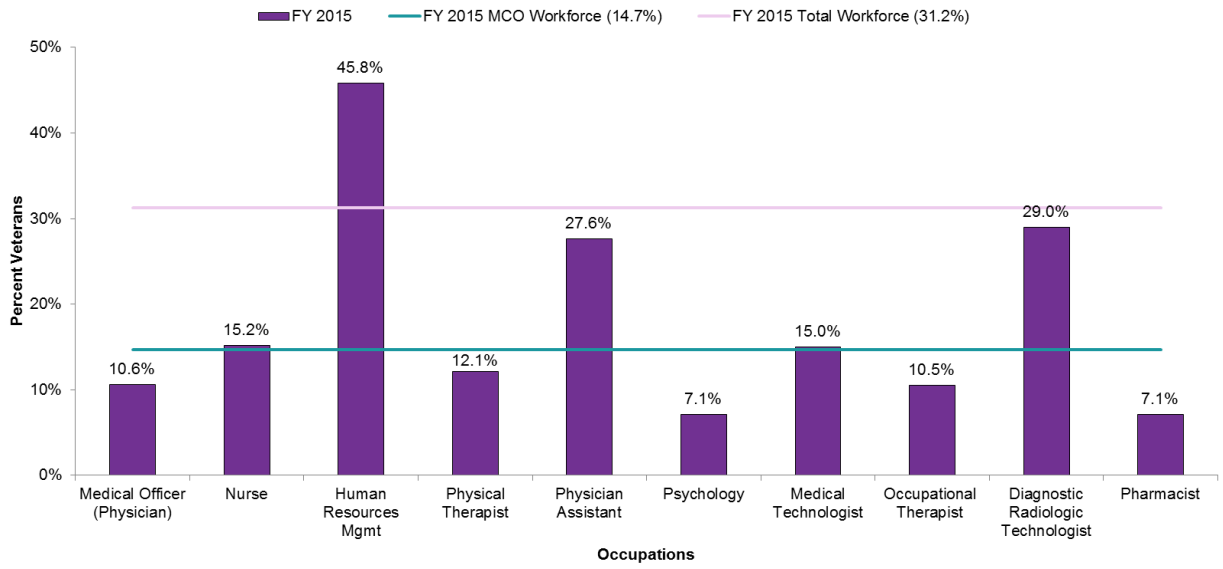

Figure 21: Veteran Representation by Occupation

Average Age

The average age for the MCO group (Figure 22) in FY 2015 was 48.2 years, as compared to the total workforce average age of 47.9 years. Physicians have the highest average age (51.2 years) among the MCO occupations and PT and pharmacy had the lowest (42.8 years).

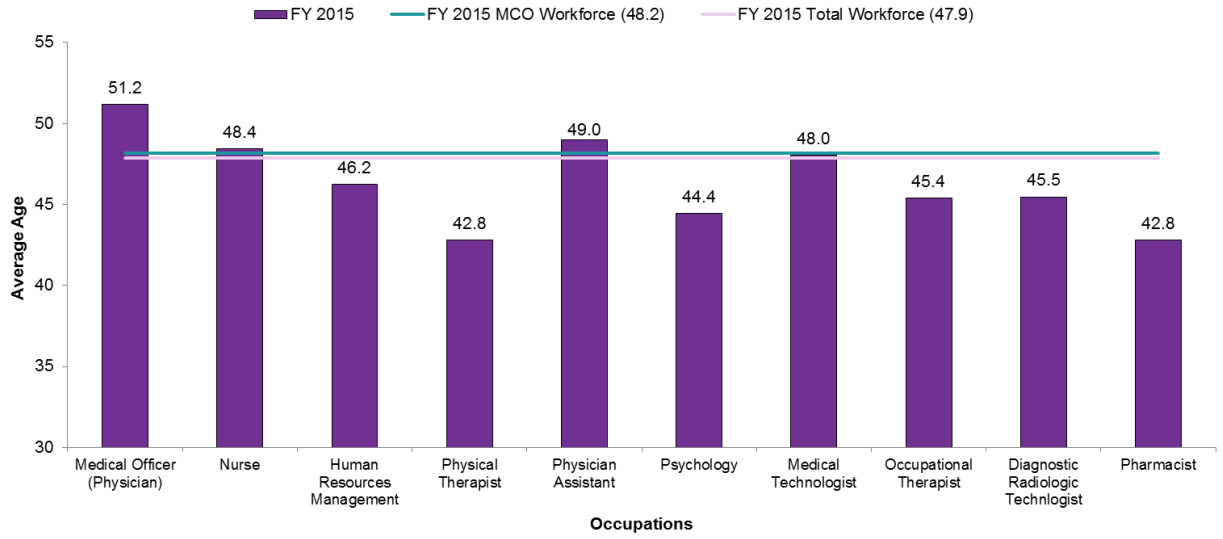

Figure 22: Average Age for VHA Mission Critical Occupations

MCO Survey Analysis

VA Entrance Survey Results

The FY 2015 VA Entrance Survey indicated that the top three reasons those in the MCOs chose to work for the VHA were:

- 21.4% benefits
- 20.5% career opportunity/advancement
- 14.3% mission/serving the Veterans

Like the workforce overall, those in the top occupations chose benefits as their number one reason for choosing VA.

VA Exit Survey Results

The FY 2015 VA Exit Survey indicated that those in the MCOs left VHA for the following reasons:

- 20.2% normal retirement
- 17.1% advancement (unique opportunity elsewhere)
- 9.6% relocation with spouse
- 8.0% family matters
- 6.2% advancement (lack of opportunity)

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 "advancement due to lack of opportunity," however, they chose "relocation with spouse" as their third reason for leaving, followed by "family matters" and "advancement lack of opportunity."

All Employee Survey Results

Workforce surveys provide important insight about how staff experience the workplace – what they perceive as strengths, challenges, and areas for improvement. In VHA, the VA AES is one instrument for assessing this feedback with its data used to support tailored action planning, particularly with critical occupations.

Several AES items of particular relevance to health care environments were assessed:

- **Cooperation** *(A spirit of cooperation and teamwork exists in my work group)*. Most physicians, nurses, and psychologists reported 'favorable' teamwork and cooperation experiences in the VHA workplace. Clinical laboratory staff, inpatient Community Living Center nurses, and diagnostic imaging technicians reported 'less favorable' experiences.

- **Collaboration** *(People from different work groups in my facility are willing to collaborate)*. Nurse managers (Levels 4 and 5) and most physicians reported 'favorable' cross-unit collaboration; although primary care physicians experience observably less cooperation than other physician groups. Clinical laboratory staff and diagnostic imaging technicians reported the 'least favorable' experiences.

- **Psychological Safety** *(Members in my work group are able to bring up problems and tough issues)*. Physicians, nurse managers (Levels 4 and 5), NP, and psychologists reported high (favorable) psychological safety in their willingness to raise tough issues with workgroup members. Lower (less favorable) levels of psychological safety were expressed by staff who work in HR, pharmacy, technician or laboratory positions, and as staff nurses (Levels 1-3).

- **Speaking Up** *(It is worthwhile in my workgroup to speak up because something will be done to address our concerns)*. Nurse managers (Levels 4 and 5), most physicians, and clinical nurse specialists reported 'speaking up' as worthwhile because action will be taken to address concerns. Primary care physicians and NP reported less favorable experiences in 'speaking up', as did clinical laboratory staff and diagnostic imaging technicians.

- **Exhaustion** *(I feel burned out from my work)*. Primary care physicians overwhelmingly reported the highest (less favorable) exhaustion, or physical burnout, while surgeons report the lowest (most favorable).[56]

MCO Recruitment, Retention, and Relocation Incentives

VHA occupations in the MCO group received 81.6% of total recruitment incentives (Table 18). The majority of recruitment incentives (51.5%) were allocated to physicians with an average award of $17,400, followed by nurses (18.1%; average of $6,869.39); and physician assistants (3.8%; average of $10,674.83).

[56] *Note: A 'Never' response is most favorable, while 'Every day' is least favorable*

Table 18: FY 2015 VHA Recruitment Incentives for MCO and Total Workforce

Occupation #	Recruitment Total $	# Recruitment	Recruitment Average
0602 Medical Officer (Physician)	$19,853,447.23	1141	$17,400.04
0610 Nurse	$2,754,623.73	401	$6,869.39
0201 Human Resources Mgmt	$95,405.52	16	$5,962.85
0633 Physical Therapist	$165,176.65	26	$6,352.95
0603 Physician Assistant	$896,685.73	84	$10,674.83
0180 Psychology	$649,211.20	63	$10,304.94
0644 Medical Technologist	$156,687.37	29	$5,403.01
0631 Occupational Therapist	$186,706.00	21	$8,890.76
0647 Diagnostic Radiologic Technologist	$84,130.20	15	$5,608.68
0660 Pharmacist	$124,270.34	12	$10,355.86
Total MCO	$24,966,343.97	1808	$87,823.31
Total Workforce	$28,001,926.76	2,215	$12,641.95

VHA occupations in the MCO group received 57.3% of the total retention incentives (Table 19). Nurses were the top recipients (22% of total awards with an average of $3,988.11), followed by physicians (17%; average of 19,335.73), and diagnostic radiologic technologist (6.9%; average of $4,604.39).

Table 19: FY 2015 VHA Retention Incentives for MCO and Total Workforce

Occupation #	Retention Total $	# Retention	Retention Average
0602 Medical Officer (Physician)	$9,957,902.40	515	$19,335.73
0610 Nurse	$2,592,274.62	650	$3,988.11
0201 Human Resources Mgmt	$237,943.71	25	$9,517.75
0633 Physical Therapist	$175,468.40	20	$8,773.42
0603 Physician Assistant	$1,044,131.84	96	$10,876.37
0180 Psychology	$227,254.73	18	$12,625.26
0644 Medical Technologist	$991,226.28	132	$7,509.29
0631 Occupational Therapist	$10,631.42	2	$5,315.71
0647 Diagnostic Radiologic Technologist	$948,504.00	206	$4,604.39
0660 Pharmacist	$644,498.54	44	$14,647.69
Total MCO	$16,829,835.94	1708	$97,193.73
Total Workforce	$25,097,368.25	2,979	$8,424.76

A total of 1,107 relocation incentives were authorized in VHA. Awards to occupations in the MCO group comprised 57.5% of the total. Physicians were awarded 25.8% of all relocation incentives, with an average amount of $18,312.17, followed by HR management (12.6%; average of $10,458.69), and nurse (11.0%; average of $11,909.23).

Table 20: FY 2015 VHA Relocation Incentives for MCO and Total Workforce

Occupation #	Relocation Total $	# Relocation	Relocation Average
0602 Medical Officer (Physician)	$4,797,788.45	262	$18,312.17
0610 Nurse	$1,333,833.22	112	$11,909.23
0201 Human Resources Mgmt	$1,338,711.86	128	$10,458.69
0633 Physical Therapist	$12,500.00	3	$4,166.67
0603 Physician Assistant	$91,812.00	11	$8,346.55
0180 Psychology	$506,850.20	49	$10,343.88
0644 Medical Technologist	$23,558.00	4	$5,889.50
0631 Occupational Therapist	$22,064.00	2	$11,032.00
0647 Diagnostic Radiologic Technologist	$36,676.00	1	$36,676.00
0660 Pharmacist	$135,711.34	13	$10,439.33
Total MCO	$8,299,505.07	585	$127,574.01
Total Workforce	$13,028,392.32	1,017	$12,810.61

86% of new EDRP were made to employees in the awards were made to employees in occupations in the MCO group. Of these new awards, nurses received 22% of the total awards and physicians received 32% of the new awards and psychology received 8% of awards.

Table 21: FY 2015 VHA EDRP Incentives for MCO and Total Workforce

Occupation #	# of EDRP Participants
0602 Medical Officer (Physician)	307
0610 Nurse	210
0201 Human Resources Mgmt	N/A
0633 Physical Therapist	48
0603 Physician Assistant	43
0180 Psychology	80
0644 Medical Technologist	25
0631 Occupational Therapist	19
0647 Diagnostic Radiologic Technologist	3
0660 Pharmacist	102
Total MCO	837
Total Workforce	969

Note: HRM is not an eligible occupation.

Summary of Challenges to Recruitment and Retention of the Top Occupations

Subject matter experts (SMEs) from relevant program offices representing each MCO provided additional analysis of the occupations and recommendations to remove barriers to recruitment and retention.

SME Findings:

Collectively, SME assessments supported workforce data that reflect a gap between supply and demand among the MCOs. SMEs stated that VHA is unable to compete for specialists in each occupation due, in part, to salary disparities when compared to the private sector. Even after retention incentives are applied, private sector salaries exceed the federal government scale for most of these occupations. Also, budgetary constraints may prevent medical centers from offering retention incentives. SMEs also stated that current hiring practices do not always attract qualified applicants to fill vacancies, and once a qualified applicant has received an offer there are lags between the date of acceptance and onboarding. For entry/junior level positions in nursing, physical therapist, physician assistant, occupational therapist, medical technologist, diagnostic radiologic technologist, and pharmacy, SMEs reported that limited promotion or leadership opportunities also hinder retention efforts. Several SMEs stated that the lack of job control and a poor organizational public image often leads to declines in morale and employee satisfaction, and may even deter potential applicants. VHA Exit Survey and AES data support the SME assertion (page 88).

SME Recommendations:

Based on the aforementioned challenges, SMEs recommended review and redesign of current recruitment and retention models and practices, and they provided a list of best practices that VISNs and facilities could undertake to eliminate barriers to MCO recruitment and retention:

- Consider establishing or adjusting special salary rates when warranted to improve the ability to compete with the private sector.
- Streamline local processes to reduce the hiring and onboarding timeline.
- Encourage more supervisor involvement with mentoring employees to enhance employees' connection with VHA.
- Offer more occupation-specific training in conjunction with program office and accrediting bodies' standards to facilitate employees' continuing education goals.
- Expand and continuously monitor and evaluate the use of the EDRP, EISP, and SLRP.
- Fully utilize non-monetary incentives such as telework, and flex-time to facilitate a work-life balance for professionals.

Additional Findings and Recommendations:

Government Accountability Office (GAO) Study on Nurse Recruitment and Retention

The GAO's[57] study on nurse recruitment and retention states that the nursing occupation in VHA is experiencing recruitment and retention challenges due to lack of sufficient administrative support for medical centers. Although multiple recruitment and retention efforts are in place, GAO recommends that a process be developed to monitor medical centers' compliance with those initiatives, conduct a system-wide evaluation of them, and evaluate the adequacy of training resources provided to nurse recruiters.

Office of Inspector General's VHA Determination of Top Five Staffing Shortage Occupations

In accordance with the Choice Act[58], the VA OIG conducted an assessment to determine VHA's top five clinical staffing shortage occupations. The OIG assessed the VHA methodology, utilized the facility rankings based on that methodology, and found its own rankings to be similar. The OIG top five shortage occupations were medical officer (physician), RN, psychologist, PA, and PT. The OIG recommended that VHA further develop staffing models for critical need occupations and review the data on regrettable losses (or quits) in both the report and in VISN Workforce and Succession Strategic Plans and, if appropriate, consider implementing measures to reduce losses. VHA concurred with these recommendations, and offered an action plan to evolve clinical staffing models and frameworks, align with workforce planning, and integrate with the Planning, Programming, Budgeting, and Execution activities over the next several years. In addition, VHA outlined actions to reduce regrettable losses by leveraging existing tools, inputs, and incentive programs such as those mentioned in the SME assessment above. VHA also plans to conduct additional statistical analysis of loss trends by profession, location, and practice area, and to review common factors that drive regrettable losses at both the local facility and national levels to identify trends, barriers, practices, and solutions.

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[57] *VA Health Care: Oversight Improvements Needed for Nurse Recruitment and Retention Initiatives (GAO 15-794)*

http://www.gao.gov/

[58] *Veterans Access, Choice, and Accountability Act (VACAA) of 2014, http://www.gpo.gov/fdsys/pkg/BILLS-113hr3230enr/pdf/BILLS-113hr3230enr.pdf*

Other Occupation-Specific Findings:

Medical Officer (Physician)

The need to recruit and retain excellent physicians is a critical workforce initiative for VHA in FY 2016, at a time when the nationwide gap between supply and demand of physicians is growing. The gap also comes amid the context of a new generation of physicians who are seeking flexible work schedules, work-life balance, careers providing ongoing professional development and advancement and collaborative team work settings.

In the midst of this growing need, recruitment and retention of physician leaders will be imperative to preventing voids in leadership and knowledge. VHA has been challenged by recent events leading Congress and the public to question current employees' integrity and ethics, resulting in an environment of declining morale and poor psychological safety. The risk created by the confluence of these forces is increasing our challenge to close the gap between physician supply and demand.

The solution to resolving this critical employment shortage will require the creative and flexible use of all employment authorities and awareness and utilization of the processes recommended in the Enhanced Physician Recruitment Model.[59] On the national front, VHA is working towards developing staffing models to determine the appropriate number of physicians needed, and to attain appropriate staffing levels or identify alternative options. Other best practices include the development of clinic management business rules, reassessing the appropriateness of VHA's productivity target for physicians, and developing a mechanism to monitor the variance in the way encounters are coded.

Medical Officer (Physician) Analysis

At the end of FY 2015, VHA's onboard physician workforce totaled 24,545 employees. This represents a 20% increase in onboard strength since FY 2011 (+4,372 employees) with rates of growth ranging between 2.3% and 5.8% annually. Over the past five years, voluntary retirements have increased from 1.9% in FY 2011 to 2.6% in FY 2015, while quit rates have remained fairly stable at an average of 5.4% per year.

[59] *Enhanced Physician Recruitment Model cited in National Strategic Recruitment Plan, June 2015* http://vaww.pdush.med.va.gov/filedownload.ashx?fid=9196

Table 22: Medical Officer (Physician) Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	20,821	21,304	22,318	23,208	24,545	N/A
Net Increase in Onboard	648	483	1,014	890	1,337	4,372
Onboard Percent Change at End of FY	3.2%	2.3%	4.8%	4.0%	5.8%	20.0%
Voluntary Retirement Rate	1.9%	1.9%	2.2%	2.5%	2.6%	2.2%
Quit Rate	5.6%	5.7%	5.2%	5.6%	5.2%	5.4%
Total Loss Rate	8.2%	8.5%	8.1%	8.8%	8.4%	8.4%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 33.3% of newly hired physicians quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Similar to the total workforce and top occupations group, nearly two-thirds of quits within the first five years occur within the first two years.

Table 23: Medical Officer (Physician) Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	10.4%	18.9%	31.2%
FY 2009	11.9%	20.3%	33.9%
FY 2010	11.2%	21.4%	34.8%
FY 2011	12.5%	22.5%	
FY 2012	12.1%	20.9%	
FY 2013	12.6%	21.6%	
FY 2014	11.3%		
Average	11.7%	20.9%	33.3%

Projections based on VISN and facility estimates indicate growth in onboard of 37.5% (9,210 employees) through FY 2022, and average total loss rates of 9.3% per year. Approximately 4,085 new hires each year will be required to maintain and grow the workforce as predicted.

Table 24: Medical Officer (Physician) Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	24,545	25,772	26,958	28,198	29,495	30,852	32,271	33,755	N/A
Employees Eligible for Regular Retirement		5,243	5,106	5,086	5,242	5,518	5,405	5,279	5,268
Voluntary Retirements	2.5%	3.0%	3.1%	3.0%	3.3%	3.5%	3.9%	4.0%	3.4%
Quits	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%
Total Losses	8.4%	8.9%	9.0%	9.0%	9.2%	9.4%	9.8%	9.9%	9.3%
Gains Needed		3,523	3,604	3,769	4,010	4,264	4,588	4,836	4,085

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Nurse (Registered Nurse)

VHA continues to face increased competition for skilled nurses. Recruitment and retention is particularly difficult for nurses with advanced professional skills, knowledge, and experience, which is critical given Veterans' needs for more complex specialized services. VHA has multiple system-wide initiatives to enhance recruitment and retention of its nurse workforce, but many VA medical centers still face challenges such as lack of sufficient administrative support, competition with private sector medical facilities, reduced pool of advanced training nurses in rural locations, and employee dissatisfaction.

In an effort to address the barriers, Office of Nursing Service SMEs recommend that VHA utilize recruitment and development efforts that involve a wide range of initiatives and strategies to attract, hire, and retain RNs. Specifically, they propose marketing and utilizing the RN Transition to Practice (RNTTP) program for nurses with less than one year experience; utilizing the VANEEP, VANAP, and NNEI scholarship programs to provide nurses with the opportunity for professional development; and collaborating with My VeHU to create more educational opportunities for nurses.

Registered Nurse Analysis

At the end of FY 2015, VHA's onboard nurse workforce totaled 64,087 employees. This represents a 20.5% increase in onboard strength since FY 2011 (+11,659 employees) with rates of growth increasing from 2.8% in FY 2011 to 6.0% in FY 2015. Over the past five years, voluntary retirements remained fairly stable at approximately 3% per year, while quit rates have increased from 3.5% in FY 2011 to 4.0% in FY 2015.

Table 25: Nurse Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	53,875	55,297	57,742	60,475	64,087	N/A
Net Increase in Onboard	1,447	1,422	2,445	2,733	3,612	11,659
Onboard Percent Change at End of FY	2.8%	2.6%	4.4%	4.7%	6.0%	20.5%
Voluntary Retirement Rate	2.7%	3.0%	3.2%	3.2%	3.0%	3.0%
Quit Rate	3.5%	3.7%	3.9%	4.0%	4.0%	3.8%
Total Loss Rate	6.9%	7.5%	7.8%	7.8%	7.6%	7.5%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 28.8% of newly hired nurses quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Similar to the total workforce and top occupations group, nearly two-thirds of quits within the first five years occur within the first two years. VA Exit Survey results reveal that, similar to the total workforce, the top three reasons for leaving among nurses were normal retirement, advancement for unique opportunity elsewhere, and relocation with spouse.

Table 26: Nurse Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	11.1%	16.9%	26.7%
FY 2009	10.1%	17.6%	28.8%
FY 2010	11.4%	19.9%	30.9%
FY 2011	11.1%	19.3%	
FY 2012	12.3%	19.8%	
FY 2013	11.3%	19.5%	
FY 2014	11.4%		
Average	11.2%	18.8%	28.8%

Projections based on VISN and facility estimates indicate growth in onboard of 36.7% (23,544 employees) through FY 2022, and average total loss rates of 7.3% per year. Approximately 8,971 new hires each year will be required to maintain and grow the workforce as predicted.

Table 27: Nurse Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	64,087	67,291	70,319	73,484	76,791	80,246	83,857	87,631	N/A
Employees Eligible for Regular Retirement		10,320	11,007	11,562	12,134	12,820	12,747	12,641	11,890
Voluntary Retirements	3.0%	2.6%	2.7%	2.8%	2.8%	2.9%	2.8%	2.7%	2.8%
Quits	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%
Total Losses	7.6%	7.1%	7.2%	7.3%	7.4%	7.4%	7.3%	7.2%	7.3%
Gains Needed		7,977	8,101	8,514	8,951	9,418	9,746	10,092	8,971

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Human Resource Management (HRM)

SME reviews and trend analysis indicate that VHA's HRM quit rate was one of the highest among VHA's MCOs. Because VHA HRM employees are well-equipped to perform HR work in other federal agencies, transfers to other federal agencies, rather than resignations, are the primary type of loss in the quit category in this occupation. In fact, the majority of VHA facilities cite transfers as the number one reason for HRM losses. Presumably, this is because HR work within VHA is considerably more complex and larger in scope than other federal agencies due to the requisite knowledge of Title 5, Title 38 and Hybrid Title 38 hiring authorities, and the ratio of HR Specialists to employees serviced tends to be higher within VHA. Because HRM is an administrative occupation it is excluded from the top five critical occupations as defined by the Choice Act and referenced in the OIG staffing shortage report mentioned above. However, VHA recognizes that the HRM occupation is essential to the recruitment and retention of clinical occupations. HRM provides the technical expertise and is the lead for many of the mitigation strategies identified. VHA further recognizes that this critical occupation requires an organization-wide commitment to ongoing staffing, training and support.

HRM Analysis

At the end of FY 2015, VHA's HRM onboard workforce totaled 3,215 employees. This represents a 29.2% increase in onboard strength since FY 2011 (+795 employees) with rates of growth ranging from 4.5% to 5.7% annually. Over the past five years, voluntary retirements were highest in FY 2011 and 2015 (3.5% and 3.4%, respectively), with rates of 2.7% to 2.8% in FY 2012 to 2014. As mentioned above, the FY 2015 quit rate (7.1%) was the highest of the MCO group, and represents a +1.3 pp increase over FY 2014. It is also higher than the total workforce rate of 4.6%. In addition, at 11.4%, HRM had the highest total loss rate of all the MCOs, and this reflected a +2.3 pp increase over FY 2014.

Table 28: HRM Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	2,530	2,709	2,878	3,041	3,215	N/A
Net Increase in Onboard	110	179	169	163	174	795
Onboard Percent Change at End of FY	4.5%	7.1%	6.2%	5.7%	5.7%	29.2%
Voluntary Retirement Rate	3.5%	2.7%	2.8%	2.7%	3.4%	3.0%
Quit Rate	5.4%	4.2%	4.1%	5.8%	7.1%	5.3%
Total Loss Rate	9.6%	7.4%	7.6%	9.1%	11.4%	9.0%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 40.7% of newly hired HRMs quits occurred within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. This is by far the largest percentage of quits in the first five years of employment of all the VHA MCOs and represents a huge loss in terms of recruitment and training costs for new employees. Approximately 55% of the quits within the first five years occur within the first two years of employment.

Table 29: HRM Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	14.3%	25.1%	45.8%
FY 2009	11.1%	23.5%	36.4%
FY 2010	8.0%	18.1%	39.9%
FY 2011	8.2%	20.6%	
FY 2012	13.0%	28.1%	
FY 2013	10.8%	30.3%	
FY 2014	24.4%		
Average	12.8%	24.3%	40.7%

Projections based on VISN and facility estimates indicate growth in onboard of 48.4% (1,556 employees) through FY 2022, and average total loss rates of 8.4% per year. Approximately 564 new hires each year will be required to maintain and grow the workforce as predicted.

Table 30: HRM Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	3,215	3,401	3,599	3,807	4,028	4,262	4,509	4,771	N/A
Employees Eligible for Regular Retirement		441	465	496	514	545	543	539	506
Voluntary Retirements	3.4%	2.1%	2.1%	2.2%	2.3%	2.3%	2.2%	2.1%	2.2%
Quits	7.1%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
Total Losses	11.4%	8.4%	8.4%	8.5%	8.5%	8.6%	8.4%	8.3%	8.4%
Gains Needed		471	498	531	563	599	627	658	564

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Physical Therapist (PT)

VHA anticipates growth in the need for rehabilitation therapies due to the large number of returning OIF/OEF/OND Veterans with traumatic injuries and comorbidities of orthopedic, sensory, PTSD, and musculoskeletal. The influx of new Veterans combined with the increasing age of VHA's traditional Veteran population and increased emphasis on non-institutional care, telerehabilitation, and rural health coverage, will contribute to continued demand for PTs in VHA. In addition, Geriatrics and Extended Care projects are expected to increase the number of Priority 1a Veterans, the ones most likely to seek service in VA, by FY 2018. The efficient utilization of telerehabilitation, community care, and community partners for PT services will be critical for ensuring timely access to care and meeting Veterans' increasing rehabilitation demands.

PT Analysis

At the end of FY 2015, VHA's PT onboard workforce totaled 1,986. This represents a 31.7% increase in onboard strength since FY 2011 (+524 employees); the FY 2015 growth rate of 9.7% represents the highest among the MCO group, and a significant increase over the 3.6% growth rate experienced in FY 2011. Over the past five years, voluntary retirements have remained fairly stable at approximately 1.4% per year, and quits have remained at approximately 3.4% per year.

Table 31: Physical Therapist Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	1,514	1,575	1,681	1,810	1,986	N/A
Net Increase in Onboard	52	61	106	129	176	524
Onboard Percent Change at End of FY	3.6%	4.0%	6.7%	7.7%	9.7%	31.7%
Voluntary Retirement Rate	1.7%	1.1%	1.3%	1.6%	1.2%	1.4%
Quit Rate	3.9%	2.8%	3.6%	3.1%	3.5%	3.4%
Total Loss Rate	8.3%	6.3%	7.3%	8.4%	7.8%	7.6%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 21.2% of newly hired PTs quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Unlike the total workforce and VHA MCO group where more than two-thirds of new hire quits occur within the first two years, just under half of quits among newly hired PTs occur within the first two years. However, the rate of quits within the first year increased from 6.4% for FY 2013 hires to 8.9% for FY 2014 hires.

Table 32: Physical Therapist Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	5.2%	10.0%	20.0%
FY 2009	5.2%	10.4%	22.8%
FY 2010	4.8%	9.6%	20.7%
FY 2011	5.9%	11.4%	
FY 2012	3.5%	9.3%	
FY 2013	6.4%	9.1%	
FY 2014	8.9%		
Average	5.7%	10.0%	21.2%

Projections based on VISN and facility estimates indicate growth in onboard of 54.9% (1,091 employees) through FY 2022, and average total loss rates of 7.5% per year. Approximately 350 new hires each year will be required to maintain and grow the workforce as predicted.

Table 33: Physical Therapist Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	1,986	2,145	2,278	2,419	2,569	2,728	2,898	3,077	N/A
Employees Eligible for Regular Retirement		138	150	158	170	187	204	211	174
Voluntary Retirements	1.2%	1.1%	1.2%	1.2%	1.3%	1.3%	1.3%	1.4%	1.3%
Quits	3.5%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
Total Losses	7.8%	7.3%	7.4%	7.5%	7.5%	7.5%	7.6%	7.6%	7.5%
Gains Needed		315	303	323	344	365	390	414	350

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Physician Assistant (PA)

Many VISNs report that the reason they could not hire PAs was because the salaries they were allowed to offer could not compete with those offered in the private sector. As a result, many VISN action plans stated they would conduct salary surveys to seek parity with private sector pay, however, only 8% of facilities submitted salary survey requests to the VA Compensation Office between January 2014 and February 2015. Facilities that did obtain special salary rates were able to significantly improve their ability to fill existing vacancies.

The PA total loss rate was the second highest among the top occupations, and increased from 9.4% in FY 2013 to 10.4% in FY 2014. Exit survey results indicate that retirement, advancement (unique opportunity elsewhere), and advancement (lack of opportunity) were the most frequently chosen reasons for leaving. In FY 2016, 37% of all VHA PAs will be eligible to retire.

To improve recruitment and retention, facilities and VISNs should implement fully functional PA Professional Standards Boards, establish special salary rates where appropriate, fully utilize national recruitment incentives, expand the OAA's PA Trainee Stipend Support Program, and continue to expand the PA Post-Graduate Year (PGY) Residency Program in PACT Primary Care.

PA Analysis

At the end of FY 2015, VHA's PA onboard workforce totaled 2,137. This represents a 14.4% increase in onboard strength since FY 2011 (+281 employees); the FY 2015 growth rate of 6.4% represents a 3.5 pp increase over FY 2014. Voluntary retirements increased from 2.9% in FY 2011 to 3.6% in FY 2014, but then decreased to 2.8% in FY 2015. Quits have remained fairly close to the average of 5.2% per year, but the FY 2015 rate of 4.9% represents a decrease of -0.6 pp over the FY 2014 rate.

Table 34: Physician Assistant Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	1,893	1,885	1,951	2,008	2,137	N/A
Net Increase in Onboard	37	-8	66	57	129	281
Onboard Percent Change at End of FY	2.0%	-0.4%	3.5%	2.9%	6.4%	14.4%
Voluntary Retirement Rate	2.9%	3.4%	3.2%	3.6%	2.8%	3.2%
Quit Rate	5.2%	5.1%	5.3%	5.5%	4.9%	5.2%
Total Loss Rate	9.3%	9.9%	9.4%	10.5%	10.3%	9.9%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 32.3% of newly hired PAs quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Nearly 54% of quits among newly hired PAs occur within the first two years.

Table 35: Physician Assistant Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	7.1%	15.0%	29.6%
FY 2009	7.1%	15.0%	29.6%
FY 2010	12.6%	22.4%	37.7%
FY 2011	12.7%	20.8%	
FY 2012	9.0%	22.0%	
FY 2013	9.7%	18.6%	
FY 2014	9.1%		
Average	9.6%	19.0%	32.3%

Projections based on VISN and facility estimates indicate growth in onboard of 28.8% (616 employees) through FY 2022, and average total loss rates of 9.6% per year. Approximately 327 new hires each year will be required to maintain and grow the workforce as predicted.

Table 36: Physician Assistant Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	2,137	2,252	2,329	2,408	2,490	2,575	2,662	2,753	N/A
Employees Eligible for Regular Retirement		346	359	378	392	403	412	407	385
Voluntary Retirements	2.8%	2.8%	2.8%	2.8%	2.9%	2.9%	2.9%	2.8%	2.8%
Quits	4.9%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%	5.1%
Total Losses	10.3%	9.5%	9.6%	9.6%	9.6%	9.6%	9.7%	9.5%	9.6%
Gains Needed		328	299	310	321	333	345	353	327

Note: Percent are calculated using the Employees Onboard at the End of FY for each year.

Psychology

VHA is revising the psychology standards to promote an increased pool of eligible psychologists for VHA hire. Once these standards are accepted, applicants with doctoral degrees from programs accredited by the Canadian Psychological Association or by the Psychological Clinical Science Accreditation System and applicants who completed an internship that was not accredited by the APA but who do have an American Board of Professional Psychology certification will be eligible for VHA employment. Once published, these new standards could be marketed nationwide to educate VA staff and potential applicants about the expanded psychology qualification standard.

Psychology Analysis

At the end of FY 2015, VHA's psychology onboard workforce totaled 5,469. This represents a 40.4% increase in onboard strength since FY 2011 (+1,755 employees) and is the result of various mental health hiring initiatives. The FY 2015 growth rate of 8.0% represents a 4.1 pp increase over FY 2014 and is the second highest growth among the MCO group. Voluntary retirements remained fairly close to the five-year average of 1.4%, while quits have increased from 2.9% in FY 2012 to 4.0% in FY 2015. The total loss rate, however, has remained constant at 7.7% for the last three years.

Table 37: Psychology Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	3,967	4,337	4,872	5,064	5,469	N/A
Net Increase in Onboard	253	370	535	192	405	1,755
Onboard Percent Change at End of FY	6.8%	9.3%	12.3%	3.9%	8.0%	40.4%
Voluntary Retirement Rate	1.6%	1.3%	1.2%	1.5%	1.6%	1.4%
Quit Rate	3.2%	2.9%	3.4%	3.2%	4.0%	3.3%
Total Loss Rate	7.4%	6.7%	7.7%	7.7%	7.7%	7.4%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 16.4% of newly hired psychologists quit within the first five years of employment, much lower than the 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Unlike the total workforce and VHA MCO group where more than two-thirds of new hire quits occur within the first two years, less than half of quits among newly hired psychologists occur within the first two years.

Table 38: Psychology Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	5.2%	8.0%	16.4%
FY 2009	2.7%	5.6%	15.1%
FY 2010	5.3%	9.6%	17.7%
FY 2011	4.8%	7.6%	
FY 2012	5.0%	10.3%	
FY 2013	4.6%	9.8%	
FY 2014	4.3%		
Average	4.6%	8.5%	16.4%

Projections based on VISN and facility estimates indicate growth in onboard of 72.5% (3,965 employees) through FY 2022, and average total loss rates of 7.7% per year. Approximately 1,149 new hires each year will be required to maintain and grow the workforce as predicted.

Table 39: Psychology Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	5,469	5,912	6,391	6,909	7,468	8,073	8,727	9,434	N/A
Employees Eligible for Regular Retirement		694	676	679	673	687	668	659	677
Voluntary Retirements	1.6%	2.1%	1.9%	1.8%	1.7%	1.6%	1.5%	1.5%	1.7%
Quits	4.0%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%	3.4%
Total Losses	7.7%	8.1%	7.9%	7.8%	7.7%	7.6%	7.5%	7.5%	7.7%
Gains Needed		920	985	1,058	1,134	1,222	1,310	1,411	1,149

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Medical Technologist (MT)

A new VHA MT qualification standard was released in May 2014. The new standard addresses some of the recruitment and retention issues VISNs and facilities reported by adding new education/experience requirements that will allow for a greater pool of potential applicants. Additionally, the new standard increased the entry grade level from GS-5 to GS-7 and clarified the requirements for the full performance level of GS-11. To address the salary and pay issues described in many facility plans, facilities should take full advantage of the flexibilities provided in VA compensation policies, and utilize position management when structuring positions, in accordance with guidance provided in VA Handbook 5003. Facilities can also increase the future supply of MTs by through partnerships with large universities that have a Clinical Laboratory Science Program.

MT Analysis

At the end of FY 2015, VHA's MT onboard workforce totaled 4,494. This represents a 2.4% increase in onboard strength since FY 2011 (+107 employees). Voluntary retirements remained fairly close to the five-year average of 3.7%, while quits increased from 2.7% in FY 2011 to 4.0% in FY 2015.

Table 40: Medical Technologist Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	4,362	4,356	4,405	4,432	4,494	N/A
Net Increase in Onboard	-25	-6	49	27	62	107
Onboard Percent Change at End of FY	-0.6%	-0.1%	1.1%	0.6%	1.4%	2.4%
Voluntary Retirement Rate	3.5%	3.4%	3.8%	4.1%	3.9%	3.7%
Quit Rate	2.7%	3.6%	3.2%	3.3%	4.0%	3.4%
Total Loss Rate	6.9%	7.5%	7.6%	8.1%	8.3%	7.7%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 28.4% of newly hired MTs quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Unlike the total workforce and VHA MCO group where more than two-thirds of new hire quits occur within the first two years, just slightly less than half (48.4%) of quits among newly hired MTs occur within the first two years.

Table 41: Medical Technologist Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	7.3%	10.8%	25.4%
FY 2009	10.4%	16.5%	31.8%
FY 2010	8.9%	14.0%	28.1%
FY 2011	9.3%	17.8%	
FY 2012	9.4%	14.4%	
FY 2013	9.9%	16.9%	
FY 2014	11.3%		
Average	9.5%	15.1%	28.4%

Projections based on VISN and facility estimates indicate growth in onboard of 10.4% (469 employees) through FY 2022, and average total loss rates of 7.6% per year. Approximately 430 new hires each year will be required to maintain and grow the workforce as predicted.

Table 42: Medical Technologist Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	4,494	4,593	4,653	4,713	4,774	4,836	4,899	4,963	N/A
Employees Eligible for Regular Retirement		962	977	986	1,005	1,027	987	956	986
Voluntary Retirements	3.9%	3.3%	3.4%	3.5%	3.7%	3.7%	3.6%	3.5%	3.5%
Quits	4.0%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Total Losses	8.3%	7.4%	7.5%	7.6%	7.7%	7.8%	7.7%	7.5%	7.6%
Gains Needed		438	408	418	430	440	438	437	430

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Occupational Therapist (OT)

According to the 2014 OT Healthcare Analysis & Information Group (HAIG) Survey[60], 33% of OT departments reported barriers to recruitment of OT and 52% reported barriers to retention. At the time of the HAIG survey, 9% of OT FTEEs were vacant; approximately 45% were vacant for more than six months, and 25% were vacant for more than one year. According to VISN plans, the most frequently identified barriers to retention of OTs were dissatisfaction with salary, limited promotion potential, competition with the private sector, dissatisfaction with continued education benefits, and limited opportunity for professional growth. Local facilities and VISNs can improve recruitment and retention of OTs by standardizing and streamlining hiring processes and timelines, increasing use of financial incentives (i.e., EDRP and SLRP), implementing stronger marketing of leadership/career development and promotional opportunities, establishing strong trainee programs and continuously monitoring their outcome.

OT Analysis

At the end of FY 2015, VHA's OT onboard workforce totaled 1,223 employees. This represents a 21.2% increase in onboard strength since FY 2011 (+228 employees). Voluntary retirements remained fairly close to the five-year average of 2.2%, while quits have remained at approximately 3.5% per year.

Table 43: Occupational Therapist Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	1,025	1,038	1,092	1,145	1,223	N/A
Net Increase in Onboard	30	13	54	53	78	228
Onboard Percent Change at End of FY	3.0%	1.3%	5.2%	4.9%	6.8%	21.2%
Voluntary Retirement Rate	2.4%	2.2%	2.3%	2.0%	2.0%	2.2%
Quit Rate	3.0%	3.7%	3.5%	3.4%	3.7%	3.5%
Total Loss Rate	7.1%	7.7%	7.3%	6.3%	7.0%	7.1%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

[60] *Healthcare Analysis & Information Group, 2014 Survey of Occupation Therapy in VHA,* http://vaww.va.gov/HAIG/survey/2014_OT.asp

On average, 25.5% of newly hired OTs quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Similar to the total workforce and VHA MCO, nearly two-thirds of new hire quits occur within the first two years.

Table 44: Occupational Therapist Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	8.7%	14.5%	26.2%
FY 2009	13.9%	18.2%	24.8%
FY 2010	10.5%	14.9%	25.4%
FY 2011	5.0%	16.0%	
FY 2012	6.1%	10.2%	
FY 2013	11.2%	21.6%	
FY 2014	8.1%		
Average	9.1%	15.9%	25.5%

Projections based on VISN and facility estimates indicate growth in onboard of 36.6% (448 employees) through FY 2022, and average total loss rates of 6.8% per year. Approximately 163 new hires each year will be required to maintain and grow the workforce as predicted.

Table 45: Occupational Therapist Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	1,223	1,290	1,347	1,406	1,468	1,533	1,600	1,671	N/A
Employees Eligible for Regular Retirement		168	169	173	172	172	179	180	173
Voluntary Retirements	2.0%	2.2%	2.1%	2.1%	2.1%	2.0%	2.1%	2.0%	2.1%
Quits	3.7%	3.4%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.4%
Total Losses	7.0%	6.9%	6.8%	6.7%	6.8%	6.7%	6.7%	6.7%	6.8%
Gains Needed		156	148	154	162	167	175	182	163

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Diagnostic Radiologic Technologist (DRT)

The revised DRT qualification standard, published June 26, 2014, establishes an advanced certification requirement by the American Registry of Radiologic Technologists for individuals assigned to computerized tomography (CT) and magnetic resonance imaging (MRI) positions. An increase in demand for CT and MRI imaging has led to a shortage of applicants with advanced certification in CT or MRI. It is not possible to fill all vacancies with new graduates since they lack certification in these specialties. *Radiologic Technology*[61] *(RT)* published a comparison of RT certification category combinations. The data showed that 11% of RTs have advanced certification and registry in radiography and CT imaging, and only 6% have certification and registration in MRI. Experienced DRTs with the advanced certification must be attracted to VA. VISNs expressed increased difficulty filling positions with qualified candidates due to salary disparities between private sector and VA, and difficulty recruiting DRTs due to limited pools of trained applicants in rural areas. To address these issues, VISNs and facilities should consider the pay flexibilities in VA policy, to include recruitment and relocation incentives to attract candidates to the agency, and should also consider establishing, or revising special salary rates when appropriate.

DRT Analysis

At the end of FY 2015, VHA's DRT onboard workforce totaled 3,747 employees. This represents a 17.5% increase in onboard strength since FY 2011 (+588 employees). Voluntary retirements remained fairly close to the five-year average of 2.4%, while quits have ranged from 2.0% to 3.5% over the last five years. The total loss rate was 1pp lower in FY 2015 (6.1%) than in FY 2014 (7.1%).

Table 46: DRT Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	3,243	3,281	3,484	3,559	3,747	N/A
Net Increase in Onboard	84	38	203	75	188	588
Onboard Percent Change at End of FY	2.7%	1.2%	6.2%	2.2%	5.3%	17.5%
Voluntary Retirement Rate	2.0%	2.5%	2.3%	2.7%	2.8%	2.4%
Quit Rate	2.4%	2.9%	2.0%	3.5%	2.8%	2.7%
Total Loss Rate	5.3%	5.9%	5.0%	7.1%	6.1%	5.9%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

[61] *Reid, J, Demographics of the profession, http://www.radiologictechnology.org/content/86/4/449.extract.*

On average, 18.1% of newly hired DRTs quit within the first five years of employment, much lower than the 28.6% rate for the VHA MCO group and 26.9% for the total VHA workforce. Similar to the total workforce and VHA MCO, nearly two-thirds of new hire quits occur within the first two years. In addition, the new hire quit rate within the first year increased from 7.9% for FY 2013 hires to 12.1% for FY 2014 new hires.

Table 47: DRT Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	7.0%	10.3%	17.1%
FY 2009	3.8%	6.6%	13.5%
FY 2010	7.7%	13.3%	23.9%
FY 2011	9.5%	16.2%	
FY 2012	7.8%	11.9%	
FY 2013	7.9%	13.0%	
FY 2014	12.1%		
Average	8.0%	11.9%	18.1%

Projections based on VISN and facility estimates indicate growth in onboard of 32.4% (1,212 employees) through FY 2022, and average total loss rates of 5.3% per year. Approximately 410 new hires each year will be required to maintain and grow the workforce as predicted.

Table 48: DRT Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	3,747	3,919	4,076	4,239	4,409	4,585	4,769	4,959	N/A
Employees Eligible for Regular Retirement		422	446	477	492	521	524	538	489
Voluntary Retirements	2.8%	1.8%	1.9%	2.0%	2.0%	2.1%	2.0%	2.0%	1.9%
Quits	2.8%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%	2.7%
Total Losses	6.1%	5.2%	5.3%	5.4%	5.4%	5.5%	5.4%	5.4%	5.3%
Gains Needed		375	371	390	405	426	441	460	410

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Pharmacist

Recruiting and retaining pharmacy leadership remains challenging. Leadership positions outside VA are in high demand resulting in a dramatic rise in salaries. VA is unable to compete and loses many leaders due to this demand. In VHA, Chief of Pharmacy and Associate Chief of Pharmacy positions remain difficult to fill. Several of these pharmacy leadership positions have been vacant for extended periods. Inaction to mitigate the risk may be worsening the difficulty in recruiting and retaining pharmacy leadership. Pharmacy students and residents are a pipeline for the development of future pharmacy leaders; therefore, local facilities and VISNs should incorporate more leadership and management training into student rotations and PGY-1 Pharmacy Residencies to increase the number of trainees who pursue an administration career path.

Regarding staffing gaps, based on staffing ratios included in VHA PACT Handbook 1101.10, only 52% of the required clinical pharmacy specialist FTEE are staffing PACTs. For mental health, Pharmacy Benefits Management (PBM) Service's assessment identified VA facilities have only 45% of the recommended two Mental Health clinical pharmacy specialist FTEEs per facility. Similarly, for pain management, PBM's assessment identified only 49% VA facilities have achieved the staffing requirements for one Pain Management clinical pharmacy specialist FTEE per facility. Specialized oncology pharmacists are also in great demand.

Pharmacists with broad-based hospital experience are currently in extremely limited supply. In this highly competitive market, it is difficult for VA to maintain a competitive salary with the non-federal sector. Hiring needs will be further increased by a significant number of retirements expected within the next six years as well as from the national PACT and Mental Health Initiatives that will require the addition of pharmacists into the team concepts of these initiatives.

Pharmacist Analysis

At the end of FY 2015, VHA's pharmacy onboard workforce totaled 7,747 employees. This represents a 19.3% increase in onboard strength since FY 2011 (+1,335 employees). Voluntary retirements remained fairly stable at approximately 2.2% per year, and quits also remained stable at approximately 2.4% per year.

Table 49: Pharmacist Workforce Trend Data

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	5 Year Cumulative or Average
Employees Onboard at End of FY	6,582	6,755	7,024	7,285	7,747	N/A
Net Increase in Onboard	170	173	269	261	462	1,335
Onboard Percent Change at End of FY	2.7%	2.6%	4.0%	3.7%	6.3%	19.3%
Voluntary Retirement Rate	1.9%	2.3%	2.2%	2.4%	2.2%	2.2%
Quit Rate	2.6%	2.4%	2.4%	2.4%	2.4%	2.4%
Total Loss Rate	5.3%	5.4%	5.4%	6.1%	5.5%	5.5%

Quit Rate includes resignations and transfers to other government agencies (Nature of Action Code 352G). Total Loss Rate includes retirements, quits, and all other losses (e.g., death, terminations, removals, and separations.)

On average, 21.2% of newly hired pharmacists quit within the first five years of employment, compared to 28.6% for the VHA MCO group and 26.9% for the total VHA workforce. Similar to the total workforce and VHA MCO, nearly two-thirds of new hire quits occur within the first two years.

Table 50: Pharmacist Quits by Year of Employment

	Year Employee Quit		
Year Hired	First Year	First 2 years	First 5 years
FY 2008	7.9%	11.5%	18.4%
FY 2009	8.6%	14.4%	23.3%
FY 2010	8.5%	13.7%	21.8%
FY 2011	7.8%	13.7%	
FY 2012	4.6%	8.3%	
FY 2013	6.9%	11.2%	
FY 2014	6.3%		
Average	7.2%	12.1%	21.2%

Projections based on VISN and facility estimates indicate growth in onboard of 35.6% (2,755 employees) through FY 2022, and average total loss rates of 5.2% per year. Approximately 879 new hires each year will be required to maintain and grow the workforce as predicted.

Table 51: Pharmacist Projected Workforce Data

	FY 2015 (Actuals)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	Average
Employees Onboard End of FY	7,747	8,158	8,508	8,874	9,256	9,654	10,069	10,502	N/A
Employees Eligible for Regular Retirement		996	991	973	956	956	936	917	961
Voluntary Retirements	2.2%	2.1%	2.1%	2.0%	1.9%	1.9%	1.8%	1.7%	1.9%
Quits	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%
Total Losses	5.5%	5.4%	5.4%	5.3%	5.2%	5.2%	5.1%	5.0%	5.2%
Gains Needed		853	808	836	865	899	930	963	879

Note: Percentages are calculated using the Employees Onboard at the End of FY for each year.

Additional Occupations to Watch:

Through the workforce and succession planning process, VISN and facility workforce planners have identified additional occupations to monitor carefully. Although these occupations have not been elevated to the top of the list, they may have recruitment and retention concerns or may have dropped from the MCO list because the issues have been effectively addressed.

Nurse Anesthetist

Despite recruiting challenges in rural markets, VHA has had success recruiting certified registered nurse anesthetists (CRNAs). However, establishing and maintaining competitive salary rates for CRNAs is a challenge for many VHA health care systems. Ongoing issues for CRNA recruitment and retention in VHA include the aggregate limit salary cap, the irregular performance of salary evaluations, and an increasing number of retirement aged individuals. Despite base salary advancement, in April 2015, 10.4% (94 of 902) of CRNAs still had retention allowances. The average allowance is $18,263 with a range of $5,691 to $49,999.The median amount is $16,689.

Licensed Practical Nurse

The loss rate for LPN has increased from 7.8% in FY 2011 to 8.2% in FY 2015. According to the exit survey the top reasons for leaving are normal retirement, early or disability retirement, unique advancement opportunity elsewhere, and to attend school. To enhance recruitment and retention efforts, local facilities and VISNs should market and provide professional development and educational opportunities, and conduct more consistent marketing and use of the VANEEP, a program which provides salary replacement dollars for full-time nurses in education programs and has been shown to increase retention. VALOR and the RNTTP program also offer ways to smooth the transition into the RN role.

Medical Instrument Technologist

This occupation is difficult-to-fill in VHA due to a limited number of qualified candidates for vacancies. Similar to other top occupations, private sector salaries are far greater than VHA. Recruitment is especially difficult in specialty areas such as cardiology and ultrasound due to rapid technology changes. If the occupation is in the facility's MCO list, it can enhance recruitment and retention by increasing the use of incentives such as EDRP and SLRP. Student internship programs and the VALOR program should also be leveraged to convert students to VHA appointments at the conclusion of the training program.

Medical Records Technician (MRT)

Hiring and retention of MRTs is more difficult at some VHA facilities than others due to the lack of a pool of qualified candidates and competition with the private sector. The lack of Health Information Technology and/or Health Information Management (HIM) schools in some states makes this even more difficult. While local facilities can enhance recruitment by partnering with technical colleges, some facilities report shortages of nearby colleges with which they can partner. Competition for graduates in areas already saturated with private sector MRT opportunities is also an issue. Skill deficiency is a critical gap due to the mandated transition to the new

International Classification of Diseases (ICD) coding system (ICD-9 to ICD-10). From the 2014 VHA HIM Inventory/Data Call: 6% of the current MRTs (Coder) indicated their intent to retire due to implementation of ICD-10, a 15% increase in MRT Release of Information(ROI) vacancies; and a 6% increase in MRT (Coder) vacancies. To mitigate this gap, VHA has provided an extensive ICD-10 training program for the MRT (Coder) through presentations and courses available live and on demand in MyVeHU and other venues. Several VHA facilities funded ICD-10 Trainer certification through the American Health Information Management Association. Continued VHA sponsored/organized training and career development efforts will aid in improving retention.

Health Aid and Technician

The health aid and technician is designed as a "catch-all" category for nonprofessional positions in health and medical work for which no adequate occupational series designation exists. Minimum educational requirements are a high school diploma or General Eligibility Determination, but some industry employers prefer an Associate's degree in a health care-related field. For VHA, the health aid and technician is an entry-level, high-school or Associate's degree program. As a result, annual average quit and total loss rates of 4.6% and 9.0%, respectively, is high because employees use the position as a stepping stone to other health care careers. In turn, these vacancies may lead to inefficiencies in clinical operations as clinical staff members are left to cover the duties. Local facilities and VISNs can improve recruitment and retention by targeting recruitment efforts to local high school or community college graduates, offering available recruitment or education incentives to entice qualified candidates, and expanding NNEI and VANEEP to employees in these positions who want to pursue higher level nursing careers.

Conclusion

FY 2015 was an unprecedented year of change in VHA and this plan reflects increased efforts by leadership and staff to define workforce actions and strategies into the future. Strategic priorities such as the MyVA Integrated Plan, Choice Act of 2014, Blueprint for Excellence, Under Secretary of Health's Five Priorities, VHA Modernization Report, projections of Veteran demand, and new models of care will drive the organization's future workforce needs.

Since FY 2011, VHA has experienced onboard growth of 17.7%, and a trend of increasing losses, particularly quits. Projections indicate continued growth of 28.6% by FY 2022.

Employees identified pay, promotion and merit/recognition systems, dealing with poor performers, and a desire for greater workforce motivation as areas for improvement. Because servant leadership principles align closely with the leadership behaviors that influence employee engagement, VHA is providing skill-building opportunities for supervisors and managers at all levels during FY 2016 and FY 2017.

VHA faces a critical number of vacancies in medical center senior leadership positions, for which a long-term strategy to identify, develop, and leverage VHA's emerging leaders is being developed. Statistics reveal supervisor loss rates of approximately 7.2% per year since FY 2011, and executive vacancies of approximately 21%, with high projected retirement eligibility.

The VHA national mission critical occupations include medical officer, nurse, human resource management, physical therapist, physician assistant, psychology, medical technologist, occupational therapist, diagnostic radiologic technologist, and pharmacist. The most critical challenges for these occupations include gaps between supply and demand, inability to compete with the private sector, local medical center budgetary restraints that prevent offering retention incentives, and inefficient hiring practices. Local actions to establish or adjust special salary rates, streamline and improve hiring processes, and fully utilize available monetary and non-monetary incentives were identified as best practices.

Clinic schedulers (i.e., Medical Support Assistants) provide services that ensure Veterans receive timely access to care. Challenges such as turnover, lack of succession planning, standardized training, and a standard organizational structure impede effective recruitment and retention. VHA has initiated on-site interviews and additional detailed analyses to inform future actions.

The Choice Act and VHA identified Mental Health, Primary Care, Gastroenterology, and Women's Health as priorities. These clinics experienced cross cutting issues such as increased need for care coordination, lack of workforce data to identify clinical and support staff via clinical service lines, and gaps in compensation with the private sector. Planned actions include development and implementation of staffing models, improved HR data systems to track the workforce, and continued analysis of private sector competition and pay.

Continuous improvements in workforce and succession planning will ensure VHA continues 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.

Appendix A: Acryonms

ACA	Affordable Care Act
ADUSH	Assistant Deputy Under Secretary for Health
AES	All Employee Survey
AF	Asian Female
AIF	American Indian Female
AIM	American Indian Male
AM	Asian Male
APA	American Psychological Association
BF	Black Female
BHIP	Behavioral Health Interdisciplinary Program
BHPR	Bureau of Health Professions
BLS	Bureau of Labor Statistics
BM	Black Male
CBOC	Community Based Outpatient Clinics
CHO	Connected Health Office
CRNA	Certified Registered Nurse Anesthetists
CT	Computerized Tomography
DoD	Department of Defense
DRT	Diagnostic Radiologic Technologist
DWHPCP	Designated Women's Health Primary Care Provider
EDRP	Education Debt Reduction Program
EE	Employee Experience
EEI	Employee Engagement Index
EHCPM	Enrollee Health Care Projection Model
EISP	Employee Incentive Scholarship Program
FEVS	Federal Employee Viewpoint Survey
FIT	Field-based Implementation Teams
FTEE	Full Time Employee Equivalent
FY	Fiscal Year
GAO	Government Accountability Office

GI	Gastroenterology
GME	Graduate Medical Education
GMH	General Mental Health
GS	General Schedule
HBPC	Home Based Primary Care
HF	Hispanic Female
HIM	Health Information Management
HM	Hispanic Male
HPSP	Health Professional Scholarship Program
HR	Human Resources
HR3	HR Restoration and Revitalization
HRM	Human Resources Management
HRSA	Health Resources and Services Administration's
ICARE	Integrity, Commitment, Advocacy, Respect, and Excellence
ICD	International Classification of Diseases
IEES	Integrated Employee Ethics Survey
IQ	Inclusion Quotient
ISP	Interim Staffing Program
IT	Information Technology
JOLTS	Job Openings and Labor Turnover Survey
LOS	Learning Organization Survey
LPN	Licensed Practical Nurses
MCO	Mission Critical Occupations
MH	Mental Health
MIP	MyVA Integrated Plan
MRI	Magnetic Resonance Imaging
MSA	Medical Support Assistant
MT	Medical Technologist
NHF	Native Hawaiian/Pacific Islander Female
NHM	Native Hawaiian/Pacific Islander Male
NNEI	National Nursing Education Initiative

NP	Nurse Practitioners
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations
OEF	Operation Enduring Freedom
OF	Other/Multiple Female
OHRM	Office of Human Resources Management
OIF	Operation Iraqi Freedom
OIG	Office of Inspector General
OM	Other/Multiple Male
OND	Operation New Dawn
OPCC&CT	Office of Patient Centered Care and Cultural Transformation
OPM	Office of Personnel Management
OT	Occupational Therapist
PA	Physician Assistants
PACT	Patient Aligned Care Teams
PAID	Personnel and Accounting Integrated Data System
PCC	Patient Centered Care
PCMHI	Primary Care Mental Health Integration
PCMM	Primary Care Management Module
PGY	Post-Graduate Year
PI	Performance Improvement
pp	Percentage Point
PT	Physical Therapist
PTSD	Post Traumatic Stress Disorder
Q	Question
RCLF	Relevant Civilian Labor Force
RN	Registered Nurses
RNTTP	RN Transition to Practice
RT	Radiologic Technology
RVU	Relative Value Unit
SES	Senior Executive Service

SLRP	Student Loan Repayment Programs
SME	Subject Matter Experts
SMH	Specialty Mental Health
SPARQ	Specialty Productivity Access Report and Quadrant
SSE	Support Service Excellence
U.S.	United States
VA	Department of Veteran Affairs
VACAA	Veterans Access, Choice and Accountability Act of 2014
VA-CASE	VA - Center for Applied Systems Engineering
VACO	VA Central Office
VALOR	VA Learning Opportunity Residency
VAMC	VA Medical Center
VANAP	VA Nursing Academic Partnership
VANEEP	VA National Education for Employee Program
VCP	Veterans Choice Program
VHA	Veterans Health Administration
VIOMPSP	Visual Impairment and Orientation and Mobility Professionals Scholarship Program
VISN	Veteran Integrated Service Networks
VSSC	VHA Support Service Center
WF	White Female
WH	Women's Health
WHP	Women's Health Programs
WM	White Male
WMC	Workforce Management and Consulting
WVPM	Women Veteran Program Manager

Appendix B: Data Defintions

Age Trends Data

Data exclude medical residents, trainees with assignment codes T0 (zero) through T9 & intermittent employees. Data include permanent & temporary, full-time & part-time employees in a pay status. Loss data are based on the date the loss was effective. Data Source: HR Turnover Cube.

Diversity Analysis (Disability & Veteran) Data

Workforce distribution data are provided as one element to be reviewed to determine if there are any barriers to meeting department hiring goals. This information is not, under any circumstances, to be used to establish hiring quotas or as the basis for any ultimate hiring decision. Data exclude medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data include permanent & temporary, full-time & part-time employees in a pay status. Loss data are based on the date the loss was effective. Targeted disabilities are blindness, deafness, missing extremities, partial paralysis, total paralysis, epilepsy, severe intellectual disability, psychiatric disability, and dwarfism. Veterans are identified from the Veteran preference dimension and include Veterans with no preference, 5 point, 10 point disability, 10 point less than 30% disability, 10 point more than 30% disability. Data Source: HR Employee Cube.

Diversity Analysis (Race/Gender) Data

Workforce distribution data are provided as one element to be reviewed to determine if there are any barriers to full participation. This information is not, under any circumstances, to be used to establish hiring quotas or as the basis for any ultimate hiring decision. Integration of diversity in the Workforce and Succession Strategic Plan does not replace MD-715 requirements (Affirmative Employment Planning). Native Hawaiian/Pacific Islander became a new category for reporting in FY 2009. Minorities include Black, Hispanic, Asian, Native Hawaiian/Pacific Islander, American Indian and other. Data source for onboard data: HR Employee Cube. VHA combined occupations relevant civilian labor force (RCLF) is computed from all census occupations used by VHA. Data source for RCLF percentages is the VSSC RCLF report. Ratio of calculated based on the current year percentage divided by the RCLF percentage. All diversity data exclude medical residents, trainees with assignment codes T0 through T9, and intermittent employees. Data include permanent & temporary, full-time & part-time employees in pay status.

Entrance Survey Data

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. Data includes VHA employees. The denominator data (total number of hires or gains) excludes temporary gains, medical residents, trainees with assignment codes T0 through

T9 & intermittent employees, but includes permanent & temporary, full-time & part-time employees in a Pay status. Data Sources: Entrance Survey Cube and HR NOA Cube.

Exit Survey Data

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, HR officers, and senior leadership with valuable information to help improve employee retention and morale. Data includes VHA employees. The denominator data (total number of voluntary losses) excludes medical residents, trainees with assignment codes T0 through T9 & intermittent employees, but includes permanent & temporary, full-time & part-time employees in a pay status, and those that left on a voluntary basis (NOA codes voluntary retirements, 317 resignations, and 352G transfers to other government agencies). Data Sources: Exit Survey Cube and HR NOA Cube.

Projected Workforce Data

Losses are aggregated into three categories for summary purposes: voluntary retirements, regrettable losses, and other losses. "Regrettable Losses" include resignations and 352G transfers to other government agencies. Other losses also include employees who were removed from their position (fired), deaths, disability retirements, and special retirements (require OPM authority). "Employees Eligible for Retirement" includes only Civil Service Retirement System (CSRS) and Federal Employee Retirement System (FERS) full annuity retirement eligibility. Few FERS Reduced or Deferred Annuity retirement-eligible employees actually retire, therefore, they are not included in computing employees eligible for retirement. "Gains Needed" includes losses plus growth compared to the previous year. Data exclude medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data include permanent & temporary, full-time & part-time employees in a pay status. Data Sources: HR NOA Cube for current year losses; VSSC Retirement Eligibility Report (for retirement projections).

Quits by Year Data

Data represent the number of resignations and 352G transfers to other government agencies for each "Gain Year" (i.e., the year the employee was hired) by their year of employment with VHA. Data exclude 901 transfers to other VA Administrations, temporary appointments, medical residents, and trainees with assignment codes T0 through T9, but include temporary assignments for psychology, social work, general health science, medical officer (physician), physician assistant, nurse anesthetist, nurse, practical nurse, dietitian and nutritionist, occupational therapist, physical therapist, corrective therapist, rehabilitation therapist assistant, health aid and technician, medical technologist, diagnostic radiologic technologist, therapeutic radiologic technologist, medical instrument technologist, pharmacist, pharmacy technician, speech pathology and audiology, orthotist and prosthetist, medical records administration, prosthetic representative, medical records technician, dental assistant, and dental hygiene. Data Source: PAID databases.

Veteran New Hire Data

Data exclude medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data include hires (gains) for permanent & temporary, full-time & part-time employees in a pay status. Veterans are identified from the Veterans preference dimension and includes Veterans with no preference, 5 point, 10 point disability, 10 point less than 30% disability, 10 point more than 30% disability Data Source: HR NOA Cube.

Workforce Trends Data

Data exclude medical residents, trainees with assignment codes T0 through T9 & intermittent employees. Data include permanent & temporary, full-time & part-time employees in a pay status. Loss data are based on the date the loss was effective. "Net increase in onboard" are computed as the growth over the previous year. *Regrettable Loss Rate includes 317 resignations and 352G transfers; it no longer includes 901 transfers to other VA administrations. Total Loss also does not include 900 transfer to another VA station or 901 transfers to other VA administrations. Sum of all category losses will not equal total losses due to the calculation to removed duplication NOA action entries. Data Source: HR Employee Cube and HR NOA Cube.