



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL Review

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Health Administration Staffing Models



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Executive Summary

This review was conducted in response to the fiscal year (FY) 2020 Appropriations Conference Report, which directed the VA Office of Inspector General (OIG) “to review [the Veterans Health Administration’s] VHA’s progress in developing a comprehensive staffing model and timeline for implementation.”¹ The OIG reviewed VHA’s staffing models, the implementation of staffing models, and staffing levels and requirements. The OIG expanded the scope of the review to include an analysis of VHA hiring during the COVID-19 pandemic.

VHA National Workforce Planning Team staff reported that staffing models exist for all occupations and, generally, facility directors reported they were aware of VHA staffing models for occupations designated as severe occupational shortages. Although the VHA staffing models (reports developed by VHA Office of Productivity, Efficiency and Staffing (VHA OPES)) referenced by VHA’s National Workforce Planning Team were available for facility use and “provide[d] information on staffing,” these models did not determine staffing requirements. VA Directive 5010 requires that staffing models used to determine staffing requirements must be verified, validated, and approved by VA Manpower. The OIG found that staffing models used to determine staffing requirements were in development, and as of October 2020, only the Caregiver Staffing Model had been validated as required by directive.² At their current staffing level, VA Manpower plans to develop *initial* staffing models for all direct patient care positions by the end of FY 2022.³ The VA Manpower Director indicated the initial staffing models will use OPES provider productivity standards and the VA Enrollee Health Care Projection Model provider work relative value unit projections to develop requirements for providers by specialty and skill type. Initial support staff staffing models will use benchmarking, with appropriate workload factors baselined to HR Smart positions by function, to develop staffing requirements. This approach to staffing models will provide workload-based staffing requirements that can be documented in the VA’s authoritative data source for staffing (HR Smart) for providers and support staff. However, it is unclear whether these initial models will be validated by FY 2024, VA Manpower’s anticipated completion date, given VA Manpower’s emphasis on the importance of a feedback loop with VHA to validate staffing models. Additionally, the manpower offices noted additional staffing resources may expedite the development and validation of VHA staffing models.

¹ Congressional Record 116th Congress, 1st Session, 2019. Vol. 165, No. 204, accessed January 12, 2021, <https://www.govinfo.gov/content/pkg/CREC-2019-12-17/pdf/CREC-2019-12-17-house-bk3.pdf>.

² VA Directive 5010, *Manpower Management Policy*, October 28, 2019.

³ This excludes nurses as the Office of Nursing Services has a Staffing Methodology for VHA Nursing Personnel. VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

Scope and Methodology

The OIG conducted a survey of VHA facility directors to evaluate awareness of staffing models, staffing levels, staffing requirements, and implementation of staffing models. Through interviews, follow-up questionnaires, and VA and non-VA data and literature reviews, the OIG gained additional insight into the development, validation, and implementation of VHA staffing models, facility-level staffing practices, and pandemic hiring during COVID-19. The OIG interviewed all 18 Veterans Integrated Service Network (VISN) directors, VA's Chief Human Capital Officer, VHA Finance leaders, as well as staff from VA Manpower, VHA Workforce Management and Consulting (VHA WMC), and VHA OPES.

Management of Staffing Models

Three offices have responsibility for VHA staffing models. VA Directive 5010, *Manpower Management Policy*, established VA Manpower in October 2019 and tasked that office with verifying, validating, and approving the staffing models and standards used to determine manpower requirements for planning, budgeting, and strategic workforce management.⁴ The VHA Manpower Management Office (VHA Manpower), which is within VHA WMC, is tasked with determining workload-based staffing levels. VHA OPES develops staffing reports designed to inform managers' staffing decisions at the facility level.

Staff from VA Manpower, VHA Manpower, and VHA OPES described their roles and responsibilities associated with the development, validation, and implementation of VHA staffing models. Through implementation of VA Directive 5010, VHA Manpower was assigned primary responsibility for the development of staffing models within VHA.⁵ However, when asked which office was responsible for development of staffing models, the directors of VA Manpower, VHA Manpower, and VHA OPES generally reported it was a collaborative effort. Although VA Directive 5010 assigns the responsibility of staffing model validation to VA Manpower, the VHA OPES Director noted they also have a role in validation.⁶ While VA Directive 5010 assigns responsibility for development and validation, it does not assign responsibility for staffing model implementation.

Staffing Model Definitions and Development

In their broadest form, staffing models are analytic tools that provide workload-based staffing data to support workforce optimization. Staffing models can be used to inform managers' decisions regarding budgetary requirements and workforce planning. Staffing model program

⁴ VA Directive 5010.

⁵ VA Directive 5010.

⁶ VA Directive 5010.

office directors from VA and VHA define staffing models differently. The VA Manpower Director operationally defines the use of a staffing model as an approach to determine manpower requirements by utilizing productivity standards or other workload-based approaches to produce the minimum number of people required to meet the functional requirements of the mission for a program or facility. In this Director's view, the approach should not implement mandatory staffing levels, but rather inform budget and workforce planning at the national level, in addition to helping facilities determine their staffing needs. The Director of VHA Manpower, along with the VHA OPES Director, defined staffing models as a set of reports that inform the process of acquiring, deploying, and retaining staff without determining a minimum threshold of staff required to fulfill operational demand. Directors from VHA Manpower and VHA OPES explained that determining the minimum number of staff is not appropriate for health care. Instead, the two staffing model program offices from VHA compare a single facility's observed staffing and productivity levels to the average levels of similar facilities.

VISN directors expressed that the available staffing models (such as those noted by VA Manpower and VHA) were used as guides and facility directors were ultimately responsible for determining staffing levels at facilities.⁷ While the available staffing models were generally described as helpful, VISN directors identified issues with these staffing models including inconsistent standards and a lack of confidence in benchmarks. Flexibility was reported as a key element of any staffing model. There was an overall concern that staffing models would be used as a mandatory metric that facilities may not be able to meet.

Facility-Level Staffing Requirements

In previous reviews, the OIG used the survey-based annual *OIG Determination of Occupational Staffing Shortages* reports to highlight severe occupational shortages. Since FY 2014, these reports have consistently recommended the development and implementation of staffing models. When asked why occupations were indicated as severe occupational shortages, facility directors cited a lack of qualified applicants, noncompetitive compensation, staff turnover, and both general and geographical recruitment challenges as the top reasons. The reasons for severe occupational shortages have remained consistent over the past three years. VHA has created action plans to address severe shortages, but these issues remain long-standing.⁸

⁷ Similar to VA Manpower, VHA Manpower, and VHA OPES; VISN directors did not all share the same definition of staffing models. When asked what made staffing models useful, VISN directors described existing staffing models (such as those noted by VA Manpower and VHA) as well as VHA staffing guidance (such as those identified in appendix F).

⁸ In the past six years, the OIG has issued 13 recommendations to VHA to develop, implement, or modify staffing models. All but one of these recommendations, to "[e]nsure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities" from *Inadequate Governance of the VA Police Program at Medical Facilities*, Report No. 17-01007-01, December 31, 2018, have been closed.

Through this review, the OIG observed that the absence of validated and implemented staffing models across VHA resulted in inconsistent approaches in how staffing requirements were determined. The OIG found facility-developed methods were primarily used to identify requirements. Additionally, the OIG requested facility directors provide the number of staff required for the top five clinical and top five nonclinical occupational staffing shortages. The OIG found that facility directors generally reported that their staffing requirements exceeded the number of staff on hand. However, it must be noted this analysis does not account for severity of the excess and is not necessarily an indicator for poor delivery of care. This highlights how challenging it is to consistently identify staffing requirements in the absence of validated staffing models.

When staffing requirements exceed the number of staff on hand, facility directors have to make difficult staffing decisions. Facility directors, using facility-level resource management boards and committees, determine which staffing requirements to prioritize and how to address those requirements. Budgetary constraints, such as limited funding, can affect determinations. In these scenarios, it was reported that facility directors make trade-off decisions in staffing, for example, hires are made in one occupation instead of another depending on the priorities of the facility.

As part of the OIG’s review of staffing levels and requirements in this report, the OIG sought staffing data on authorizations and vacancies for selected occupations at the facility level. However, the data was not readily available as the authorization data could not be provided by occupation. Additionally, staff from VHA WMC were not confident of the historical vacancy data prior to December 31, 2019, due to a comprehensive cleanup of data. An estimated 20,000–25,000 positions were involved in the cleanup, and VHA WMC staff reported that vacancy data maintenance is not yet complete. Without this data, the OIG did not consider VHA in alignment with policy that requires VHA Manpower to ensure validated manpower requirements and position data are appropriately documented.⁹

VHA Staffing Related to VHA’s COVID-19 Pandemic Response

In response to the COVID-19 pandemic, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act in March 2020, which provided VHA with \$17.2 billion in funding to ensure VHA had the staff, equipment, telehealth capabilities, supplies, and support services necessary to support employees and veterans.¹⁰ The COVID-19 pandemic altered the delivery of health care, which in turn, affected staffing needs at facilities. However, CARES Act funding is temporary, and the staff hired under this Act “do not reflect an ongoing capacity

⁹ VA Directive 5010.

¹⁰ Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136 (2020).

requirement.”¹¹ The OIG suggests it is important for VA and VHA to accurately track and report the number of COVID-19 employees as these positions are funded through the CARES Act.

During the pandemic, VA and VHA reported annual increases in net staffing levels at VHA. However, VA and VHA could benefit from consistency when reporting staffing data. VHA's methodology for calculating onboard staffing levels yielded annual net increases nearly three times those indicated in VA's Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act 505 Data. Separately, the OIG obtained line-level HR Smart data which indicated VHA increased net staffing levels by over 5,000 for the top five clinical and top five nonclinical severe shortage occupations from March 2020 to October 2020.

VISN directors reported a hiring surge that included doctors, nurses, respiratory therapists, custodians, and housekeeping staff to address increased demand for inpatient care, along with human resources staff to support hiring efforts. Additionally, existing staff were repurposed to address changes in workload. Examples given included utilizing outpatient doctors and nurses to deliver care in inpatient settings, and training administrative staff for entrance screening duties.

VISN directors generally described positive outcomes related to the speed and volume of pandemic hiring. Flexibilities in hiring practices increased staffing levels while decreasing time-to-hire rates, allowing the backlog of care that was deferred by the pandemic to be reviewed and addressed. However, a few directors reported negative outcomes that needed to be overcome, such as issues with existing administrative processes and functions. For example, facilities were not initially prepared to bring new employees onboard during a pay period because it was standard practice to onboard new employees at the beginning of a pay period.

Some of the unintended consequences of the hiring surge required changes in processes. Prior to the pandemic, provider credentialing and background checks took place before a new employee was onboarded. In an effort to onboard providers as quickly as possible, these human resources processes were postponed until after the employee was onboard. Despite these changes, VISN directors expressed confidence in the quality of hired providers. Focused and ongoing professional practice evaluations still applied, and VISN directors reported having the authority to separate new providers who were deemed unsuitable for federal employment.

The Acting Director of the Office of Personnel Management authorized the use of temporary appointments under 5 C.F.R. § 213.3102(i)(3) “to address the need for hiring additional staff in response to [COVID-19].”¹² VISN directors expressed that bringing employees on in a temporary appointment allowed the opportunity for both the facility and new employee to

¹¹ VA, *VA MISSION Act, Section 505 Annual Report – 2021: Annual Report on the Steps Taken to Achieve Full Staffing Capacity*, May 2021.

¹² OPM, “Coronavirus (COVID-19) Schedule A Hiring Authority,” March 20, 2020, accessed December 28, 2020, <https://www.opm.gov/policy-data-oversight/covid-19/opm-memorandum-coronavirus-schedule-a-hiring-authority/>.

determine if the VA was a good fit before converting to permanent employee status. VISN directors were generally satisfied with the quality of staff hired during the surge.

VISN directors praised the hiring flexibilities afforded them during the pandemic and expressed the need for continued or expanded authority to hire staff noncompetitively, with specific focus on positions hired under Title 5, such as Housekeeping Aid positions. Leaders from VHA WMC supported making the flexibilities granted during the pandemic permanent, and VA submitted a legislative proposal aimed at expediting recruitment and hiring of Housekeeping Aids.

OIG Recommendations

The OIG made three recommendations to the VHA Under Secretary for Health to coordinate with VA to

- Review the roles, responsibilities, and number of staff required for the VA and VHA offices involved in the development, validation, and implementation of staffing models, and ensure that staffing model-related efforts are prioritized and supported;
- Evaluate the status of, and provide a timeline for, the development, validation, and implementation of VHA staffing models for all occupations; and
- Evaluate the status of, and provide a timeline for, the implementation of HR Smart-related requirements referenced in VA and VHA policy, with a specific focus on the authorizations, vacancies, budgeted positions, and unbudgeted requirements at the facility, Veterans Integrated Service Network, and national levels.¹³

Comments

It is important that VA and VHA continue to work collaboratively on the staffing model issues discussed in this report. The Acting Under Secretary for Health concurred with the recommendations and provided an action plan (see appendix L). The OIG will follow up on the planned actions until they are completed.



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¹³ VA Directive 5010; HR Smart is VA's human capital system of record for positions.

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Abbreviations

CARES Act	Coronavirus Aid, Relief, and Economic Security Act
FTE	full-time equivalent
FY	fiscal year
GAO	Government Accountability Office
MISSION	VA Maintaining Internal Systems and Strengthening Integrated Outside Networks
OIG	Office of Inspector General
OPM	United States Office of Personnel Management
VA Manpower	VA Manpower Management Service
VHA	Veterans Health Administration
VHA OPES	VHA Office of Productivity, Efficiency and Staffing
VHA Manpower	VHA Manpower Management Office
VHA WMC	VHA Workforce Management and Consulting
VISN	Veterans Integrated Service Network



Introduction

This review was conducted in response to the fiscal year (FY) 2020 Appropriations Conference Report, which directed the VA Office of Inspector General (OIG) “to review [the Veterans Health Administration’s] VHA’s progress in developing a comprehensive staffing model and timeline for implementation.”¹⁴ The OIG reviewed VHA’s staffing models, the implementation of staffing models, and staffing levels and requirements. The OIG expanded the scope of the review to include an analysis of VHA hiring during the pandemic.¹⁵

Background

Legislative History

Congress has had a long-standing interest in ensuring appropriate staffing at VHA. The Veterans Access, Choice, and Accountability Act of 2014 was passed by Congress in response to concerns about the quality of VHA care, scheduling practices, and excessive wait times. The Choice Act required the OIG to annually determine the five VHA occupations with the largest staffing shortages.¹⁶ Starting with the first annual staffing determination report, published in January 2015, the OIG made several recommendations regarding the development and implementation of staffing models for critical-need occupations.¹⁷

Since 2014, Congress has passed additional legislation regarding VHA staffing. The VA Choice and Quality Employment Act of 2017 expanded the OIG’s annual determination to include a minimum of five clinical and five nonclinical VHA occupations with the largest staffing shortages within each medical center (facility).¹⁸ Subsequently, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 established the Veterans Community Care Program to assess and improve how veterans receive care from providers outside the VA.¹⁹ Additionally, the MISSION Act provided improvements to

¹⁴ Congressional Record 116th Congress, 1st Session, 2019. Vol. 165, No. 204, accessed February 4, 2020, <https://www.govinfo.gov/content/pkg/CREC-2019-12-17/pdf/CREC-2019-12-17-house-bk3.pdf>.

¹⁵ Mayo Clinic, “Coronavirus disease 2019 (COVID-19),” accessed November 23, 2020, <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963>. A new virus known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was discovered to cause the novel coronavirus outbreak in China. This disease was later renamed COVID-19 by the World Health Organization and was declared a pandemic because it occurred over a wide geographic area and affected a high proportion of the world’s population.

¹⁶ Veterans Access Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1754 (2014).

¹⁷ VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages*, Report No. 15-00430-103, January 30, 2015. Language has changed since the first report from critical need to severe shortage.

¹⁸ VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, 131 Stat. 958 (2017).

¹⁹ VA MISSION Act of 2018, Pub. L. No. 115-182, 132 Stat. 1412 (2018).

recruitment incentives for VA healthcare professionals. The VA MISSION Act requires the Secretary of VA to submit to Congress an annual report of steps taken to achieve full staffing capacity and the amount of additional funds necessary to reach full staffing capacity. The VA MISSION Act also requires that VA publicly provides transparency of staffing and vacancies on their website with the following information by facility: (1) number of personnel encumbering positions, (2) number of acquisitions and separations during the quarter, (3) number of vacancies by occupation, and (4) percentage of new hires within the time-to-hire target of the Office of Personnel Management (OPM).

Staffing Models

Previous reviews conducted by the Government Accountability Office (GAO) and OIG related to staffing models have not clearly defined what constitutes a staffing model. In their broadest form, staffing models are analytic tools that provide workload-based staffing data to support workforce optimization. Such a model can be used at various levels of the agency such as individual VHA facilities, Veterans Integrated Service Networks (VISNs), or across VHA to inform budgetary requirements and workforce planning.

It is important to note that within VA and VHA, staffing models used for manpower requirement determinations must be validated.²⁰ So, while staffing models may have been developed, if they are to be used for determining requirements, they must also be validated.

Management of Staffing Models

VA Directive 5010, *Manpower Management Policy*, establishes roles, responsibilities, and manpower management functions throughout VA.²¹ VA Manpower Management Service (VA Manpower) was established to facilitate planning, budgeting, and strategic workforce management by implementing policy and processes for oversight and organizational design. Additionally, the directive requires VA Manpower to initially verify, validate, and approve staffing standards or models used for manpower requirements determination. VA Manpower is also responsible for the revalidation of staffing models every three years, or when there is a change to mission or functions, and ensuring changes are documented within the VA's human capital system of record known as HR Smart.²²

²⁰ VA Directive 5010, *Manpower Management Policy*, October 28, 2019.

²¹ VA Directive 5010; The Office of Management and Budget Memorandum 17-22, *Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce*, April 12, 2017, required federal agencies to adapt manpower management to reform the federal government and take long-term steps to reduce the size and cost of the federal civilian workforce. Agencies were to develop long-term staffing plans to include consideration of determining appropriate full-time equivalent levels utilizing data to establish appropriate staffing levels in order to accomplish the agency's objectives. In response, VA established VA Manpower on October 5, 2017, and issued VA Directive 5010 in October 2019.

²² VA Directive 5010.

The VHA Manpower Management Office (VHA Manpower), within VHA’s Office of Workforce Management and Consulting (VHA WMC), is the appointed manpower management program for VHA. This office is responsible for determining workload-based staffing levels, and aligning staffing requirements to mission priorities and funding within VHA.²³

VHA’s Office of Productivity, Efficiency and Staffing (VHA OPES), within VHA’s Office of Quality and Patient Safety, assists VHA Manpower with “developing management tools, systems, and studies” to optimize staffing and inform decision-making. This office utilizes data and mapping of productivity to produce staffing reports that include both the clinical and administrative functions for medical specialties.

Although VA Manpower, VHA Manpower, and VHA OPES fall under different areas of the VA organizational structure, they often collaborate. (For reference to the above offices’ organizational structures, please refer to appendix A.)

Budget Effects on Staffing Levels

VA requires facilities to use authorized positions for strategic workforce planning and recruitment actions.²⁴ Accordingly, facilities can hire for budgeted positions approved by a resource board or authoritative resource manager through a budgeting process at each facility. These budgeted positions are based on the total number of positions at the facility, including part-time and intermittent positions, but do not account for staff turnover. A vacant position is a required and budgeted position that is unfilled. Although the process for approving budgeted positions is influenced by clinical need, VHA facilities also consider other non-staffing-related expenses such as leases, contracts, equipment, and supplies. As such, affordability is a major factor in the prioritization and authorization of positions. Unbudgeted positions are defined by VHA as those positions that represent a requirement to complete a mission function, but funding is unavailable to fund the requirement. For example, if a facility has 40 staff employed (on hand) for an occupation that has an identified operational requirement of 70, but the funding stream only allows the facility to hire 10 for a total of 50 positions, it would likely need additional funding to be able to hire for the 20 required, but unbudgeted, positions. While facility directors have autonomy over resource allocation, to include budgeting for positions, facility directors would not be able to hire staff according to the operational demands of the facility if they were not fully funded.

²³ VA Directive 5010.

²⁴ VA Directive 5010.

The data for both budgeted and unbudgeted positions are required to be documented in HR Smart.²⁵ Position managers are responsible for this documentation, which involves creating a position record using the functions in HR Smart’s Position Management pages.

COVID-19 and the Coronavirus Aid, Relief, and Economic Security Act

In late 2019, a new virus known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was discovered to cause the novel coronavirus outbreak in China. This disease was later renamed COVID-19 by the World Health Organization and was declared a pandemic because it occurred over a wide geographic area and affected a high proportion of the world’s population.²⁶ After the pandemic began in the United States, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was passed by Congress on March 27, 2020. The Act awarded VHA \$17.2 billion in funding to ensure that VHA had the staff, equipment, telehealth capabilities, supplies, and support services necessary to support employees and veterans across facilities.²⁷

In response to the pandemic, VHA implemented the COVID-19 Response Plan to protect and mitigate the impact of COVID-19 on veterans, employees, and the VHA healthcare delivery system.²⁸ Facilities assessed patients and placed them into one of two treatment zones: (1) suspected and confirmed COVID-19 cases, and (2) standard healthcare cases. Care providers in community-based outpatient clinics were to use an “all telehealth” mode with the exception of some urgent care patients. Patient aligned care teams and specialty clinics were also to use non-face-to-face methods of communication with their scheduled patients, and elective surgeries were to be deferred in anticipation of a patient surge related to COVID-19 cases.²⁹

Prior Reports

The development, validation, and implementation of staffing models at VHA has been an ongoing topic of concern for several years. In the past six years, the OIG has issued 12 reports

²⁵ VA Directive 5010.

²⁶ Mayo Clinic, “Coronavirus Disease 2019 (COVID-19): Symptoms & causes,” accessed November 23, 2020, <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963>.

²⁷ Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136 (2020).

²⁸ VHA—Office of Emergency Management, *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan, ver 1.6*, March 23, 2020.

²⁹ “Patient-aligned care team is a team-based model of care in which a team of health professionals, led by a provider, works collaboratively with the patient to provide for all of the patient’s healthcare needs—or appropriately coordinates care with other qualified professionals.” Health Services Research & Development, *Research Topics: Patient-Aligned Care Teams*, accessed December 30, 2020, https://www.hsrd.research.va.gov/research_topics/pact.cfm.

related to occupational staffing shortages and the impact to operations at VHA facilities.³⁰ The OIG has issued 13 recommendations to VHA involving the development, implementation, or modification of staffing models. Two of the 13 recommendations were specific to single programs, Mental Health and Police. The remaining 11 recommendations have been issued for *critical-need occupations* in six of the OIG's seven annual staffing determination reports.³¹ As of this report, one recommendation from the OIG's 2019 *Inadequate Governance of the VA Police Program at Medical Facilities* report, to ensure police staffing models are implemented, remains open. (Appendix B provides detailed information on the status of the recommendations for all 12 reports.)

Within the VA report, *Department of Veterans Affairs Agency Financial Report Fiscal Year 2020*, the OIG had the opportunity to provide input and identified Leadership and Governance as a VA Management and Performance Challenge, stating the "OIG has repeatedly called for VHA to develop additional comprehensive staffing models that address national needs while supporting flexibility at facilities. This approach would help ensure taxpayer dollars are invested in delivering the highest quality of care to veterans as promptly as possible."³²

The OIG staffing determination reports differ from most other national-level reviews in that they are required, by law, to be repeated annually. The OIG recognized, from the very first report, that implementation of staffing models would take more than a year. The recommendation to develop staffing models for critical-need occupations from the FY 2014 report was closed because a similar recommendation to develop and implement staffing models was made in the FY 2015 report. Similarly, recommendations from the FY 2015 and 2016 reports were closed and re-issued in the FY 2016 and 2017 reports, respectively. The OIG recognized that VHA had provided evidence of work that demonstrated a progression toward a staffing model and closed the recommendations.

³⁰ VA OIG: *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, Report No. 15-00430-103, January 30, 2015. *Audit of VHA's Efforts to Improve Veterans' Access to Outpatient Psychiatrists*, Report No. 13-03917-487, August 25, 2015. *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, Report No. 15-03063-511, September 1, 2015. *OIG Determination of VHA Occupational Staffing Shortages*, Report No. 16-00351-453, September 28, 2016. *OIG Determination of VHA Occupational Staffing Shortages, FY 2017*, Report No. 17-00936-385, September 27, 2017. *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018*, Report No. 18-01693-196, June 14, 2018. *Inadequate Governance of the VA Police Program at Medical Facilities*, Report No. 17-01007-01, December 31, 2018; *Staffing and Vacancy Reporting under the MISSION Act of 2018*, Report No. 19-00266-141, June 25, 2019. *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2019*, Report No. 19-00346-241, September 30, 2019. *VA Improved the Transparency of Mandatory Staffing and Vacancy Data*, Report No. 20-00541-149, June 3, 2020. *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020. *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020.

³¹ The OIG did not issue any recommendations in the report, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*.

³² VA, *Agency Financial Report Fiscal Year 2020*, November 24, 2020.

Scope and Methodology

The OIG conducted a survey of VHA facility directors to identify staffing levels, staffing requirements, and implementation of staffing models at each facility across VHA. In addition, the OIG analyzed administrative data and conducted interviews with VHA staff to review pandemic hiring during COVID-19.

From October 15, 2020, through December 16, 2020, the OIG team interviewed and/or surveyed all 18 VISN directors, the VA Manpower Director, VA's Chief Human Capital Officer, VHA WMC and VHA Finance leaders, and VHA OPES staff.

The OIG reviewed VA and VHA directives, policies, memorandums, and documentation; conducted a literature search for VA and VHA staffing models; and researched staffing flexibilities granted by the OPM during the pandemic.

Survey Development and Distribution

The OIG consolidated the data request for this review and the data request for the FY 2020 staffing determination report into a single survey to limit the number of requests being made of facilities.³³ As part of the survey, the OIG requested that each facility director identify, specific to their facility, the occupations with severe occupational staffing shortages, on hand and required staffing levels, the methods to determine required staffing levels, and their awareness of VHA staffing models.³⁴ Because this review was conducted in response to a congressional request related to staffing models, the analysis in this report primarily focuses on the questions related to VHA staffing models and requirements (see questions 5–9 listed below).

The occupations listed on the survey were categorized by (1) OPM occupational series code, (2) VHA assignment code, (3) clinical or nonclinical designation, and (4) hiring authority.³⁵ Facility directors were asked to select their facility from a pre-populated, drop-down menu based

³³ VA OIG Report, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020.

³⁴ The VA Choice and Quality Employment Act of 2017 requires the OIG to determine, on an annual basis, a minimum of five clinical and five nonclinical VHA occupations with the largest staffing shortages within each VHA facility. Facility directors determined severe occupational staffing shortages as defined by 5 Code of Federal Regulations (C.F.R.) CFR § 337.204.

³⁵ The survey listed 474 VHA clinical and nonclinical occupations. The list included both OPM occupational series and VHA assignment codes. OPM created occupational series to classify positions in the General Schedule. To provide further detail to the OPM occupational series, VHA developed assignment codes as an administrative option within the VA Human Resource Information System. The Office of Workforce Management classifies occupations as clinical and nonclinical. For example, a Thoracic Surgeon would have an OPM occupational series of 0602 – Medical Officer, and a VHA assignment code of 11. VHA facilities may or may not hire for a given occupational category or assignment code depending on VHA requirements and other factors such as local demands or facility complexity level.

on a directory provided by VHA, and to answer the following questions for each occupation listed in the survey:

1. What was the number of staff within the occupation as of December 31, 2019?
2. Do you consider there to be a severe shortage in this occupation?
3. If yes to #2, why do you consider there to be a severe shortage in this occupation?
4. How would you rank the designated shortages in priority order?
5. What is the total number of staff required in this occupation to meet the demands, clinical or otherwise, of the facility as of December 31, 2019?
6. How did you determine the number of staff required in this occupation?
7. What was the source of the method used to determine the number of staff required to meet demand in this occupation?
8. Why is there a difference between the number of staff in this occupation and the number of staff required to meet the demand of the occupation?
9. Are you aware of a VHA staffing model that exists for this position?

The OIG distributed the survey to 139 facility directors on February 18, 2020, with a completion requirement of March 13, 2020. To facilitate completion of the survey, the OIG met with VHA leaders to discuss the survey and its purpose and responded to questions.³⁶ Additionally, the OIG reviewed submissions as received and, when necessary, worked with the facility to clarify responses.

As the deadline for survey submissions approached, the COVID-19 pandemic crisis began to affect VHA facility operations. Facility leaders shifted their primary attention to emergent facility response activities. Consequently, on behalf of VHA directors, VHA's GAO OIG Accountability Liaison requested, and the OIG granted, four successive extensions of the survey submission deadline.³⁷ The OIG confirmed receipt of surveys from 130 facilities as of September 16, 2020. The OIG did not receive completed responses from nine facilities and the OIG did not

³⁶ The OIG presented at the VISN Directors' Call on February 13, 2020, and hosted a national call with facility directors on March 3, 2020.

³⁷ The third extension was granted and modified to prioritize to obtain data associated with OIG's *Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020* (Report No. 20-01249-259) review, which has an annual congressionally mandated publication date of September 30. Although that data request was prioritized, the OIG informed facility directors the Staffing Model review was still an active project and the data would be collected later.

grant additional extensions.³⁸ (See figure 1 for a timeline of the OIG survey deadlines, extensions, and select COVID-19-related events.)

³⁸ Completed responses were not received from the following nine facilities: White River Junction VA Medical Center in Vermont (VISN 1, Station 405); Washington, DC VA Medical Center (VISN 5, Station 688); San Juan VA Medical Center in Puerto Rico (VISN 8, Station 672); Nashville VA Medical Center in Tennessee (VISN 9, Station 626); Chillicothe VA Medical Center in Ohio (VISN 10, Station 538); Biloxi VA Medical Center in Mississippi (VISN 16, Station 520); Michael E. DeBakey VA Medical Center in Houston, Texas (VISN 16, Station 580); Rocky Mountain Regional VA Medical Center in Aurora, Colorado (VISN 19, Station 554); Sheridan VA Medical Center in Wyoming (VISN 19, Station 666).

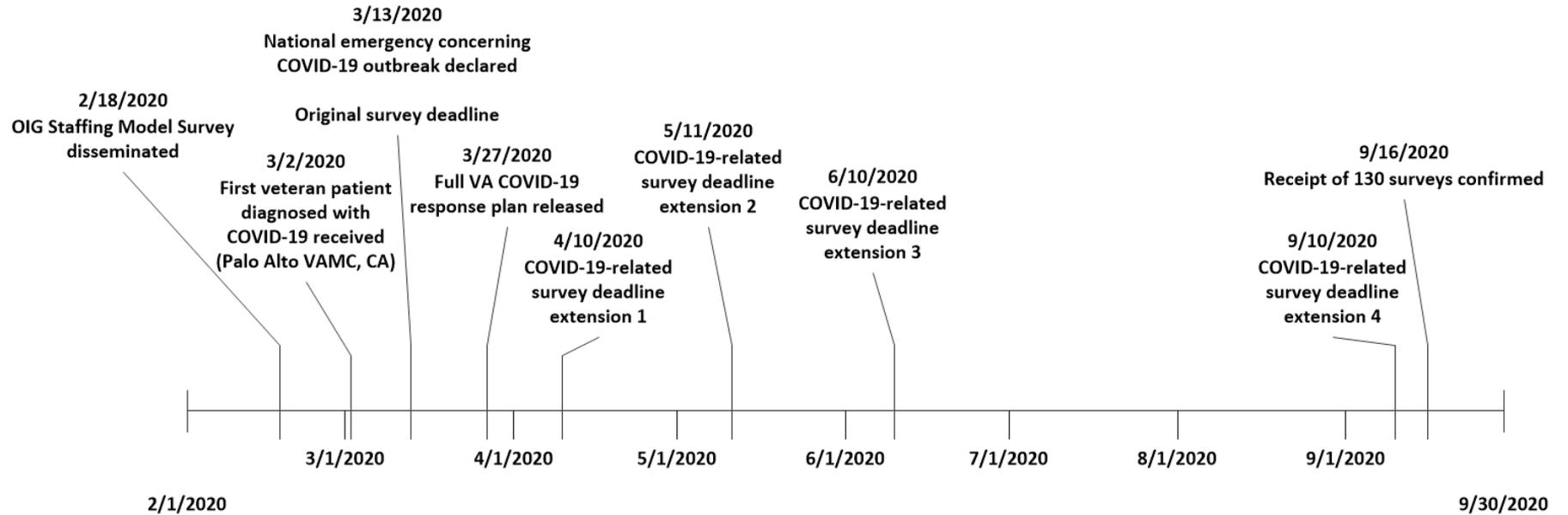


Figure 1. Timeline of OIG survey deadlines, extensions, and select COVID-19-related critical events.
 Source: OIG analysis.

Survey Data Analysis

The OIG compiled survey data, using JMP[®], from the 130 facilities to create a master file of 23,270 responses for the top five clinical and top five nonclinical severe occupational shortages.³⁹ The occupations used for analysis were those most frequently cited by facilities as severe occupational staffing shortages. Although the OIG received complete responses from 130 facilities for this review, these 10 occupations were the same as those identified by 139 facilities in the *OIG Determination of*

³⁹ JMP[®] is a suite of data analysis software programs developed by the SAS[®] Institute that includes a tool to consolidate data from multiple sources. The responses for these 10 occupations accounted for 38 percent (23,270/61,620) of all responses. Top five clinical OPM occupational series and titles: 0602 Medical Officer, 0610 Nurse, 0620 Practical Nurse, 0180 Psychology, 0644 Medical Technologist. Top five nonclinical OPM occupational series and titles: 3566 Custodial Worker, 0083 Police, 0801 General Engineering, 7408 Food Service Worker, 0679 Medical Support Assistance.

Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020 report.⁴⁰ VHA designates an occupation as clinical or nonclinical based on whether the occupation provides direct patient care or services.⁴¹ This designation is important because the OIG requested that facility directors identify the number of staff required to meet the demand, clinical or otherwise, of the occupation and how those requirements are determined may differ. Because the OIG did not analyze the data for all occupations, analysis conducted on these 10 occupations may not reflect all VHA occupations.

The OIG used the on board (employed) and required numbers provided by facility directors to create three staffing level categories for the 10 occupations the OIG reviewed:

1. Employed Equal to Required. The number of staff employed is equal to the number of staff required to meet the demands of the occupation at the facility.
2. Employed Less than Required. The number of staff employed is less than the number of staff required to meet the demands of the occupation at the facility.
3. Employed More than Required. The number of staff employed is more than the number of staff required to meet the demands of the occupation at the facility.

Responses that did not fall under these three categories were captured in the “Unable to Calculate” category. Examples included if an occupation had no staff employed and the occupation was not required at the facility or if an occupation had staff employed but the number of staff required was null or unknown.

The OIG used Braun and Clarke’s thematic analysis approach to generate themes for the free text responses received in the survey.⁴² Upon initial review of the data, the OIG discovered that many of the responses were brief and lacked detail thereby making it difficult to understand the underlying meaning in the free text responses. As a result, the OIG analyzed the data for content, not meaning. Additionally, some facilities designated multiple reasons for a given occupational shortage, while other facilities provided only one reason per occupational shortage. The OIG did not make a judgment with respect to the accuracy of each reason provided.

The OIG derived theme assignments for the Medical Officer and Nurse occupations because the survey was constructed to allow responses at the OPM occupational series level, the VHA

⁴⁰ The OIG needed completed responses for all nine survey questions for this review and needed responses for only questions 1–4 of the survey to complete the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020* report.

⁴¹ Clinical: Personnel who provide direct patient care or services incident to patient care, and whose efforts have a therapeutic intent (such as physical, mental, social, spiritual). Nonclinical: Administrative and maintenance personnel who do not provide direct patient care or services incident to patient care.

⁴² Virginia Braun and Victoria Clarke, “Using thematic analysis in psychology,” *Qualitative Research in Psychology*, 3(2), 77–101. July 2006.

assignment code level, or both. The OIG assigned a theme to one of these occupations if the theme showed up either at the occupational series or VHA assignment code level. For example, if “Lack of qualified applicants” was the theme for how a facility determined that Medical Officer (an OPM occupational series job title) and Psychiatry (a VHA assignment code job title falling under Medical Officer) were both severe occupational staffing shortages, “Lack of qualified applicants” would be counted once for the theme in Medical Officer.

HR Smart Data Analysis

The OIG worked with VHA to obtain line-level staffing data from their human resources information system, HR Smart, for the top five clinical and top five nonclinical severe occupational staffing shortages at two points in time: March 28, 2020, and October 10, 2020.⁴³ March 28, 2020, was selected because it was the earliest date after VHA issued the COVID-19 Response Plan, and October 10, 2020, was selected because it was the most recent data available at the time of the OIG review.⁴⁴

To understand changes in staffing levels, the OIG compared the HR Smart data across the two points in time. The OIG counted the total number of unique employees as of March 28, 2020, and subtracted that from the total number of unique employees as of October 10, 2020, to calculate net changes in onboard staffing levels.

Authorities

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

⁴³ VA Directive 5010; HR Smart is VA’s human capital system of record for positions.

⁴⁴ COVID-19 Response Plan, *Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, March 23, 2020.

Results

1. Staffing Models

The OIG explored perspectives on, as well as the availability of, staffing models to better understand to what extent VHA had implemented staffing models. The OIG analyses of VHA staffing models determined that

- Program office directors reported inconsistent staffing model roles and responsibilities,
- VA and VHA Manpower offices had limited staffing resources,
- VA and VHA defined staffing models differently,
- Validated VHA staffing models did not exist for all occupations,
- VISN directors described staffing models as guides and stressed flexibility as key, and
- Facility directors reported being generally aware of VHA staffing models for the top five clinical and top five nonclinical severe shortage occupations.

As of October 2020, VA Manpower has only validated the Caregiver Staffing Model. However, other staffing models have been, or are currently being, developed by various program offices throughout VHA. Developed staffing models must be validated, as required by VA directive, if they are to be used to determine staffing requirements.⁴⁵ Although staffing models (reports developed by VHA OPES) were available for facility use, these models did not determine staffing requirements and had not been validated by VA Manpower. VA and VHA Manpower directors reported that additional staffing may expedite the development and validation of VHA staffing models. The VA Manpower Director anticipates that *initial* staffing models will be developed for all direct care positions, excluding nursing, by the end of FY 2022. However, it is unclear whether these models will be validated by FY 2024 given VA Manpower's emphasis on the importance of a feedback loop with VHA to validate staffing models.

Program Office Directors Reported Inconsistent Staffing Model Roles and Responsibilities

The OIG surveyed directors from VA Manpower, VHA Manpower, and VHA OPES (staffing model program offices) to determine their perception of the roles and responsibilities related to the development, validation, and implementation of VHA staffing models. The reported responses were inconsistent regarding the roles and responsibilities of each office.

⁴⁵ VA Directive 5010.

Development of VHA Staffing Models Was Reported to Be a Collaborative Effort Between VA and VHA

The OIG found that perceptions of which office was responsible for the development of VHA staffing models differed between staffing model program office directors. VHA Manpower is the appointed manpower office for VHA. As of November 2020, VA Manpower was establishing technical foundations and promoting skill development, such as development of staffing models, throughout all VA Manpower management programs, which includes VHA, the Veterans Benefits Administration, and the National Cemetery Administration.

Through implementation of VA Directive 5010, the responsibility for the development of VHA staffing models resides with VHA Manpower.⁴⁶ The VA Manpower Director reported the responsibility resides with VHA Manpower. The VHA Manpower Director reported VHA staffing models were developed through a collaboration of all three staffing model program offices. The Director of VHA OPES reported that, in addition to the three staffing model program offices, VHA program offices, VISNs, and VA facility leadership are also involved in the collaborative effort. While all three staffing model program office directors reported VHA Manpower is involved in the development of VHA staffing models, the directors of the two VHA staffing model program offices reported that responsibility is a collaborative effort across VA and VHA.

The OIG proposes that it is important that relevant areas of VA actively and continuously collaborate to develop VHA staffing models. Further, the collaborative environment described could result in the development of more comprehensive staffing models for VHA. However, the OIG concludes it is important for a single office to take responsibility for those developed staffing models. In VA's Management Response to the OIG's identified Leadership and Governance challenge, VA reported that VHA OPES takes the lead in developing staffing models for clinical positions.⁴⁷ This response serves as a point of departure from VA Directive 5010 and suggests a lack of organizational clarity in roles and responsibilities with respect to the development of staffing models.⁴⁸

⁴⁶ VA Directive 5010, *Manpower Management Policy*, October 28, 2019. Responsibility for the development of staffing models within VA resides with appointed Manpower Management Programs. VHA Manpower is the appointed manpower office for VHA.

⁴⁷ VA, *Agency Financial Report Fiscal Year 2020*, November 24, 2020.

⁴⁸ VA Directive 5010.

Staffing Model Program Office Directors Largely Agreed that VA Manpower Was Responsible for Validation of VHA Staffing Models

Validation of staffing models and standards is the responsibility of VA Manpower per VA Directive 5010.⁴⁹ (See appendix C for the VA Manpower five-step validation process.) The staffing model program office directors' responses were in alignment with VA Directive 5010, with the exception of the VHA OPES Director. The VHA OPES Director reported validation efforts were a collaboration between VHA WMC and VA Manpower. The VA Manpower Director also emphasized the importance of a model's inputs and outputs when determining staffing requirements. To improve the accuracy of staffing requirements, data input into the model must be valid and the outputs must be thoroughly *vett*ed by VHA within an ongoing feedback loop.⁵⁰

The OIG recognizes a natural collaboration between VA and VHA when validating staffing models because VHA Manpower is responsible for the development of staffing models. However, the directive does not give VHA authority to validate staffing models.⁵¹ Developed staffing models must be validated by VA Manpower in order to be used for staffing requirement determination.⁵² Clarity on the status of both developed and validated VHA staffing models promotes transparency in which staffing models can be used to determine staffing requirements.

Authority to Implement Staffing Models Has Not Been Specified

Implemented staffing models can help inform workforce resource decisions.⁵³ While the responsibilities for development and validation of VHA staffing models are defined within VA Directive 5010, authority to implement staffing models is not specified.⁵⁴ VA Directive 5010 suggests VHA Manpower is responsible for implementation of staffing models as this office is responsible for coordinating with position managers and budget boards or officials to align

⁴⁹ VA Directive 5010.

⁵⁰ The VA Manpower Director stated "VA (Manpower) will work with VHA (Manpower) to develop an approach to review and vet the results with each VAMC [VA Medical Center] through virtual meeting[s] and [an] ongoing feedback loop to ensure the impact of emerging issues such as market area assessments, decisions to leverage community care network contracts, changes in physical space, and ability to hire the skills needed. This review will clarify those factors and additional unknowns not available in the workload projections and other transactional data used to develop the models or benchmarks."

⁵¹ VA Directive 5010.

⁵² VA Directive 5010.

⁵³ The OIG considers a staffing model to have been implemented when it has been made available to staff, VHA-wide, and is actively used to identify and inform staffing requirements and decisions at the facility, VISN, and national levels. Staffing models should only be implemented upon completion of both the development and validation processes as directed by VA Directive 5010.

⁵⁴ VA Directive 5010.

manpower requirements with mission priorities and available funding.⁵⁵ However, the VHA Manpower Director stated there is no direct authority or order to implement staffing models. As a result, VHA and VA Manpower could expend manpower resources developing and validating staffing models that may or may not be used because program offices and facilities are not required to use the staffing models. Without clear authority to implement staffing models, the return on resources utilized to develop and validate staffing models may be diminished.

VA and VHA Manpower Offices Had Limited Staffing Resources

Directors from both VA and VHA Manpower offices reported limited staffing resources. This limitation could result in delays in manpower program functions.⁵⁶ The VA Manpower Director reported that limited staffing affects the ability to quickly carry out their responsibilities. Some of the responsibilities include supporting staffing model development, validating staffing models, and promoting manpower management technical foundations and skill development within VA Manpower and across VA. The VHA Manpower Director reported that while the office has 12 staff members, work on staffing models is hindered due to additional responsibilities not related to staffing models and the effort staffing models require.⁵⁷ The OIG found that additional staffing resources for both VA and VHA Manpower offices may expedite the development, validation, and implementation of staffing models.

VA and VHA Defined Staffing Models Differently

The OIG requested the directors of VA Manpower, VHA Manpower, and VHA OPES provide a definition for the term staffing model as these three program offices collaborate in the development of staffing models. An understanding of their definitions contextualizes how each

⁵⁵ VA Directive 5010.

⁵⁶ According to organizational charts obtained by the OIG, VA Manpower is authorized to have eight positions and VHA Manpower is authorized to have 17 positions.

⁵⁷ The VHA Manpower Director stated one staffing model can take up to a year to develop, validate, and implement. One example of an additional responsibility, as required by VA Directive 5010, is the development of a VA Manning Document for VHA Central Office. The VA Manning Document “maps the qualitative and quantitative expression of manpower requirements and budgeted positions for an organization. It is the authoritative source of current and future human resource requirements to guide strategic human capital plans for recruiting, training, retention, compensation, and distribution.” As of October 2020, the VHA Manpower Director was in the process of securing a contract to assist with this effort. The time frame for completion, with the office’s current staffing level, was estimated to take two to three years.

program office approaches the development and utility of any staffing model.⁵⁸ The OIG found VA and VHA define staffing models differently, in part, because their developed models serve different purposes for VA.

VA issued Directive 5010 on October 28, 2019, in response to the Office of Management and Budget Memo 17-22.⁵⁹ The directive established a manpower management program that, among other things, provided a framework for identifying workload-based staffing requirements across VA and created VA Manpower.⁶⁰ The VA Manpower Director operationally defines the use of a staffing model as an approach to determine manpower requirements by utilizing productivity standards or other workload-based analyses to produce the minimum number of people required to meet the functional requirements of the mission for a program or facility.⁶¹ An example of this approach would be a staffing model that identifies the specific number of medical officers and medical support assistants needed to facilitate the facility's projected number of patient encounters for the year. The VA Manpower Director believes staffing models and standards should inform budget and workforce planning, as well as local management resource boards, without implementing mandatory staffing levels. (See appendix C for the VA Manpower Director's full response.)

In contrast, the VHA Manpower Director, in collaboration with the VHA OPES Director, defined a staffing model as a set of reports that "provide information on staffing: the process of acquiring, deploying and retaining a workforce of sufficient quantity and quality to create positive impacts on the organization's effectiveness." Using standards similar to those defined by VA Manpower, these reports (staffing models) provide a comprehensive picture of a facility's existing workforce, and how that compares to internal benchmarks (medical complexity group

⁵⁸ For example, other federal healthcare agencies use staffing models to determine staffing requirements. According to a 2018 GAO report, the Army uses a workload-based staffing model to determine the number of dentists required at each facility. The Army's dental clinic staffing model utilizes the historical number of dental procedures performed and how long it takes to perform each procedure. Additionally, the Army's model factors in variables such as fixed positions required at each clinic, and variable positions, which are workload dependent. *GAO, Military Personnel: DOD Needs to Improve Dental Clinic Staffing Models and Evaluate Recruitment and Retention Programs*, GAO-19-50, December 13, 2018.

⁵⁹ Office of Management and Budget Memorandum 17-22, *Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce*, April 12, 2017.

⁶⁰ Office of Management and Budget Memorandum 17-22, *Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce*, April 12, 2017. This memorandum required federal agencies to adapt manpower management to reform the federal government and take long-term steps to reduce the size and cost of the federal civilian workforce. Agencies were to develop long-term staffing plans to include consideration of determining appropriate full-time employee equivalent levels utilizing data to establish appropriate staffing levels in order to accomplish the agency's objectives. In response, VA established VA Manpower on October 5, 2017, and issued VA Directive 5010, *Manpower Management Policy*, on October 28, 2019.

⁶¹ The VA Manpower Director defines productivity (staffing) standards as approved quantitative and qualitative expressions of manpower requirements needed to perform prescribed tasks at varying levels of workload. The object of such a standard is to articulate the mathematical relationship between a work center's requirements and workload.

average).⁶² VHA OPES staff explained that their approach intentionally does not determine the number of staff required to meet demand, because of the complexity of staffing and care provided in VHA's healthcare system.⁶³ (See appendix D for the VHA Manpower Director's, in collaboration with the VHA OPES Director's, full response.) VHA likely takes this approach because VHA Directive 1065 states that facilities must monitor and assess data provided in VHA OPES staffing models annually to determine whether productivity levels fall within "acceptable range of productivity," requiring an action plan when productivity is below the "minimum productivity threshold."⁶⁴

While the program offices differ in their definitions, the VHA OPES staffing models can inform the development of what VA considers a staffing model. The VA Manpower Director stated that reports created by VHA OPES for VHA could, *with significant changes*, be developed into staffing models that determine the required levels of staff. The VA Manpower Director pointed out that comparing staffing levels to the medical complexity group average does not accurately reflect what staffing levels should look like; if facilities are not staffed appropriately in a particular occupation, the benchmark of the average staffing levels would reflect inappropriate staffing levels. For example, if a medical complexity group consisted of 15 facilities, which were all understaffed in the custodial workers occupational series, the average for custodial workers would reflect a benchmark that is less than the number of custodial workers needed.

While both VA and VHA consider a staffing model to be an assessment of staffing, VA considers a model to be a tool that determines workload-based staffing requirements whereas VHA considers a model to be a set of reports that provides information on staffing and

⁶² Medical Complexity Groups are defined in VHA OPES, "Facility Complexity Level Model Fact Sheet," December 15, 2017. "Facilities are categorized into one of five groups: 1a (most complex), 1b, 1c, 2, and 3 (least complex)." VHA describes Level 2, medium complexity as, "[f]acilities with medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA describes Level 3, low complexity as "[f]acilities with low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

⁶³ VHA OPES staff stated they prefer analyzing the existing state of health care over projecting an ideal state of health care because they don't know what the workload will be. VHA OPES staff added that an approach identifying a prescribed number of people drives down productivity, as such approaches don't necessarily take efficiency of staff into account. To determine adequate staffing levels, VHA OPES develops staffing models that identify whether existing staff are able to keep up with workload, and how that compares to other facilities using the medical complexity group average as a benchmark.

⁶⁴ VHA Directive 1065, *Productivity and Staffing Guidance for Specialty Provider Group Practice*, December 22, 2020. By default, the acceptable range of productivity falls within the 25th to 75th percentile of the medical complexity group productivity values for each medical specialty group. Based on input from program offices, acceptable range of productivity may be set at different levels to ensure quality and patient access standards are not compromised. Minimum productivity threshold is set to the median productivity minus 1.25 standard deviations of prior VHA internal experience for each medical specialty group. The minimum productivity threshold may be altered based on input from responsible parties.

productivity relative to internal benchmarks. Given the different definitions, it is incumbent on VA to provide clarity to stakeholders when discussing the status of VHA staffing models.

Validated VHA Staffing Models Did Not Exist for All Occupations

The OIG interviewed leadership and staff from staffing model program offices and reviewed prior OIG reports, GAO reports, reports from a VA contracted advisor, and VA and VHA documentation to assess the existence of VHA staffing models, *regardless of the definition*, and to establish which staffing models are available to facility directors.⁶⁵ Through directive, VHA Manpower is responsible for the development of VHA staffing models, and VA Manpower is responsible for the validation of developed VHA staffing models. Staffing models verified, validated, and approved by VA Manpower are to be used for determining staffing requirements.⁶⁶

Inconsistent Messaging from VHA Pertaining to Staffing Model Availability, Development, Validation, and Implementation

The OIG reviewed information regarding VHA staffing models provided by VA and VHA to better understand VHA's progress in developing staffing models. The OIG found that the availability of staffing models, as portrayed through VHA leadership and program offices, is not consistent. Published oversight reviews further demonstrate conflicts regarding VHA staffing model availability, development, implementation, and validation.

VA, in their FY 2020 Budget Request, stated VHA has staffing models for nearly all functional areas including mental health, primary care, women's health, and rehabilitation services.⁶⁷ Additionally, the OIG received communication from a facility in which the VHA National Workforce Planning Team—an office within VHA WMC—had provided data to assist facilities in completing the OIG's FY 2020 staffing determination and staffing model survey. The email informed facility personnel that national staffing models for *all* occupations and specialties can be found on VHA OPES' website. The email specifically referred to the *Specialty Productivity Access Report and Quadrant Tool* and *Operational Workforce Report* as the staffing models that provide benchmarking for all occupations and specialties. However, in VHA WMC's *VHA Workforce and Succession Strategic Plan FY 2020-21*, it was noted that while staffing models

⁶⁵ National Academy of Sciences, Engineering, and Medicine is an independent advisor. This private, nongovernmental institution provides objective analysis and advice to solve complex problems and inform policy decisions.

⁶⁶ VA Directive 5010.

⁶⁷ VA, *Volume II Medical Programs and Information Technology Programs, Congressional Submission, FY 2020 Funding and FY 2021 Advance Appropriations*, March 2019.

had been developed for specialty care, primary care, mental health, nursing, pharmacy, and rehabilitative care, there is continuing effort to develop and validate other models.⁶⁸

Recently published oversight work provides additional clarity and context regarding VHA staffing models, as well as VHA's response to the identified deficiencies within these reports:

- Both VA and VHA stated that a VHA mental health staffing model existed. However, the absence of a specific VHA, VISN, or local staffing methodology to determine the required number of medical providers within inpatient mental health units was identified by the OIG in August 2020. Within this report, the Office of Mental Health and Suicide Prevention reported a safe *rule of thumb* was used to determine the maximum number of acute patients a psychiatrist can safely manage.⁶⁹
- Development of staffing models for some of the top five nonclinical occupations is in progress.⁷⁰ VHA contracted an advisor for assistance with developing a staffing model guidebook to assist with the development of a General Engineering staffing model.⁷¹ Additionally, a Police staffing model has been developed as highlighted in a previous OIG report. This report has one open recommendation related to implementation of the staffing model.⁷²
- Validation of staffing models remains a critical aspect of ensuring consistent and accurate identification of staffing requirements throughout VHA. An oversight review of Psychiatry staffing noted two separate staffing models were available for use by facilities. The staffing models were developed by different offices within VHA, and each presented different results. The differing results created a scenario in which facility leaders reported not knowing how to use or interpret the information from the two staffing models.⁷³
- Two oversight reports identified the presence of psychiatry and community care staffing models that determine staffing requirements; however, the reports found that facilities

⁶⁸ VHA, *VHA Workforce and Succession Strategic Plan FY 2020-21*.

⁶⁹ VA OIG, *Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 19-09669-236, August 20, 2020.

⁷⁰ The top five nonclinical OPM occupational series and titles refers to those identified in VA OIG Report, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020.

⁷¹ National Academies of Sciences, Engineering, and Medicine. 2020. *Facilities Staffing Requirements for the Veterans Health Administration Resource Planning and Methodology for the Future (2020)*, Washington D.C. National Academy Press. DOI 10.17226/25454.

⁷² VA OIG, *Inadequate Governance of the VA Police Program at Medical Facilities*, Report No. 17-01007-01, December 13, 2018.

⁷³ GAO, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*, GAO-18-124, October 19, 2017.

were able to choose whether or not to accept and adopt those staffing models.⁷⁴ One report presented statements from the Under Secretary for Health suggesting, but not requiring, a staffing model to determine the number of psychiatrists at a facility. The second report found that the Community Care program office lacked organizational authority to enforce use of a staffing model used to determine the number of community care staff needed. Facilities reviewed within the reports that did not use the available staffing models were determined to have less than the required number of staff.

The OIG identified several reports that reviewed progress toward the availability, development, validation, and implementation of VHA staffing models. Oversight work from the OIG and GAO determined that several occupations lack staffing models due to issues with the development and validation processes. Although VA's FY 2020 Budget Request states that nearly all functional areas have staffing models within VHA, the OIG found several sources that differed with that statement. VHA's inconsistent messaging conveys a general lack of clarity with respect to the availability, development, validation, and implementation of VHA staffing models.

VHA's Developed Staffing Models Provided Staffing Information Using Broad Occupational Families

Through directive, VHA Manpower is responsible for the development of VHA staffing models.⁷⁵ Since VHA Manpower and VHA OPES were in agreement in their definition of a staffing model, the OIG requested that the VHA Manpower and VHA OPES Directors provide available staffing models for the top five clinical and top five nonclinical severe occupational staffing shortage occupations. In response, the VHA OPES Director provided three reports (staffing models) that provide staffing information across broad occupational families instead of

⁷⁴ VA OIG, *Veterans Health Administration Audit of VHA's Efforts to Improve Veterans' Access to Outpatient Psychiatrists*, Report No. 13-03917-487, August 25, 2015. GAO, *Veterans Community Care Program: Improvements Needed to help Ensure Timely Access to Care*, GAO-20-643, September 28, 2020. The referenced OIG report uses the term *staffing model* whereas the referenced GAO report uses the term *staffing tool*. For the purposes of this report, the OIG used the term *staffing model* when referencing the *staffing tool* in the GAO report because, similar to the referenced OIG report, it determined a required number of staff.

⁷⁵ VA Directive 5010.

individual OPM occupational series.⁷⁶ These staffing models, by design, do not determine the number of staff required to meet demand. (Examples of the *Operational Workforce Report*, the *Specialty Workforce Report*, and the *Specialty Productivity Access Report and Quadrant Tool* can be found in appendix E.)

There are merits to how the VHA-provided staffing models are constructed because the delivery of health care is not specific to a single OPM occupational series.⁷⁷ Grouping by broad occupational families is helpful, for example, when determining whether clinical teams (which are composed of medical officers, nurses, and other support staff) in a particular service line, such as gastroenterology, are staffed appropriately. However, such groupings are not as helpful in determining whether a specific OPM occupational series within the service line is staffed appropriately. This is especially the case for nonclinical staff who may not be aligned with a clinical team, such as custodial workers, police, engineers, and food service workers. The OIG proposes that consideration be made to how VHA staffing models are constructed because that affects how developed staffing models can, and will, be used.

Currently, according to VHA Finance leadership, staffing models do not inform the budget request. The VA Enrollee Healthcare Projection Model produces workload projections, and those

⁷⁶ 1) The *Operational Workforce Report* identifies the total number of full-time equivalent employees associated with providing medical services to veterans, and a metric comparing the number of full-time equivalent employees to the amount of work being completed (productivity). The *Operational Workforce Report* also included the medical complexity group average for total full-time equivalent employees and the productivity metric. The *Operational Workforce Report* used broad groupings and sub groupings to provide data for occupational groups labeled *Medical Providers, Nursing, Associates & Assistants, Support Staff, and Other*.

2) The *Specialty Workforce Report* provides several staffing and productivity metrics for each medical specialty within a single facility, the selected facility's medical complexity group average, and the VHA average. The *Specialty Workforce Report's* objectives include identifying opportunities to enhance productivity and administrative and clinical support staffing levels. The report identifies the number of full-time equivalent employees for each specialty, the number of residents, and productivity score. It uses ratios to compare physicians to number of unique patients, and number of various support staff groups to physicians. While the report only provides observed metrics at the facility and VHA average level, the medical complexity group average includes an *Annual Productivity Target*. This target allows a facility to compare productivity not only to the observed rates of their medical complexity group and VHA average, but a target identified for all facilities within the medical complexity group.

3) The *Specialty Productivity Access Report and Quadrant Tool* expands upon specialty practice management data found in the *Specialty Workforce Report* to help determine the resource levels of a specialty. The *Specialty Productivity Access Report and Quadrant Tool* report provides several more staffing, demand and productivity measures for medical specialties within a single facility, and provides a medical complexity group comparison at the 10th, 50th, and 90th percentile. This report is designed to determine if each specialty, when compared to the medical complexity group, is an *Optimized Practice, Possibly Under-Resourced, Inefficient, or Possibly Over-Resourced*.

⁷⁷ The VHA OPES reports group categories based on occupational specialties, budget object class codes, and cost centers. Budget object class codes classify obligations and expenditures according to the nature of the services or items purchased. Cost centers are mechanisms used to accumulate costs incurred by area of responsibility or geographic regions. They represent a fusion of organization, function, type of procurement (such as travel and commodities), project, and in some cases may represent an individual employee.

projections inform VHA’s budget request.⁷⁸ Because VHA’s full-time staff accounts for 89 percent of all VA staff, and “Medical Services FTE [full-time equivalent] represents the largest share of VHA obligations by budget class,” it is incumbent upon VHA to construct staffing models in a way that informs budget.⁷⁹ If VHA’s staffing models are meant to inform budget, consideration should be made as to how staffing models are constructed—whether by OPM occupational series, broad occupational families, a mix, or some other method.⁸⁰

While Some VHA Staffing Models Have Been Developed, VA Manpower Has Validated a Single VHA Staffing Model

As of October 2020, only the Caregiver Staffing Model, developed by the VA Manpower program office in May 2020, had been validated as required by VA Directive 5010.⁸¹ (See appendix C for the VA Manpower five-step validation process.) By directive, VA Manpower is responsible for validating staffing models and standards that are used to determine staffing requirements. Although one staffing model has been validated by VA Manpower, the OIG located, through a review of VHA directives and handbooks, VHA-issued guidance on staffing requirements, in which a minimum number of staff is either required or suggested, for 14 occupations or service lines. These are separate from the VHA OPES reports (staffing models). (See appendix F for a listing of staffing guidance and affected occupations or service lines.) Since VA Manpower is responsible for validating staffing models and standards used to determine staffing requirements, and VHA has issued guidance related to staffing requirements, the OIG proposes VA Manpower review and validate VHA’s existing staffing guidance in accordance with VA Directive 5010.

It will take years to validate additional staffing models at VA Manpower’s current staffing levels. The VA Manpower Director reported in January 2021 that their office was conducting a staffing analysis to generate *staffing benchmarks* that will cover approximately “50 percent of all VAMC [VA medical center] positions.”⁸² While the VA Manpower Director expected to have benchmarking results by March 2021, those results would be considered preliminary. The

⁷⁸ The VA Enrollee Health Care Projection Model projects, for 20 years into the future, the number of veterans expected to enroll for VA health care in a geographic area, their total health care needs, and what proportion of care is expected to be received from VA versus other healthcare providers.

⁷⁹ VA, *Volume II Medical Programs and Information Technology Programs, Congressional Submission, FY 2021 Budget Submission*, February 2020.

⁸⁰ Of note, the Office of Management and Budget Circular A-11 and 31 U.S.C. 1104(b) require federal agencies to use object codes when reporting obligations as part of the Presidential Budget request. VA uses budget object class codes, the lowest level of object codes, to categorize and report the Department’s obligations and expenditures.

⁸¹ VA Directive 5010.

⁸² Staffing benchmarks provide an approximate range of full-time equivalent employees. This percentage excludes nurses as the Office of Nursing Services has a Staffing Methodology for VHA Personnel. VHA Directive 1351.

importance of a *feedback loop* with VHA Strategic Analysis Service, VISN planners, VISN leadership, and the facilities to improve the accuracy of the benchmarking results was emphasized to complete the benchmarking results. Contingent on VHA's availability for feedback, VA Manpower anticipates the first iteration of staffing models for all direct care positions to be completed by the end of FY 2022. These initial staffing models will use the OPES provider productivity standards and the VA Enrollee Health Care Projection Model provider work relative value unit projections to develop requirements for providers by specialty and skill type. Initial support staff staffing models will use benchmarking, with appropriate workload factors baselined to HR Smart positions by function, to develop staffing requirements. This approach to staffing models will provide workload-based staffing requirements that can be documented in the VA's authoritative data source for staffing (HR Smart) for providers and support staff. Using these initial staffing models, the VA Manpower program office plans to refine them by FY 2024 given their current staffing level. In light of the program office's emphasis on the importance of a feedback loop with VHA in the development and validation of staffing models, it was unclear if these models would also be validated by FY 2024.⁸³

Separate from VA Manpower's effort to conduct a staffing analysis and validate staffing models for direct care positions, the VA Manpower Director reported that VHA staffing models were in various stages of development and validation. Although VHA considered the VHA OPES reports staffing models, the VA Manpower Director indicated VHA had developed additional staffing models for acquisitions, supply management, scheduling, mental health, readjustment counseling, sterile supply, environmental management, nurse staffing, and dental services. Additionally, the VA Manpower program office is currently reviewing VHA's Procurement Staffing Model and VHA's Readjustment Counseling Staffing Model. The VA Manpower Director also informed the OIG that a staffing model for Police was developed and has been provided to VHA for review and *vetting*. However, none of these developed staffing models have been validated by VA Manpower.

⁸³ The VA Manpower Director also indicated that their office could "validate the staffing models for nurse staffing and develop staffing models for provider requirements using the [VHA] OPES productivity standards and EHCPM [Enrollee Healthcare Projection Model] projections in FY 2022 (note this is not the current approach [VHA] OPES uses for providers). In addition, estimated requirements for support staffing by function (i.e., housekeeping, appointment scheduling, medical records) by like medical complexity groups using internal benchmarks of staff size and workload indicators appropriate for that function (i.e., square footage, unique patients, etc.) can be developed to provide information for VAMCs [VA medical centers] in their decisions on staffing levels. The benchmarking will be a starting point for the support staff with 'bands of reasonableness' around standard deviations. Because the benchmarking approach would be based upon current staffing levels at like medical complexity group facilities, there is a risk of either under or overestimating the staffing needs. The benchmarking should only be used as an interim measure until standards (models) for each function can be developed. But the benchmarks against meaningful workload indicators to set initial requirements consistently across the VAMCs is better than the status quo."

Validation of developed staffing models is central to having staffing models to determine staffing requirements. Because, to date, only one staffing model has been validated, the OIG proposes that VA prioritize the development, validation, and implementation of staffing models, and identify how that priority can be supported.

VISN Directors Described Staffing Models as Guides and Stressed Flexibility is Key

The OIG interviewed all 18 VISN directors to get their perspectives on how facilities determine the number of positions necessary to meet clinical, and operational demand.

Similar to VA Manpower, VHA Manpower, and VHA OPES, VISN directors did not all share the same definition of staffing models. When asked what made staffing models useful, VISN directors described existing staffing models (such as those noted by VA Manpower and VHA) as well as VHA staffing guidance (such as those identified in appendix F). The OIG did not define staffing models for VISN directors and did not make a judgment with respect to what they considered a staffing model to be. This resulted in VISN directors discussing staffing models fairly consistently.

VISN directors generally responded that staffing models were used as guides to help determine staffing requirements. Facility directors are ultimately responsible for determining staffing levels at each facility. To accomplish this task, facility directors designate other facility leaders and subject-matter experts, often referred to as a resource management committee or board, to review staffing levels, workload, demand, and budget. Based on the committee's recommendations, facility directors use discretion to authorize and hire a set number of positions for each occupation to fit within the available budget. Authorized numbers of staff are adjusted throughout the year to respond to shifts in demand, efficiency, policies, or funding.

One VISN director explained that not every staffing model was set up the same way. VHA's Office of Nursing uses a formula to determine the number of nursing hours per patient day, based upon the occupancy rate of beds.⁸⁴ Environmental management models use the square footage to clean. Laundry models are based on the pounds of laundry. Staffing models are a multifactorial process that differ greatly across occupations. The VISN director further stated that the most useful staffing models use industry standards for work that were developed over time with a historical baseline describing how long it takes to perform a particular task.

Another VISN director explained that using a single staffing model, such as VHA OPES' *Specialty Productivity Access Report and Quadrant* tool is problematic, as it does not show the

⁸⁴ VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

whole picture.⁸⁵ The VISN director went on to say facilities are compared to their medical complexity group average, which creates issues as facilities within the same medical complexity group are different. Facilities within a medical complexity group do not necessarily offer the same services or have the same patient demand. An example provided compared the size of community living centers within Level 3 facilities. Even more variability was described as the complexity increased where Level 1a facilities may or may not offer transplants. From the VISN director's perspective, the medical complexity group is based on rankings, which change every other year, rather than a certain set of conditions. The VISN director explained that one facility, that completes more surgeries than another, was recently changed to a lower complexity group than the facility with lower surgery rates.

Almost unanimously, VISN directors responded that an element of flexibility was most useful in staffing models. Staffing models that produce a minimum level of staff required to meet demand were described as helpful. However, VISN directors were concerned that a model determining a minimum level of staff would be used as a mandatory metric. VISN directors explained that budgetary restraints, or the inability to hire certain occupations due to a lack of qualified applicants, especially in more rural areas, often made mandatory staffing levels unachievable in certain occupations.

One VISN director stated that some facilities cannot hire the number of psychologists specified by the mental health staffing model because the patient-to-provider ratios do not consider local challenges. For example, in some geographical areas, psychologists are difficult to recruit. The facility could hire a combination of social workers, pharmacists, and other providers who could provide mental health services within their licensure as a team, but that would not meet the specified number of psychologists identified by the mental health staffing model.

VISN directors noted current staffing determinations are made locally by the facility and must fit into a specified budget. In general, VISN directors gave favorable comments about the staffing models available to facility directors, but stated they often result in occupational trade-offs, taking staff away from one service to add staff to another service. While the VA Manpower Director conveyed staffing models identifying minimum staffing levels should be used to inform manpower and budget allocations, VISN directors require flexibility to respond to local demands.

⁸⁵ *The Specialty Productivity – Access Report and Quadrant Tool* is a report that allows for the comparison of key specialty measures of productivity and access to identify potential areas for improvement within a specialty and a station. A particular specialty's productivity is plotted against its access measures for a given peer group. This allows for identifying which specialties are inefficient (low productivity, low access), possibly over-resourced (low productivity, high access), possibly under-resourced (high productivity, low access), or optimized (high productivity, high access).

Facility Directors Reported Being Generally Aware of VHA Staffing Models for the Top Five Clinical and Top Five Nonclinical Severe Shortage Occupations

Facility directors were asked about their awareness of existing staffing models for all occupations through the FY 2020 staffing determination and staffing model survey. The OIG asked facility directors to reply to the awareness question even if the facility did not hire for the occupation. Therefore, responses may have been *No* because the facility did not hire for the occupation and, understandably, would not be aware of a staffing model. Additionally, the OIG did not define the term *staffing models* for facility directors. So, facility directors may have responded using different interpretations of what a staffing model is. The OIG determined that the majority of facility directors were not aware of VHA staffing models for *all* occupations. However, facility directors were generally aware of VHA staffing models for the top five clinical and top five nonclinical severe shortage occupations.

Seventy-eight percent of facility directors reported they were generally not aware of staffing models for *all* occupations (see table 1a). Among the 28 facility directors who indicated awareness of staffing models for all occupations, 54 percent responded they had awareness at mixed levels (see table 1b).⁸⁶

Table 1a. Facility Director Awareness of Staffing Models for All Occupations

All Occupations	Number of Facilities (130)	Percentage of Facilities
No	102	78
Yes*	28	22

Source: OIG analysis of VHA facility directors' responses to the FY 2020 Staffing Determination and Staffing Model survey

** Aggregation of Yes, National; Yes, VISN; Yes, Local; and Yes, Mixed responses*

⁸⁶ Facility directors were asked about their awareness of staffing models for each occupation. Available responses included *No*; *Yes, National*; *Yes, at the VISN*; *Yes, Local*; and *Yes, Mix*. The OIG derived a response of *Yes, Mix* for those responses which contained more than one *Yes* response or *Yes, Mix* was directly reported.

Table 1b. Facility Director Yes Awareness of Staffing Models for All Occupations

All Occupations	Number of Facilities (28)	Percentage of Facilities
Yes, National	10	36
Yes, at the VISN	1	4
Yes, Local	2	7
Yes, Mix	15	54

Source: OIG analysis of VHA facility directors' responses to the FY 2020 Staffing Determination and Staffing Model survey

The OIG also reviewed the responses by assessing awareness of staffing models for the top five clinical and top five nonclinical severe shortage occupations. (See appendix G for additional detail on facility directors' reported awareness for each of the occupations.) Of note, less than 50 percent of facility directors indicated they were aware of staffing models for 3 of the 10 occupations: Medical Technologist, General Engineering, and Food Service Worker (see table 2).

Table 2. Facility Director Awareness of a Staffing Model for Top Five Clinical and Top Five Nonclinical Severe Shortage Occupations

Occupation	Facility Directors Aware of Staffing Models (%)*
Psychology	76 (58)
Medical Officer	80 (62)
Nurse	107 (82)
Practical Nurse	87 (67)
Medical Technologist	60 (46)
Police	80 (62)
Medical Support Assistance	69 (53)
General Engineering	53 (41)
Custodial Worker	70 (54)
Food Service Worker	49 (38)

Source: OIG analysis of VHA facility directors' responses to the FY 2020 Staffing Determination and Staffing Model survey

** Aggregation of Yes, National; Yes, VISN; Yes, Local; and Yes, Mixed responses.*

The OIG reviewed selected VHA assignment codes within the OPM occupational series Medical Officer to further explore staffing model awareness in this occupation. VHA assignment codes,

such as Chief of Staff, were removed from analysis as there would not necessarily be a staffing model for this occupation—typically only one position is needed at each facility. The OIG focused on 52 specialty assignment codes that provided a significant portion of veteran care. Facility director responses, for these specialty assignment codes, were aggregated for reporting. (See appendix H for the list of specialties.)

Sixty-two percent of facility directors reported being aware of a staffing model for the Medical Officer occupation when reviewing responses at the OPM occupational series level. However, when analyzing the focused Medical Officer specialties, awareness of a staffing model decreased. Forty-five percent of facility directors indicated awareness of a staffing model for the specialties at any level. While facility directors indicated general awareness of any level staffing model for the Medical Officer occupation, more than half stated they were unaware of an existing staffing model for the provider specialties providing the bulk of veteran care.

The interpretation of responses for the Nurse occupation was more complex due to the presence of VHA Directive 1351. The directive provides a *must follow* nurse staffing methodology for staffing *direct care* nursing occupations.⁸⁷ Because there may be various interpretations of whether or not this directive applies to all VHA assignment codes within the Nurse occupation, the OIG utilized only responses to the OPM occupational series for analysis.⁸⁸

Eighty-two percent of facility directors reported awareness of a staffing model for the Nurse occupation, the majority of which, indicated knowledge of a staffing model at the national level. Approximately one in six facility directors reported no awareness of a staffing model for the Nurse occupation despite VHA Directive 1351.⁸⁹ Some facility directors may have perceived VHA Directive 1351 as a staffing model, whereas others may not have. This illustrates the importance of consistency in terminology when discussing staffing models. Had the OIG used terms in the survey such as standards, guidance, and methodologies, the ‘yes’ response rate could have been higher.⁹⁰

Facility directors indicated that they were generally aware of staffing models for the top five clinical and top five nonclinical severe shortage occupations. However, variation exists across facilities regarding at what level a staffing model comes from (National, VISN, Local, or Mix). This suggests facilities may have differing views or familiarity with a staffing model, or that an occupation may have multiple models at different levels within VHA.

⁸⁷ VHA Directive 1351.

⁸⁸ VHA Directive 1351.

⁸⁹ VHA Directive 1351.

⁹⁰ VHA Directive 1351.

2. Staffing Levels and Requirements

Upon learning of the inconsistencies related to staffing models throughout VHA, the OIG reviewed staffing levels and requirements across VHA facilities. The absence of validated and implemented staffing models across VHA can promote differing approaches in how operational staffing requirements are determined. Additionally, the OIG wanted to better understand how facilities were making resource decisions. In the course of the review, the OIG found:

- Reliance on facility-developed methodologies to determine staffing requirements
- Gaps between staffing levels and staffing requirements for occupations most frequently reported as severe occupational staffing shortages
- Deficiencies in VHA-collected occupational data
- The lack of qualified applicants, noncompetitive compensation, and staff turnover were reasons for severe occupational staffing shortages
- Budget constraints on the ability of facilities to meet staffing requirements

Facility-Developed Methods are Primarily Used by Facility Directors to Determine Staffing Requirements

Because only one staffing model has been validated and VHA has issued staffing guidance related to staffing requirements, the OIG determined it was important to understand the source of the methods facilities were using to determine their staffing requirements. (See appendix F for a listing of staffing guidance and affected occupations or service lines.) The OIG asked facility directors to provide the source of the method used to determine the number of staff required to meet the demands of the facility for each occupation listed in the survey. This provides insight whether a facility is using, for example, VHA (national-level) or local (facility-developed) guidance to determine requirements. Forty-five percent of facility directors indicated using facility-developed methods to determine staffing requirements for the top five clinical and top five nonclinical severe shortage occupations.

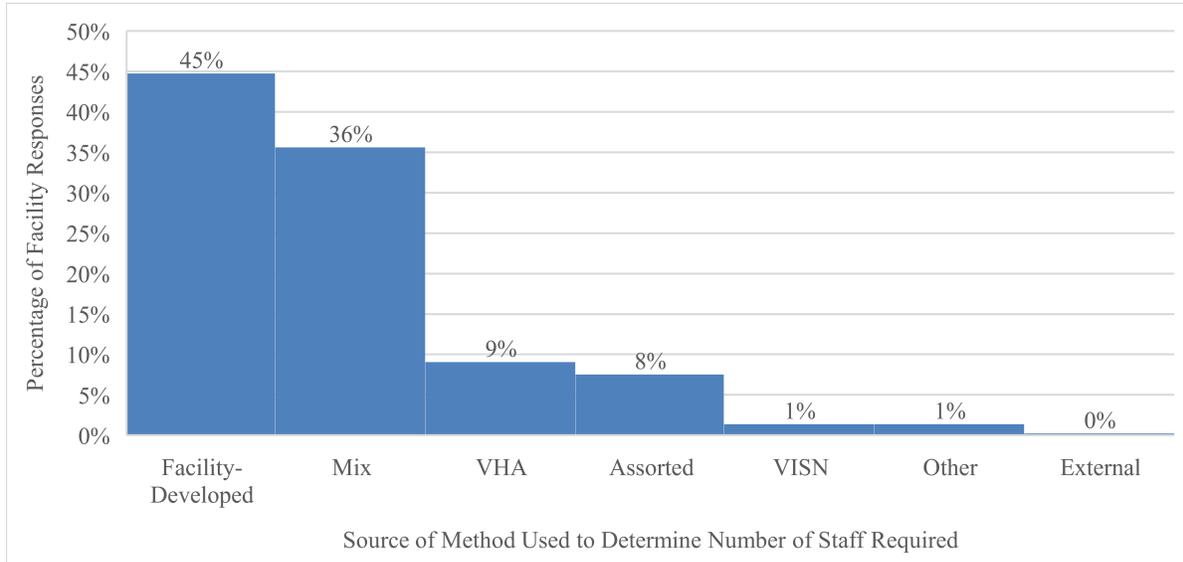


Figure 2. Distribution of facility responses to the source of the method used to determine the number of staff required to meet the facility’s operational demands.

Source: OIG analysis of VHA facilities’ responses to the FY 2020 Staffing Determination and Staffing Model survey.

Not every occupation is hired at every facility; therefore, the number of responses varied between each occupation. To account for responses that fell outside of the standard six sources, the OIG created an *Assorted* source. This source reflected free text responses, responses that were reported as *Unknown*, and responses indicating the facility did not hire for the occupation.⁹¹

The OIG found that, for 8 of the 10 occupations the OIG reviewed, facility-developed methods were most frequently used by directors to determine staffing requirements.⁹² Food Service Worker represented the occupation with the largest percentage (59 percent) of facility directors using facility-developed methods to determine staffing requirements. While VHA has not developed a staffing model that determines staffing requirements for Food Service Worker, one has been developed for Police.⁹³ Forty-six percent of facility directors indicated the use of facility-developed methods to determine number of staff required for Police. Five percent and

⁹¹ If a facility director did not know the number of staff required for the occupation, the OIG provided a drop-down menu response of *Unknown*. This response, within the survey, did not require a source of method used to determine the number of staff needed for the occupation.

⁹² Facility directors reported primarily using a mix of methods for Medical Officer and Nurse, 73 percent and 61 percent, respectively.

⁹³ VHA OPES developed a staffing model for Clinical Dietetic Services (formerly titled Nutrition and Food Services) in their *Operational Workforce Report*, but it does not determine staffing requirements. VHA considers a staffing model to be a set of reports that provides information on staffing and productivity relative to internal benchmarks. The referenced Police staffing model “establishes the minimum patrol FTE” and has not yet been validated by VA Manpower.

14 percent of directors reported using national-level methods to determine requirements for these two occupations, respectively. These percentages suggest development of VHA staffing models may increase the use of national-level methods to determine requirements. (Additional information on each occupation can be found in appendix I.)

The OIG derived responses for the OPM occupational series Medical Officer and Nurse to include the VHA assignment codes into a singular response for each occupation.⁹⁴ If a facility director indicated more than one type of source in their response, within these two occupations, the source for the occupation was determined to be *Mix*. VHA Directive 1351 is recognized by VHA as a national staffing methodology for the Nurse occupation; however, less than 10 percent of facility directors reported that a VHA source of method was used to determine staff for this occupation.⁹⁵

Validated staffing models can provide a level of consistency in how staffing requirements are determined across facilities. The OIG finds it is unlikely there is currently consistency in how requirements are determined because facilities are primarily using locally-developed methods to determine their staffing requirements. For example, one facility may use a ratio of one provider per 1,000 patients to determine they require 10 providers, whereas another facility may base their requirements on available funding. The absence of a consistent way to identify requirements makes it difficult to identify whether facilities are appropriately funded. An opportunity exists for VHA to develop staffing models that provide a level of consistency in how staffing requirements are determined across facilities.

Facility Directors Reported Variation in How They Determined Requirements Across Staffing Methods

The OIG conducted a bag-of-words text analysis to examine which words and phrases commonly appeared in facility directors' responses to the question "Explain how you determined the number of staff required in this occupation" when grouped by source as referenced above:⁹⁶

- For responses with the source specified as local, the analysis showed staffing requirements were determined by facility decision makers and use of operational data.

⁹⁴ The Medical Officer occupation contains one OPM occupational series code and 99 VHA assignment codes. The Nurse occupation contains one OPM occupational series code and 70 VHA assignment codes. The OIG analysis used both OPM occupational series and VHA assignment code responses to derive a singular response for the Medical Officer and Nurse occupations in order to compare them with other occupations.

⁹⁵ VHA Directive 1351.

⁹⁶ Bag-of-words is a text analysis approach within the JMP software package. The approach provides frequency counts of terms and phrases from text.

Commonly cited words and phrases were *workload*, *demand*, *organizational chart*, *HR Smart*, *annual service-level planning*, and *resource/position management committees*.

- For responses with the source specified as *VHA*, the analysis highlighted that *staffing methodologies* was the most common phrase identified in this group, with the nurse staffing methodology being the most frequently cited of these.
- For responses with the source specified as *mixed*, the analysis showed words and phrases from the previous two groups such as *workload* and *staffing models*, but it also emphasized new words and phrases such as *productivity* and *PACT [Patient Aligned Care Team] models*.

Most facilities were using either facility-developed or a mix of methods to determine requirements even though national-level staffing guidance existed for some occupations.⁹⁷ Although facilities may have used a single staffing method to determine their staffing requirements, variation existed in how facility directors were determining requirements across methods. This data provides VHA insight on the use of national-level staffing guidance in determining requirements by facilities in the absence of validated staffing models. Opportunity also exists to view the sources used for severe shortage occupations for prioritization of staffing model development and validation.

Review of Staffing Data

The OPM Workforce Planning Best Practices document states that an organization’s review of its supply and demand, and conducting an evaluation of the gap between supply and demand, are “primary elements of a workforce analysis framework and methodology.”⁹⁸ These reviews would not only evaluate the current number of staff and identify current skills and competencies in the existing workforce, they will also provide a forecast of what the optimal number of staff should be, as well as “identify skills and competencies needed in mission-critical occupations in the future workforce.”

The OIG proposes that awareness of occupational staffing levels and staffing requirements, especially in severe shortage occupations, is crucial for informing strategic planning to meet current and anticipated operational demands. For VHA, this information includes access to data that confirms if the number of staff employed in each occupation is equal to, less than, or more than what its facilities require. An understanding of staffing levels relative to staffing requirements is helpful in identifying whether or not VHA is fully staffed.

⁹⁷ See appendix F for a listing of staffing guidance and affected occupations or service lines.

⁹⁸ OPM, *Migration Planning Guidance Information Documents, Workforce Planning Best Practices*, October 7, 2011.

For this reason, quality data on VHA’s authorized staffing levels, as well as on vacancies (vacancies are unfilled authorized positions), are essential. Accurate and reliable data on authorized and vacant positions may help enable VHA to conduct assessments of staffing more accurately.

More Than Half of Facility Directors Reported the Number of Staff Employed was Less Than the Number of Staff Required

The OIG found that while most facilities were using facility-developed or a mix of staffing methods to determine requirements, it was also important to understand what those staffing requirements were given the general absence of validated staffing models. The OIG asked facility directors to provide both the number of staff employed as well as the number of staff required to meet the demand for each occupation listed in the survey.

An understanding of the number of staff employed relative to the facility’s operational requirements can provide a basis for manpower management discussions. The OIG created three staffing level categories to understand whether or not the number of staff employed was in alignment with staffing requirements.

Generally, facility directors reported that staffing requirements exceeded the number of staff employed. For example, over three-quarters of facilities indicated having fewer staff than what was required to meet the demands for both Police and Custodial Worker occupations.⁹⁹ Both occupations perform critical functions at facilities.

VHA relies on VA Police for security and law enforcement services at its facilities. VA police officers provide protection to patients, visitors, employees, and federal property. Custodial Workers perform additional cleaning and disinfection after a person screens positive for respiratory symptoms or COVID-19 exposure.¹⁰⁰ A shortage in custodial workers may affect compliance with VHA’s *COVID-19 Response Plan, Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan* as well as VHA’s ability to provide care safely during the pandemic.

⁹⁹ Police and Custodial Worker were reported as two of the most frequently cited nonclinical severe occupational staffing shortages in OIG’s FY 2020 staffing determinations report. A severe shortage is defined by OPM as when particular occupations are difficult to fill, and a shortage exists as defined by 5 C.F.R. § 337.204 for the occupational series. The staffing level categories presented in Table 3 are distinct from the designation of a severe shortage. Using Police as an example, 98 out of 130 facilities reported having fewer staff than what was required to meet the demands, whereas 57 out of 130 facilities reported Police as a severe occupational shortage.

¹⁰⁰ COVID-19 Response Plan, *Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, March 23, 2020.

Table 3. Staffing Level Categories for the Top Five Clinical and Top Five Nonclinical Severe Occupational Staffing Shortages

Occupation	Clinical/ Nonclinical	Employed Equal to Required # (%)	Employed Less than Required # (%)	Employed More than Required # (%)	Unable to Calculate # (%)
Psychology	Clinical	27 (20.8)	89 (68.5)	4 (3.1)	10 (7.7)
Medical Officer*	Clinical	27 (20.8)	74 (56.9)	2 (1.5)	27 (20.8)
Nurse*	Clinical	19 (14.6)	79 (60.8)	4 (3.1)	28 (21.5)
Practical Nurse	Clinical	28 (21.5)	89 (68.5)	2 (1.5)	11 (8.5)
Medical Technologist	Clinical	37 (28.5)	87 (66.9)	1 (0.8)	5 (3.8)
Police	Nonclinical	21 (16.2)	98 (75.4)	1 (0.8)	10 (7.7)
Medical Support Assistance	Nonclinical	24 (18.5)	91 (70.0)	2 (1.5)	13 (10.0)
General Engineering	Nonclinical	43 (33.1)	75 (57.7)	1 (0.8)	11 (8.5)
Custodial Worker	Nonclinical	19 (14.6)	102 (78.5)	1 (0.8)	8 (6.2)
Food Service Worker	Nonclinical	31 (23.8)	85 (65.4)	3 (2.3)	11 (8.5)

Source: OIG Analysis of facility Directors' responses to the FY 2020 Staffing Determination and Staffing Model survey

** VHA facilities provided the number of staff employed and the number of staff required for Medical Officer and Nurse at the OPM occupational series level, the VHA assignment code level, or both. The comparatively high numbers shown for the Medical Officer and Nurse in the "Unable to Calculate" category is likely due to this reporting variability.*

The OIG acknowledges that facility directors tried to provide the most accurate number of staff required to meet the operational demand of the facility and recognizes the difficulty of making precise determinations for what that required number of staff is. Given the multiple factors involved, it is important to exercise caution when interpreting this information.

These categories are not necessarily an indicator for the delivery of care. While the information highlights staffing level categories, the categories should be interpreted less as an assessment of sufficiency of staffing and more as highlighting the challenges of interpreting, what appears to be a simple number, staffing requirements in the absence of consistency. Further, table 3 does not account for the severity of requirements exceeding the number of staff employed for a given occupation (magnitude). For example, if Facility A reported five staff members were employed for an occupation and required six to meet demand (a difference of only *one*), Facility B could have also reported five employed but required 15 to meet demand (a difference of *10*).

(Histograms of the magnitude of shortages for each of the occupations can be found in appendix J.) Additional caveats included the reporting variability for Medical Officer and Nurse by OPM occupation code, VHA assignment code, or both; changes in staffing requirements throughout the year given the OIG requested survey data as of December 31, 2019; methodological differences between facilities for determining requirements; and, differences in geographical demand for care and regional availability of staff to hire. For example, even if a facility hired all the physicians in a single geographic area, their requirements may exceed available staff in that area due to the demand of the patient population.

The OIG analysis does not consider budgeted positions that are unfilled or unbudgeted staffing requirements. For example, if a facility has 40 custodial workers employed and a funding stream that limits them to 50 budgeted positions, the facility can hire 10 more custodial workers.¹⁰¹ However, if the facility has an identified operational requirement of 70, the facility would likely need additional funding to be able to hire the 20 required, but unbudgeted, positions.

Although facility directors have autonomy over resource allocation (to include budgeting for positions) at their facilities, if they are not funded appropriately, they will not be able to staff according to the operational demands of the facility. Regardless of whether positions are budgeted or unbudgeted, the OIG found that facilities have unmet staffing requirements, and facilities generally reported more unmet staffing requirements in nonclinical occupations than clinical occupations.

The OIG proposes that the lack of validated staffing models makes accurate and consistent assessments of staffing requirements challenging. This limits VHA's ability to identify and mitigate instances in which staffing requirements exceed staffing levels and, by extension, makes it difficult for VHA to determine which facilities are fully funded. This puts facility and VISN directors in a position where they may make trade-offs between staffing requirements and budget in the absence of input from VHA. The OIG concludes that the development, validation, and implementation of VHA staffing models will help VHA strengthen and support its efforts to better identify the number of staff required to meet operational demands.

VHA-Level Authorized Position Data Not Readily Available

Per VA Directive 5010, VA Manpower management is requirements-based as well as workload-based.¹⁰² The directive requires that position data are maintained and that validated manpower requirements are appropriately documented in HR Smart. The OIG requested VHA-level authorized position data to better understand how VHA is tracking budgeted and approved

¹⁰¹ Although the facility's budget allows it to hire 10 more custodial workers in this example, it does not mean the facility would not have difficulty filling those 10 positions. Prior OIG work identified lack of qualified applicants as a primary reason for severe occupational staffing shortages at VHA.

¹⁰² VA Directive 5010.

positions. The OIG also requested vacancy data, which reports the number of authorized positions that are unfilled. Both data requests focused on the top five clinical and top five nonclinical severe shortage occupations at the facility level as of December 31, 2019.¹⁰³

VHA WMC's response to the OIG's data request indicated that the authorized data by occupation was not readily available. Staff from VHA WMC noted their office could provide authorized positions by facility and VISN levels, but did not have authorized positions by occupation. While staff from VHA WMC likely could have provided the total number of authorized positions at a facility, they could not say, for example, how many Custodial Workers were authorized at that facility. The VHA Manpower Director did not expect to have authorized positions by occupation until the manpower module in HR Smart was fully implemented in mid-2021.¹⁰⁴ The VHA Manpower Director also informed the OIG there are plans to initiate manpower assessments to identify staffing requirements. These assessments would promote a better understanding of unbudgeted staffing requirements and help identify the appropriate number of authorized positions at each facility. Staff from VHA WMC anticipates that assessments of each facility would take approximately eight months. VHA's intent for the assessments is to identify need in terms of authorized and budgeted positions, as well as identify unbudgeted requirements.

Staff from VHA WMC also indicated vacancy data as of December 31, 2019, was significantly different from current vacancy data due to a comprehensive cleanup of the data after that date.¹⁰⁵ VHA WMC staff offered to provide the data as requested; however, they were not confident of the historical data as of December 31 because of the subsequent cleanup and preferred to provide updated data, because it was more accurate. VHA WMC staff estimated that between 20,000 to 25,000 positions were involved in the cleanup, which included removal of duplicate positions and marking positions as unbudgeted if they were not under active recruitment. Although VHA conducted this cleanup, staff from VHA WMC indicated vacancy data maintenance is not complete and is an ongoing, continuous process.

The OIG does not consider VHA in full alignment with VA Directive 5010 that requires VHA Manpower to ensure that validated manpower requirements and position data are appropriately documented in HR Smart. Although steps were taken, VHA did not yet have program office level access to data on authorized positions by occupation to enable stronger management of its

¹⁰³ The OIG requested authorized and vacant position data from the VA Office of the Under Secretary for Health for Operations and Management on September 21, 2020, and subsequently met with VHA WMC staff on October 26, 2020.

¹⁰⁴ Per the VHA WMC Director, the manpower module will allow the identification of authorized positions in HR Smart through the use of an indicator field. The indicator is determined at the facility level and shows whether a position is funded or not.

¹⁰⁵ VHA conducted the data cleanup after noticing a disconnect between the budget and the anticipated number of vacant positions after accounting for an assumed 10 percent vacancy rate.

position inventory as of the date of this report. The inability to provide VHA-wide authorized data by occupation is problematic given HR Smart is VA’s human capital system of record. Program office leaders’ awareness and VISN and facility-level maintenance of accurate data on authorized and vacant positions are essential to understanding occupational staffing levels across VHA. Accuracy in staffing level data serves as the basis of comparison for which staffing requirements, as identified by validated staffing models, can be compared.

Lack of Qualified Applicants, Noncompetitive Compensation, and Staff Turnover Were the Most Commonly Cited Reasons for Severe Occupational Staffing Shortages

As noted earlier, the OIG asked facility directors to provide a reason for each designated staffing shortage. Among other uses, this information can help VHA address challenges associated with retention and recruitment, resource allocation, and action planning.

The most frequently cited reasons for severe occupational shortages among the top five clinical, and top five nonclinical occupations were (1) lack of qualified applicants, (2) noncompetitive compensation, (3) staff turnover, (4) recruitment challenges, and (5) geographical recruitment challenges.¹⁰⁶

Table 4. Top Five Themes for Severe Occupational Staffing Shortages¹⁰⁷

Themes	Number of Responses (565)	Percent of Responses
Lack of Qualified Applicants	207	36.6
Noncompetitive Compensation	191	33.8
Staff Turnover	182	32.2
Recruitment Challenges	148	26.2
Geographical Recruitment Challenges	132	23.4

Source: OIG analysis of VHA facilities’ responses to the FY 2020 Staffing Determination and Staffing Model survey

¹⁰⁶ The OIG counted the number of times a theme showed up for each of the top five clinical and top five nonclinical occupations.

¹⁰⁷ Some facilities designated multiple reasons for a given occupational shortage, while other facilities provided only one reason per occupational shortage resulting in the sum of the percentage of responses exceeding 100 percent.

While many directors noted a general lack of qualified applicants, some directors highlighted challenges when selected candidates could not pass preemployment screening and were no longer considered qualified.

Directors also highlighted challenges associated with the inability to compete with private-sector pay, benefits, and incentives. One director noted a “high percentage of declinations for pay,” which resulted in it taking “up to a year to fill one vacancy.” Some directors reported that incentive caps, or the inability to offer incentives, had contributed to shortages. Other directors reported severe shortages despite incentives, with one director opining, “Other local hospitals are difficult to compete with due to significant disparities in pay and incentives packages.”¹⁰⁸

High rates of staff turnover pose a challenge for facility directors, with several directors noting difficulty retaining staff. Subsequently, high staff turnover necessitates increased recruiting, which remains a challenge. One director highlighted how several of the themes discussed above impacted turnover and recruiting and resulted in a severe shortage:

Competition for qualified staff in this field is extremely challenging. Other local hospitals pay significantly more than our facility and offer benefits and flexibilities not available to us. We experience difficulty both recruiting and retaining staff in this occupation.

Just under 50 percent of responses cited recruitment challenges as a reason for shortages. Upon review, the OIG divided these responses into two themes. The first theme, *recruitment challenges*, represents general recruitment challenges. *Geographical recruitment challenges* refer to challenges specific to the facility’s location to include the desirability of the location, rurality, and high cost of living. While one director noted that “there is a high cost of living in our area and the wage limitation makes it difficult to attract candidates,” another stated their facility’s “highly rural location” was the reason for numerous shortages.

While most reasons for severe shortages fell into one of the five themes discussed above, there were additional themes that represented other challenges faced by facilities. Examples of other themes noted by directors included non-VA competition to hire staff, position-specific challenges that included the desirability of certain shifts, and national shortages.¹⁰⁹ The range of themes identified by the OIG highlights that facilities are facing varied challenges beyond a lack of qualified candidates, noncompetitive compensation, staff turnover, and recruiting.

As discussed in the *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages, FY 2020* report, the total number of severe occupational shortages has

¹⁰⁸ The quotations listed are not the full listing of quotations by respondents but were selected to provide the reader with examples. The OIG made edits to statements to correct spelling.

¹⁰⁹ Regarding national shortages, the Association of American Medical Colleges reports that physician shortages have increased over the last two decades and projects that these shortages will continue to increase.

decreased comparatively over the last three fiscal years.¹¹⁰ However, the reasons for severe shortages provided in this survey were consistent with many of the challenges noted in the OIG's FY 2018 and FY 2019 staffing reports. While VHA has put together action plans to address severe occupational shortages, these issues are long-standing and require regular attention. As such, the OIG continues to identify the cause of shortages to facilitate better understanding of opportunities for staffing improvements across VHA.

VISN Directors Reported That Facility Directors Prioritized Staffing Requirements Within the Constraints of Available Budgets

VHA facilities are organized into 18 VISNs that are responsible for managing operations, planning, and allocation of resources among the facilities within their control. To better understand the responsibilities and process for determining the number of positions at VHA facilities, the OIG interviewed all 18 VISN directors. Such an understanding provides insight into how directors balance staffing levels and requirements.

VISN directors explained that authorizing positions was typically done through local governance processes, by committees comprised of various facility leaders that consider and prioritize requests for resources. They reported that when considering staffing requests, leaders and committees weighed evidence of need, including available staffing models and local factors, against the budget and priorities of the facility. VISN directors reported that responsibility for authorizing the number of positions at VHA facilities ultimately rests with facility directors.

VISN directors reported that the number of authorized positions was reviewed or revised at various intervals. They reported meeting with facility leaders to review their staffing levels and needs during annual reviews associated with budget allocations. They reported that facility leaders also make quarterly attestations to the accuracy of facility and service-level organizational charts. VISN directors also reported monthly or more frequent reviews and revisions by facility governance committees to authorize new positions or make other changes to their facilities' organizational structures.

The OIG also asked VISN directors about the relationship between the budget and the number of authorized positions for an occupation at a facility. VISN directors reported that the number of authorized positions was generally dependent on available budgets. They made distinctions between authorized and budgeted positions, explaining that some positions might be authorized but not necessarily budgeted. Several VISN directors reported that there was a disconnect between the way budgets are informed by historical workload and mandated staffing levels for

¹¹⁰ VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020. There were 2,430 occupations identified as severe staffing shortages in FY 2020; this is down from 2,685 in FY 2019 and 3,068 in FY 2018.

certain occupations. They cited caregiver support and homeless programs as examples with workloads not sufficiently measured to support the fiscal burden of their staffing requirements.

VISN directors reported that if the number of budgeted positions does not meet the number required to address staffing requirements, facilities would attempt to reduce their expenditures to free up the necessary funds. Examples given included delaying hiring for authorized positions or delaying execution of contracts for necessary equipment. If a facility were unable to free up the funds to support those positions, the VISNs may then supplement the facility budget from the VISNs' reserves. VISN directors stated that in some instances, a VISN may receive additional funding from other VISNs or VHA Central Office.

Several VISN directors reported that limitations in how they can use various appropriations to fund different types of positions creates challenges for VISNs and facilities to resource identified staffing requirements. VISN directors reported being well-resourced to support their clinical staffing needs but reported issues with the amount and timing of funding for administrative staffing. It was explained that in order to address staffing needs in the context of such limitations, VISNs with different funding needs may trade funds of one appropriation type for another. An example given was trading funds for community care for funds to support administrative staffing.

VISN directors described the identification of requirements and authorization of positions as constrained by the level of funding at the facility level, the need to support staffing for mandated programs, and limitations on the use of funds. The reported result of these constraints was the need to prioritize between identified needs and requirements.

3. Pandemic Hiring

The COVID-19 pandemic altered the delivery of health care in several ways. For example, healthcare systems began shifting care from in-person to telehealth to limit face-to-face interaction. In addition, the demands for inpatient care increased as COVID-19 hospitalizations grew, whereas the demand for elective and outpatient care decreased. As a result, healthcare staffing needs changed and one study indicated that healthcare practices, ranging from small private practices to large provider organizations, began furloughing providers due to decreases in demand.¹¹¹

¹¹¹ The New England Journal of Medicine Catalyst Innovations in Care Delivery, "Economic and Clinical Impact of Covid-19 on Provider Practices in Massachusetts," September 11, 2020, accessed December 10, 2020, <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0441>.

While VA faced similar alterations in the delivery of health care, VA is, through their fourth mission, the nation’s support system during times of emergencies.¹¹² As a result of the COVID-19 pandemic, Congress appropriated VA money through the CARES Act to, among other things, bolster staffing levels. In an April 2020 press release, VA’s Office of Public and Intergovernmental Affairs noted that the VA was moving “aggressively” to hire staff who could provide care for the rising number of patients as a result of the COVID-19 pandemic. The VA’s Office of the Chief Human Capital Officer stated it was “imperative that VA fill positions expeditiously if not immediately.” Consequently, VA sought and obtained direct hire authority for several occupations from OPM eight days after the Worldwide Health Organization declared COVID-19 a worldwide pandemic. With support from OPM, as well as through the use of existing flexibilities and by modifying internal policy, VHA reportedly dropped hire time from 94 days to approximately 11 days. The OIG obtained staffing data from VA and VHA as well as line-level HR Smart data for the occupations that were most frequently cited as severe occupational shortages prior to the pandemic, and interviewed all VISN and VHA WMC program office directors to better understand COVID-19 hiring and staffing.¹¹³

Workforce Levels During the Pandemic

HR Smart Data Limitations

HR Smart provides personnel data useful to this review; however, it has documented reliability issues.¹¹⁴ The OIG used this data because it provides personnel data at the occupation level, and is VA’s human capital system of record for positions.¹¹⁵

VA and VHA Could Benefit from Consistency when Reporting Staffing Data

Data made available by VA indicated a substantial hiring effort by VHA. VA’s COVID-19 Pandemic Response Weekly Report reported that VHA had over 100,000 new hires in just over a year. Additionally, VHA’s methodology for calculating onboard staffing levels yielded annual net increases nearly three times those indicated in VA’s MISSION Act 505 Data (16,157 versus

¹¹² VHA, *Coronavirus Disease 2019 (COVID-19) Response Report*, October 27, 2020. “In emergency situations, VA avails itself to national, state, territorial, tribal, and local [civilian] governments to prepare and support relief efforts. This service is known as VA’s Fourth Mission.”

¹¹³ A severe shortage is determined by OPM when particular occupations are difficult to fill, and a shortage exists as defined per 5 C.F.R. § 337.204 for the occupational series. 5 C.F.R. 337.204 – Severe Shortage of Candidates.

¹¹⁴ HR Smart issues included VHA WMC reporting data quality issues as a result of the pandemic, recent OIG work related to the MISSION Act that identified staffing and vacancy reporting issues with HR Smart data, and OIG staff who analyzed the data for this report identified records that may inflate full-time equivalent totals.

¹¹⁵ VA Directive 5010.

5,487). The differing numbers made it difficult to reconcile and interpret reported staffing data across VA and VHA.

Public data from VA indicated significant hiring increases at VHA. VA’s COVID-19 Pandemic Response Weekly Report, May 15–21, 2021, reported there were 113,950 VHA “new hires” from March 29, 2020–May 15, 2021.¹¹⁶ The reported data suggests an unprecedented level of hiring given that VHA indicated having 353,268 staff onboard as of March 31, 2020. Assuming the phrase “new hires” refers to unique external hires, as it did in VHA’s COVID-19 Response Report, it suggests an annual net increase of over 60,000 staff at a loss rate of nine percent.¹¹⁷

However, in a press release associated with VHA’s COVID-19 Response Report, it was noted that VA hired over 59,000 “new employees” from March 2020 to November 2020.¹¹⁸ VHA WMC leadership indicated the term “new employees” referred to total hires—both internal and external. It was unclear whether the referenced internal “new employees” included those who were reassigned or reallocated in response to the increased patient demands related to the pandemic.¹¹⁹ The OIG proposes that VA and VHA consider the verbiage used when describing staffing data so there is clarity and consistency in the interpretability of their reporting.

To better understand the reported size of VHA’s workforce, the OIG sought onboard staffing data from VA and VHA. VHA WMC staff indicated the data obtained through VHA’s HR Employee Cube could be used for reporting, and VHA Support Service Center staff indicated the HR Employee Cube data was a monthly extract from HR Smart.¹²⁰ The OIG applied VHA’s methodology to VHA’s HR Employee Cube and calculated quarterly onboard staffing levels at

¹¹⁶ VA’s *COVID-19 Pandemic Response Weekly Report*, May 15–21, 2021, accessed May 25, 2021, https://www.va.gov/health/docs/VA_COVID_Response.pdf.

¹¹⁷ The OIG interpreted these terms using similar methodology and verbiage as presented in VHA’s *COVID-19 Response Report*, October 27, 2020, because there was a lack of clarity in the weekly report defining a “new hire.” “New Hires represents unique external hires, which is exclusive of transfers from other VA entities; Total Loss represents all employees who have been removed from, or departed, the VA for any reason.”

¹¹⁸ In a November 2020 press release, VA’s Office of Public and Intergovernmental Affairs reported hiring over 59,000 employees since March 29, 2020. VA, *VA releases COVID-19 Response Report*, November 9, 2020, accessed November 15, 2020, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5564>.

¹¹⁹ VA OIG, *OIG Inspection of VHA’s COVID-19 Screening Processes and Pandemic Readiness*, Report No. 20-02221-120, March 26, 2020. VA OIG, *Review of Veteran Health Administration’s COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020. “Facility leaders reported allocating staff from to needed areas, moving towards telehealth, and offering overtime pay to address staff absences.” “Facility leaders reported using a variety of methods to address staffing shortages, most notably with contract staff, reassigning staff to higher areas of need, and utilizing staff from other VHA facilities.”

¹²⁰ VHA indicated the HR Employee Cube data on VHA Support Service Center yielded similar results to HR Smart. To support their statement, VHA used the HR Employee Cube to identify onboard employees for the ten occupations the OIG reviewed as of March 31, 2020, and September 30, 2020, the closest possible dates to the two points in time to the OIG review (March 28, 2020, and October 10, 2020), and compared them to the total onboard numbers to the HR Smart data pull which showed a difference of 92 onboard staff. Similar methodologies were applied to both the HR Employee Cube data as well as the HR Smart data the OIG reviewed.

VHA.¹²¹ The OIG compared VHA's calculated onboard staffing levels to those in VA's MISSION Act Section 505 Data.¹²² Documentation for VA's MISSION Act Section 505 Data indicates that quarterly comparisons cannot be drawn prior to March 31, 2020, therefore, the OIG used March 31, 2020, as the initial point in time and analyzed VHA's quarterly onboard staffing levels through March 31, 2021.¹²³

As of March 31, 2021, VHA's HR Employee Cube reported 369,425 VHA onboard employees whereas VA's MISSION Act 505 Data reported 357,578 VHA onboard employees resulting in annual net increases of 4.6 percent and 1.6 percent, respectively (see table 5). While VHA's onboard levels increased over the year, both VHA and VA data indicated declining quarterly net increases after September 30, 2020. Additionally, the differences between VHA's and VA's quarterly net increases generally grew. As of March 31, 2021, VHA's Employee Cube indicated a quarterly net gain whereas VA's MISSION Act 505 Data indicated a quarterly net loss, 2,180 and -1,026, respectively. However, VA's MISSION Act 505 Data uses a different methodology than VHA to calculate onboard staffing levels.¹²⁴ While the primary source of data for both is HR Smart, it is likely VHA's HR Employee Cube yields different onboard staffing levels than VA's MISSION Act 505 Data, in part, due to the differing methodologies applied.¹²⁵ Additionally, neither VA's reported 113,950 new hires nor the suggested net increase of 60,000 is consistent with the data in VHA's HR Employee Cube or VA's MISSION Act 505 Data.

¹²¹ VHA methodology exclusions for HR Employee Cube: non-VHA employees (Organization field), employees who are trainees/unknown trainee status (Trainee field), employees in an intermittent/unknown status (Duty Basis field), employees in a non-pay/unknown status (Pay Status field), and medical residents (Medical Resident field).

¹²² *Human Resources and Administration/Operations, Security, and Preparedness*, VA MISSION Act Section 505 Data, accessed June 11, 2021. <https://www.va.gov/employee/va-mission-act-section-505-data/>.

¹²³ The MISSION Act 505 Data was produced using VHA Support Service Center cubes prior to March 31, 2020, and HR Smart thereafter. The VA Manpower Director indicated the transition from using the VHA Support Service Center cubes to using HR Smart occurred because the cube data was not *static or transparent*. As a result, the cubes could not be validated or recreated. It was also indicated that because there were known coding issues within HR Smart, that may have gone undetected when using the cubes to produce the data, VA Manpower staff were now able to conduct quality checks on reported MISSION Act 505 Data.

¹²⁴ VHA methodology exclusions for HR Employee Cube: non-VHA employees (Organization field), employees who are trainees/unknown trainee status (Trainee field), employees in an intermittent/unknown status (Duty Basis field), employees in a non-pay/unknown status (Pay Status field), and medical residents (Medical Resident field). VA MISSION Act 505 Data methodology exclusions: trainees, medical residents, students, interns, fellows, unpaid health professional trainees or other volunteers, employees in a non-pay/intermittent status, the OIG, the Veterans Canteen Services, fee-basis only employees, and employees hired in support of COVID-19.

¹²⁵ VA Directive 5010; HR Smart is VA's human capital system of record for positions. VA's MISSION Act 505 Data is a direct pull of data from HR Smart. VHA's HR Employee Cube is a monthly extract from HR Smart.

Table 5. Comparison of Quarterly Onboard Staffing Levels at VHA

Date (as of)	VHA's HR Employee Cube			VA's MISSION Act 505 Data		
	Onboard Levels at VHA	Net Change		Onboard Levels at VHA	Net Change	
		Number	Percent		Number	Percent
March 31, 2020	353,268	—*	—	352,091	—	—
June 30, 2020	358,287	5,019	1.4	354,213	2,122	0.6
September 30, 2020	363,474	5,187	1.4	357,843	3,630	1.0
December 31, 2020	367,245	3,771	1.0	358,604	761	0.2
March 31, 2021	369,425	2,180	0.6	357,578	-1,026	-0.3
<i>Annual (March 31, 2020, vs. March 31, 2021)</i>	369,425	16,157	4.6	357,578	5,487	1.6

Source: OIG analysis of VHA's HR Employee Cube and VA's MISSION Act Section 505 Data

* This indicates there is no data because this is a baseline value and comparisons are unavailable.

The OIG found it difficult to reconcile reported staffing data received from VA and VHA. VA as well as VHA reported annual net increases in staffing at VHA from March 2020 to March 2021. However, the inconsistencies in methodologies as well as reported data made it difficult to quantify the extent of hiring during the pandemic as VA and VHA indicated different increases in staffing levels. While the OIG commends VA and VHA's efforts to provide staffing data publicly, the OIG concludes that it is important VA and VHA report consistent information related to staffing levels so that a clearer narrative can be provided to the public.

VHA Increased Net Staffing During the COVID-19 Pandemic in 10 Occupations Reported by VHA as Severe Shortages

From FY 2015–FY 2019, VA reported an average annual net increase of 11,011 onboard employees across all components and occupations.¹²⁶ From March to October 2020, VHA experienced a net increase of over 5,600 staff in the 10 occupations most frequently cited by facility directors as severe shortages (see table 6).¹²⁷ This increase brought VHA's staffing levels

¹²⁶ VA, *VA MISSION Act, Section 505 Annual Report – 2020: Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act Section 505(b)*, June 2020. The term *component* refers to VHA, National Cemetery Administration, Veterans Benefits Administration, and Staff Offices. "Staff Offices include all General Administration appropriations, Board of Veterans Appeals, and the Office of Information Technology."

¹²⁷ The OIG used VHA's methodology for analyzing line-level HR Smart data. VHA's methodology exclusions for line-level HR Smart data were non-VHA employees, fee basis employees, trainees, and intermittent employees. Top five clinical OPM occupational series and titles: 0602 Medical Officer, 0610 Nurse, 0620 Practical Nurse, 0180 Psychology, and 0644 Medical Technologist. Top five nonclinical OPM occupational series and titles: 3566 Custodial Worker, 0083 Police, 0801 General Engineering, 7408 Food Service Worker, and 0679 Medical Support Assistance.

for those occupations to over 181,000 and was largely driven by increases in clinical staff. The net increase for these 10 occupations represented approximately half of VA's average annual net increase for all components and occupations. Because VHA accounts for approximately 90 percent of all VA employees, this net increase suggests VHA may have onboarded more staff as a result of the pandemic than they have, on average, in recent years.

The OIG used line-level HR Smart data for the analysis of the selected occupations. This level of data allowed the OIG to identify who was onboard at VHA and their assigned occupation, which provided insight into workforce levels during the pandemic. However, the data did have some analytical limitations. The OIG could not use this data to review movement within the VHA system during the pandemic, because the data represented two single points in time, March 28, 2020, and October 10, 2020. For example, the OIG could not identify VHA providers who transferred to other VHA facilities that were experiencing surges in demand because of the pandemic. Additionally, the nearly seven months between those two points in time limited the OIG's visibility into short-term, temporary appointments as those cannot exceed four months (120 days). The analysis below was based on the 10 occupations most frequently cited by facility directors as severe shortages and represents a subset of the occupations for which VHA hires. The OIG focused on these occupations because they were determined to be the most frequently cited severe shortages; however, the results of the analysis may not be reflective of all VHA occupations.

To better understand how staffing levels changed for the 10 occupations reviewed, the OIG analyzed the HR Smart data by clinical or nonclinical occupational series. As of October 10, 2020, clinical employees made up 72 percent of the total number of employees in the occupations the OIG reviewed. The OIG found that VHA increased net staffing in the clinical and nonclinical occupations at similar rates, four percent and three percent, respectively.

Analysis of selected occupations suggested that hiring patterns changed during 2020. Data from VHA's COVID-19 Response Report suggested VHA experienced net increases of approximately 28 Medical Officers and 185 Custodial Workers per month from February through June 2020.¹²⁸ The data the OIG reviewed, which reflected onboard employees as of March and October 2020, showed monthly net increases of 62 and 58 employees per month for these two occupations, respectively. Given the end dates of June and October 2020, it suggests that the rate of hiring for Medical Officers increased over the summer as COVID-19 positivity rates were decreasing, and the rate of hiring for Custodial Workers increased during spring 2020 but declined during the summer. (Additional occupation-level data can be found in appendix K.)

Among the clinical employees on board as of October 10, 2020, in the 10 occupations the OIG reviewed, nearly 80 percent were either Medical Officers or Nurses. These two occupations are

¹²⁸ COVID-19 Response Report, October 27, 2020.

key to the delivery of health care and have been the most commonly cited occupational shortages since 2014 in the OIG's annual *Determination of VHA's Occupational Staffing Shortages* reports.¹²⁹ Nursing was the clinical occupation with both the largest percentage net increase (3.8 percent) as well as the largest net increase (2,821).

Thirty-six facilities reported the Nurse occupation as a severe shortage in FY 2020, and this occupation has been cited annually as a severe shortage since FY 2018.¹³⁰ Other OIG work identified that facility leaders reported being sufficiently staffed to manage the increased patient demands related to the pandemic.¹³¹ As of October 2020, twenty percent of Nurses were Registered Nurse Staff Nurses-Inpatient—an occupation of high demand during the pandemic. VHA increased staffing by five percent in this occupation when comparing staffing levels from March to October 2020, which exceeded the rate of the Nurse occupation overall (4 percent). However, leaders also had to use a variety of methods, such as reallocating staff due to absenteeism, to address staffing shortages to manage those demands.¹³² The OIG found that VHA increased the number of Resource/Float Pool Nurses by 43 percent suggesting VHA increased staffing levels of nurses who could move across units to address shifting patient demands during the pandemic.

Eighty-five percent of the approximately 2,000 nonclinical net increase in staff were in either the Medical Support Assistance or Custodial Worker occupations. Custodial Worker was the most cited nonclinical severe occupational staffing shortage in FY 2020. VHA's Response Plan requires both routine cleaning as well as additional cleaning and disinfection if someone presents

¹²⁹ VA OIG: *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, Report No. 15-00430-103, January 30, 2015; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, Report No. 15-03063-511, September 1, 2015; *OIG Determination of VHA Occupational Staffing Shortages*, Report No. 16-00351-453, September 28, 2016; *OIG Determination of VHA Occupational Staffing Shortages, FY 2017*, Report No. 17-00936-385, September 27, 2017; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018*, Report No. 18-01693-196, June 14, 2018; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2019*, Report No. 19-00346-241, September 30, 2019; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020.

¹³⁰ VA OIG: *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018*, Report No. 18-01693-196, June 14, 2018; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2019*, Report No. 19-00346-241, September 30, 2019; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020.

¹³¹ VA OIG, *Review of Veteran Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020.

¹³² VA OIG, *OIG Inspection of VHA's COVID-19 Screening Processes and Pandemic Readiness*, Report No. 20-02221-120, March 26, 2020. VA OIG, *Review of Veteran Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020. "Facility leaders reported allocating staff from to needed areas, moving towards telehealth, and offering overtime pay to address staff absences." "Facility leaders reported using a variety of methods to address staffing shortages, most notably with contract staff, reassigning staff to higher areas of need, and utilizing staff from other VHA facilities."

with COVID-19 symptoms or has been exposed to COVID-19.¹³³ The OIG concluded there will be a continued need to increase staffing levels in this occupation during the pandemic as the Center for Disease Control reported that weekly hospitalization rates increased in fall 2020 and, although vaccines have been developed, the director of the National Institute of Allergy and Infectious Diseases did not anticipate *herd immunity* prior to the fall of 2021.¹³⁴

Table 6. VHA Onboard Levels for the Top Five Clinical and Top Five Nonclinical Severe Shortage Occupations

Hiring Status	Overall	Five Clinical Severe Shortage Occupations	Five Nonclinical Severe Shortage Occupations
Total Onboard as of March 28, 2020	175,777	126,492	49,285
Less than Full-Time	14,222	12,612	1,610
Total Onboard as of October 10, 2020	181,427	130,229	51,198
Less than Full-Time	14,493	12,837	1,656
Net Change*	5,650	3,737	1,913

Source: OIG analysis of VHA-provided HR Smart data

* The OIG compared VHA onboard staffing levels as of March 28, 2020, to those as of October 10, 2020.

Net change represents the total onboard as of October 10, 2020, minus the total onboard as of March 28, 2020.

As reported in each of the past seven OIG annual *Determination of VHA Staffing Shortages* reports, staffing shortages exist throughout VHA. However, VHA experienced net increases in every clinical and nonclinical occupation the OIG reviewed. The net increases in these 10 occupations total approximately half the net increases VA experiences over an entire year suggesting that VHA may be able to increase staffing at a greater rate than they had, on average, in recent years.

Looking forward, it is unclear how budget resources may be allocated given providers were shifting on-site workload to virtual care during the pandemic.¹³⁵ The Veterans Equitable Resource Allocation Model allocates financial resources to VISNs based on two categories of

¹³³ COVID-19 Response Plan, *Incident-specific Annex to the VHA High Consequence Infection (HCI) Base Plan*, March 23, 2020.

¹³⁴ Centers for Disease Control and Prevention, *COVIDView Week 45*, ending November 7, 2020, accessed November 15, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-11-13-2020.pdf>. Herd immunity refers to a reduction in the risk of infection with a specific communicable disease (such as measles or influenza) that occurs when a significant proportion of the population has become immune to infection (because of previous exposure or vaccination) such that susceptible individuals are much less likely to come in contact with infected individuals.

¹³⁵ VA OIG, *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*, Report No. 20-02717-85, March 11, 2021.

care: basic care that is calculated using two years of historical patient workload data, and complex care that is calculated using five years of historical patient workload data. The increased staffing levels coupled with the shifts in the delivery of health care from face-to-face examinations to virtual care bring in to question the utility of the Veterans Equitable Resource Allocation Model in its current state as it uses historical data to allocate funds to the VISN. VHA Finance Office staff reported they are reviewing available information to determine how the shifts in the delivery of care will affect the Veterans Equitable Resource Allocation model.

Tracking Staff Funded Through the Coronavirus Aid, Relief, and Economic Security Act

In response to the pandemic, Congress passed the CARES Act that provided VHA with a time-limited \$17.2 billion to, among other things, hire new staff. This funding is temporary, and the staff hired under this Act “do not reflect an ongoing capacity requirement.”¹³⁶ VHA Finance leadership reported it was up to facility and VISN leadership to identify pandemic hires. Staff from VHA WMC noted HR Smart was not the ideal human resources information system for tracking COVID-19 hires, and they usually have a year to implement statutory requirements, but only had 30 days to implement the CARES Act.

At the time of this review, there was not a way to identify COVID-19 employees in VHA’s HR Employee Cube. As a result, the OIG was unable to compare COVID-19 employees against statements made in VA’s MISSION Act 505 2021 Annual Report regarding an “estimated” 8,000 additional employees funded through the CARES Act or the 7,246 onboard VHA COVID employees in VA’s MISSION Act 505 FY 2021 Quarter 2 report.¹³⁷

The OIG has concerns with the accuracy of HR Smart data regarding VHA’s COVID-19 employees. First, VHA’s Chief Officer for Workforce Management indicated there was a *loosening of controls* as to who can enter data (allowing additional staff to enter data), which resulted in *less than clean data* that may create *a challenge when analyzing data*. Second, the VA Manpower Director indicated that there was a potential for HR Smart data coding issues that could impact the accuracy of reported COVID-19 employees. However, internal VHA documentation obtained by the OIG indicated that VHA conducted a review of approximately 15,000 filled and vacant COVID-19 positions within HR Smart during March 2021; but, it was unclear how VHA’s review changed the number of COVID-19 positions. The OIG suggests it is

¹³⁶ VA, *VA MISSION Act, Section 505 Annual Report – 2021: Annual Report on the Steps Taken to Achieve Full Staffing Capacity*, May 2021.

¹³⁷ VA, *VA MISSION Act, Section 505 Annual Report – 2021: Annual Report on the Steps Taken to Achieve Full Staffing Capacity*, May 2021. VA MISSION Act 505 Data FY 2021 Quarter 2, accessed June 10, 2021, <https://www.va.gov/EMPLOYEE/docs/Section-505-FY21-Q2.xlsx>.

important for VA and VHA to accurately track and report the number of COVID-19 employees as these positions are funded through the CARES Act.

VISN Director Interviews

VHA’s operational model places “decision authority for daily operations and execution with the [VISN directors] applying standards, support and tools supplied by the VHA Central Offices.”¹³⁸ In the context of rapid implementation of policies to address a novel pandemic, the OIG sought the perspectives of VISN directors to gain insight into how VHA operationalized its staffing response to COVID-19. The majority of VISN directors reported that major shifts in the delivery of health care and associated staffing requirements were met by a surge in hiring, and by leveraging existing VHA personnel to support pandemic-related demands. VISN directors were generally satisfied with the quality of staff hired during the surge. VISN directors also expressed that they were hopeful that those staff members and the flexibilities used to hire them would become permanent.

Significant Changes to Staffing Requirements at VHA Facilities Related to the COVID-19 Pandemic

During interviews, every VISN director reported significant changes in staffing requirements since the beginning of the COVID-19 pandemic. The changes in staffing requirements were reported as being driven by necessary operational responses to the pandemic, including

- Increasing capacity for inpatient care,
- Cancelling or deferring elective and nonemergent care,
- Converting in-person appointments for outpatient care to virtual appointments,
- Managing COVID-19 exposures of staff,
- Supporting the pandemic-related hiring surge,
- Screening individuals entering VHA facilities, and
- Supporting VA’s Fourth Mission.

The majority of VISN directors reported hiring for various occupations and functions within their VISNs to address the shift in staffing needs associated with the pandemic. VISN directors reported hiring doctors, nurses, respiratory therapists, custodians, and housekeeping staff to address the increased demand for inpatient care. Additionally, VISN directors reported hiring additional human resources staff to support the surge in hiring.

¹³⁸ COVID-19 Response Report, October 27, 2020.

The majority of VISN directors also reported training and repurposing existing staff to address changes in workload and staffing requirements. Examples included utilizing outpatient administrative staff for screening and training outpatient doctors and elective procedure nurses in competencies necessary to deliver care in inpatient settings.

VHA Guidance and Resources to Support Planning Since the Beginning of the COVID-19 Pandemic

VISN directors emphasized how difficult or even impossible it was to accurately predict their needs at the outset of the pandemic. Most VISN directors spoke favorably of staffing models and resources provided by the Office of Nursing Services in planning for nurse staffing needs during the pandemic. VISN directors also cited a VHA-specific report by McKinsey & Company as being helpful to plan for potential staffing and bed shortages based on projected numbers of COVID-19 cases in their respective VISNs.¹³⁹ Additionally, VISN directors reported utilizing their incident command systems in communication with VA Central Offices to plan and respond to needs as they developed.

Consequences Associated With the Hiring Surge Related to the COVID-19 Pandemic

As a response to COVID-19, VHA's Executive in Charge set an initial goal of hiring 5,000 personnel and shortening onboarding time to 3 days. To meet this goal, VHA utilized various waivers and flexibilities to expedite the hiring process in response to the COVID-19 pandemic. Accordingly, the OIG asked VISN directors to describe unintended consequences related to the speed and volume of surge hiring and plans to address those consequences. The majority of VISN directors did not report negative consequences. Rather, several VISN directors described positive consequences, such as the influx of staff allowing VHA facilities to work through the backlog of care deferred due to the pandemic and to help compensate for vacancies and attrition.

Of those who reported negative consequences, VISN directors described issues with existing administrative processes and functions unable to initially handle new demands associated with expedited hiring processes. Several VISN directors explained that facilities were not initially prepared for new employees to start work in the middle of a pay period, versus the pre-pandemic

¹³⁹ VHA, "COVID-19 update – Key Markets," March 27, 2020. "Our COVID-19 work in the United States," McKinsey & Company, accessed December 28, 2020. <https://www.mckinsey.com/industries/public-and-social-sector/how-we-help-clients/our-covid-19-work-in-the-united-states>. McKinsey & Company described this pandemic-related work as "help[ing] the VA better understand the COVID-19 outbreak's potential impact on the VA's enrollees and medical centers. Initial work includes modeling and scenario analysis pertaining to epidemiology and the availability of workforce, supplies, and capacity."

norm of starting at the beginning of a pay period, but had addressed this by revising onboarding processes. Several VISN directors cited an unanticipated increase in workload to ensure that credentialing and other hiring requirements were monitored and met. That increased workload was reported to have overwhelmed human resources staff. To address these issues, VISN directors reported solutions such as developing tracking systems and hiring additional human resources staff.

Notably, several VISN directors expressed concern about future budgetary implications of the surge in hiring. Those concerns arose from increased staffing in response to the COVID-19 pandemic using temporary funding from the CARES Act.

Quality of Staff Hired Since the Beginning of the COVID-19 Pandemic

The majority of VISN directors expressed confidence in the quality of providers hired since the beginning of the pandemic. They noted that despite some processes being expedited or waived, the normal checks and processes such as credentialing and background checks were still required, albeit on a different timeline. VISN directors across the country reported that the hiring surge came at a time when the private sector was laying off or furloughing healthcare professionals, creating an opportunity for VHA to recruit quality candidates who might not have applied for VHA positions. Additionally, VISN directors reported that once hired, normal professional practice evaluation processes still applied; and that if new employees were found to be unsuitable, they could be separated within their one-year probationary period.¹⁴⁰

The OIG also asked VISN directors if they had concerns about temporary employees hired under pandemic-related authorities. While some VISN directors expressed concerns about the future budgetary implications or the reluctance of candidates to accept temporary appointments, the majority of VISN directors expressed minimal concern with hiring temporary staff. VISN directors described the temporary appointments of staff in positive terms as an opportunity to see if an employee would be a good fit for conversion to a permanent appointment. VISN directors reported that many employees hired temporarily would be extended or retained permanently.

COVID-19 Pandemic-Related Process Changes and Flexibilities to Enhance VHA Hiring Efforts

Most VISN directors expressed support for permanently adopting processes and flexibilities that shortened the time to hire new employees. VISN directors credited a combination of process changes and waivers that resulted in reduction in the time to hire new staff including delaying fingerprinting, physical exams, drug testing, and portions of the credentialing processes until

¹⁴⁰ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. The normal evaluations referenced by VISN directors include focused professional practice evaluations and ongoing professional practice evaluations.

employees were onboarded. However, VISN directors also reported that despite the success in reducing the time to hire, improvements were needed to human resources processes and HR Smart to sustain expedited hiring.

VISN directors expressed the need for continued or expanded authority to hire staff noncompetitively, specifically related to hiring staff under Title 5.¹⁴¹ VISN directors expressed support for an exception to the hiring requirements related to preference eligible veterans for Housekeeping Aid positions under 5 U.S.C. § 3310.¹⁴² VISN directors were also in favor of extending pay flexibilities; delegation of approval for dual compensation waivers; and use of recruitment, relocation, and retention incentives.¹⁴³

VISN directors supported reviewing pandemic-related flexibilities to help sustain the speed of hire achieved during the pandemic. Staff from VHA WMC supported making permanent the flexibilities granted during the pandemic. Additionally, VA's Office of the Chief Human Capital Officer noted that certain authorities assisted VA in meeting staffing needs during the pandemic. That Officer also examined barriers to expedited hiring and submitted a legislative proposal aimed at expediting recruitment and hiring of Housekeeping Aids.

¹⁴¹ VA Directive 5005, *Staffing*, April 15, 2002. Title 5 occupations utilize competitive hiring processes and follow veterans' preference and preference eligible rules. OPM, "Coronavirus (COVID-19) Schedule A Hiring Authority," March 20, 2020. This temporary authority allowed agencies to hire Title 5 employees in response to the COVID-19 into excepted service appointments without the need to follow normal competitive hiring requirements.

¹⁴² 5 U.S.C. § 3310. "In examinations for positions of ... custodians in the competitive service, competition is restricted to preference eligibles as long as preference eligibles are available." An exception as proposed by VA was intended to allow hiring managers to initially consider a wider pool of candidates for Housekeeping Aid positions.

¹⁴³ OPM, "Dual Compensation Waiver Requests for COVID-19 Emergency," March 20, 2020. This OPM delegation of dual compensation waiver authority enables agencies to waive a salary off-set when rehiring retired employees in response to COVID-19.

Conclusion

Staffing models provide a way to proactively, and consistently, identify staffing requirements. An understanding of staffing requirements—the number of staff required to meet the operational demands, clinical or otherwise, of VHA—provides a basis for comparison against the number of staff VHA has on board. Such a comparison can help inform VHA’s budget and workload analysis.

However, limitations related to staffing models can exist. First, although staffing models can provide a way to identify requirements, the requirements may exceed available staff.¹⁴⁴ Second, staffing requirements change as the demand for healthcare shifts. As seen during the COVID-19 pandemic, there was an increased need for inpatient providers. Third, budget constraints may limit how many people a facility can hire, regardless of the facility’s requirements. Implemented staffing models should acknowledge such limitations. Staffing models should be used to inform discussions around staffing and should not be used as a measure of success. Currently, staffing models do not inform VHA’s budget requests. However, as indicated in their strategic plan, VHA hopes that the staffing needs determined by validated staffing models will eventually drive budget requests.

VA Manpower, VHA Manpower, and VHA OPES are collaborating to develop and validate VHA staffing models. However, the three staffing model program office directors reported differing views on which office was responsible for the development, validation, and implementation of VHA staffing models. Additionally, VA and VHA provided differing perspectives on the definition of a staffing model. The VA Manpower Director also emphasized that outputs of any staffing model should be routinely reviewed for accuracy by VHA prior to implementation.

Staff from VHA’s WMC reported that national-level staffing models exist for all occupations; facility directors reported they were generally aware of a VHA staffing model for selected occupations. However, the OIG found that staffing models used to determine staffing requirements were still in development and that only one staffing model had been validated by VA Manpower. VA Manpower plans to develop *initial* staffing models that provide staffing requirements for all direct care positions by the end of FY 2022 given their current staffing level.¹⁴⁵ It is unclear whether these initial models will be validated by FY 2024, VA Manpower’s anticipated completion date, provided VA Manpower’s emphasis on the importance of a feedback loop with VHA to validate staffing models.

¹⁴⁴ The Association of American Medical Colleges projected a physician staffing shortage of 54,000–139,000 physicians by 2033.

¹⁴⁵ This excludes nurses as the Office of Nursing Services has a Staffing Methodology for VHA Nursing Personnel. VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

The OIG concludes that governance, with respect to staffing models, could be improved. Inconsistencies in program office perceptions of staffing model roles and responsibilities, as well as terminology, likely contributed to the conflicting responses the OIG received regarding the existence of VHA staffing models. If the program offices responsible for developing and validating staffing models are not consistent in their perceptions, facilities receive conflicting information regarding the availability of staffing models, and by extension, may result in inconsistent implementation. The OIG considers clarity across VA as key to ensuring the success of staffing models at VHA.

VA Manpower and VHA WMC directors also noted they had limited staffing resources and that was a barrier to the development, validation, and implementation of VHA staffing models. The OIG proposes that VA prioritize the development, validation, and implementation of staffing models, and identify how that priority can be supported.

Facility directors have annually, since FY 2018, reported widespread severe occupational staffing shortages in large part due to a lack of qualified applicants, recruitment challenges, turnover, and noncompetitive salary. Although the total number of reported severe shortages has decreased, approximately two-thirds of facilities reported having fewer staff than was required to meet the operational demands of the facility for the five clinical and five nonclinical occupations the OIG reviewed. Additionally, nearly half of the facilities were using local methods to determine their staffing level requirements. This suggests there was a lack of consistency in how requirements were determined across VHA. Without some level of consistency across VHA in how requirements are determined, collected facility-level requirements cannot be aggregated in a reliable way to inform budget or workload. Additionally, staff from VHA WMC reported known data issues within HR Smart and expressed a desire to replace it as the human resources information system for VHA.

VHA's inability to reliably identify aggregated requirements puts them at a disadvantage when attempting to align staffing levels with operational requirements because VHA's budget requests are not tied to a facility's operational requirements. This inability suggests operational requirements are not informing VHA's budget requests. Instead, VHA's budget request is based on workload projections made by the VA Enrollee Healthcare Projection Model. Consequently, facilities make trade-offs in their staffing decisions. Facility directors are allocated funds at the beginning of each year and must determine staffing needs to fit within that allocation. VISN directors reported that facilities must make trade-offs in how they address such gaps based on available budget. Facilities are balancing efficiencies by taking positions away from one service with less demand to authorize new positions in a service with higher demand. This can create difficulties when position funds are authorized through different appropriations, such as clinical positions and administrative positions. Some VISN directors described having insufficient nonclinical staff, because funds cannot be transferred from medical operations appropriations into general purpose appropriations, even if there was a surplus in medical operations funds.

Transfers above one percent require congressional notification and approval. If the facility cannot fund additional staff, they cannot hire additional staff.

The OIG has identified long-standing and widespread staffing shortages throughout VHA.¹⁴⁶ During the COVID-19 pandemic, there were alterations in the delivery of health care as COVID-19 hospitalizations increased. The demand for VHA health care increased to a point where providers needed to be hired *immediately* to respond to the pandemic. VA and VHA reported annual increases in net staffing levels at VHA from March 31, 2020 to March 31, 2021, but VA and VHA reported different increases making it difficult to reconcile and interpret the reported staffing data. It is important for VA and VHA report consistent information related to staffing levels so that a clearer narrative can be provided to the public.

During the pandemic, VHA reported bringing hire time down by over 80 days with support from OPM, as well as through the use of existing flexibilities and by modifying internal policy. VISN directors supported making such flexibilities and process changes permanent. VISN directors also noted few negative consequences as a result of the reported hiring surge and expressed confidence in those hired. VHA should identify those legislative and regulatory issues that provided benefit during the pandemic and consider seeking legislative relief, as necessary, to address staffing shortages.

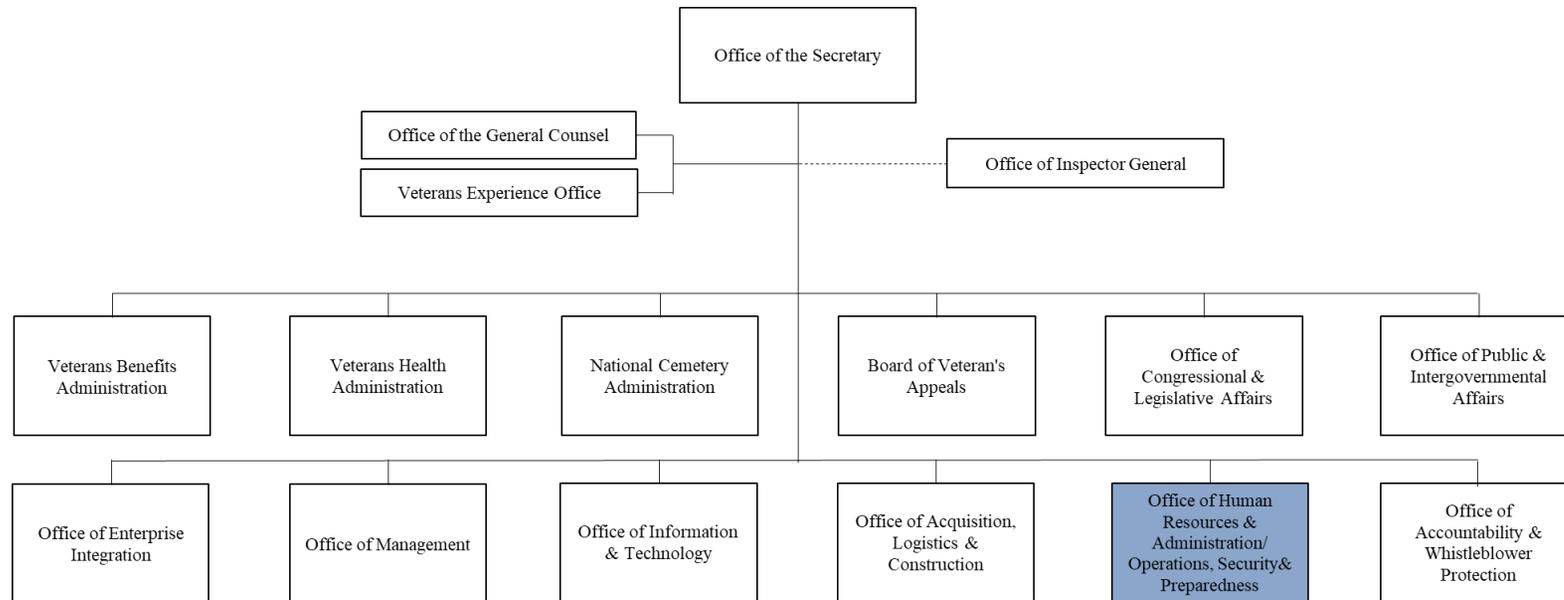
¹⁴⁶ VA OIG: *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, Report No. 15-00430-103, January 30, 2015; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, Report No. 15-03063-511, September 1, 2015; *OIG Determination of VHA Occupational Staffing Shortages*, Report No. 16-00351-453, September 28, 2016; *OIG Determination of VHA Occupational Staffing Shortages, FY 2017*, Report No. 17-00936-385, September 27, 2017; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018*, Report No. 18-01693-196, June 14, 2018; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2019*, Report No. 19-00346-241, September 30, 2019; *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2020*, Report No. 20-01249-259, September 23, 2020.

Recommendations 1–3

1. The Under Secretary for Health coordinates with VA to review the roles, responsibilities, and number of staff required for the VA and Veterans Health Administration offices involved in the development, validation, and implementation of staffing models, and ensure that staffing model-related efforts are prioritized and supported.
2. The Under Secretary for Health coordinates with VA to evaluate the status of, and provide a timeline for, the development, validation, and implementation of Veterans Health Administration staffing models for all occupations.
3. The Under Secretary for Health coordinates with VA to evaluate the status of, and provide a timeline for, the implementation of HR Smart-related requirements referenced in VA and Veterans Health Administration policy, with a specific focus on the authorizations, vacancies, budgeted positions, and unbudgeted requirements at the facility, Veterans Integrated Service Network, and national levels.

Appendix A: Manpower Management Governance Structure Organizational Charts

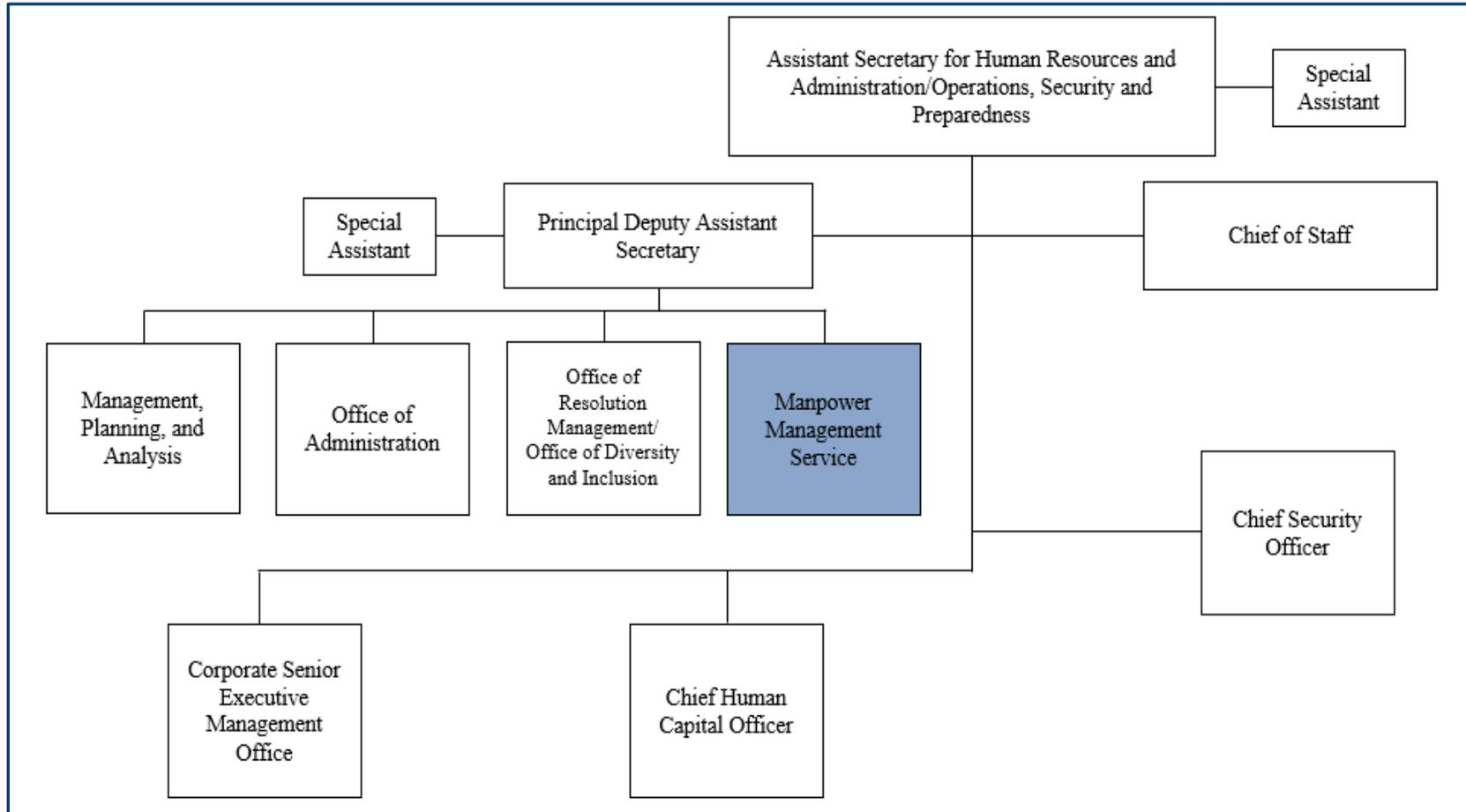
U.S. Department of Veterans Affairs¹⁴⁷



Source: U.S. Department of Veteran's Affairs VA Functional Organization Manual Version 6.0

¹⁴⁷ The OIG modified the organizational chart to remove names, to ensure consistent formatting, by adding color to highlight the program offices relevant to this review, and by adding a dotted line to the Office of Inspector General. Although the U.S. Department of Veteran's Affairs VA Functional Organization Manual Version 6.0 indicates that the Office of Inspector General reports to the VA Secretary, the Inspector General Act of 1978 established the VA OIG as an independent oversight body. Neither the Secretary nor any VA official designated by the Secretary possess supervisory authority over any of VA OIG's operations. The VA OIG is responsible for conducting independent oversight of VA and for its own internal management, to include matters involving budgeting and personnel.

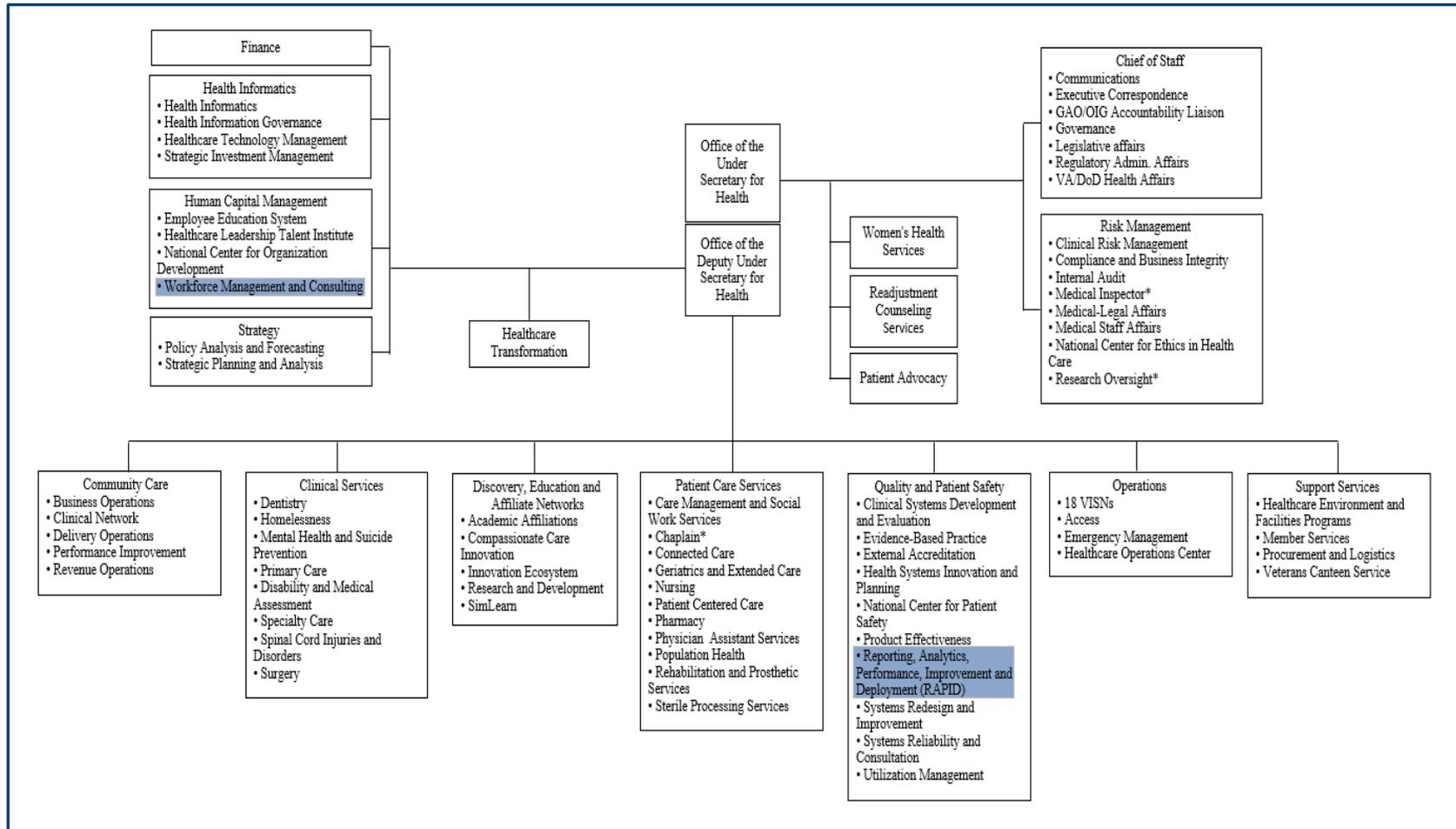
VA Manpower Management Services, Office of Human Resources Administration/Operations, Security, and Preparedness¹⁴⁸



Source: Email submission from Director of Manpower Management Service

¹⁴⁸ The OIG modified the organizational chart to remove names, ensure consistent formatting, and highlight the program offices relevant to this review.

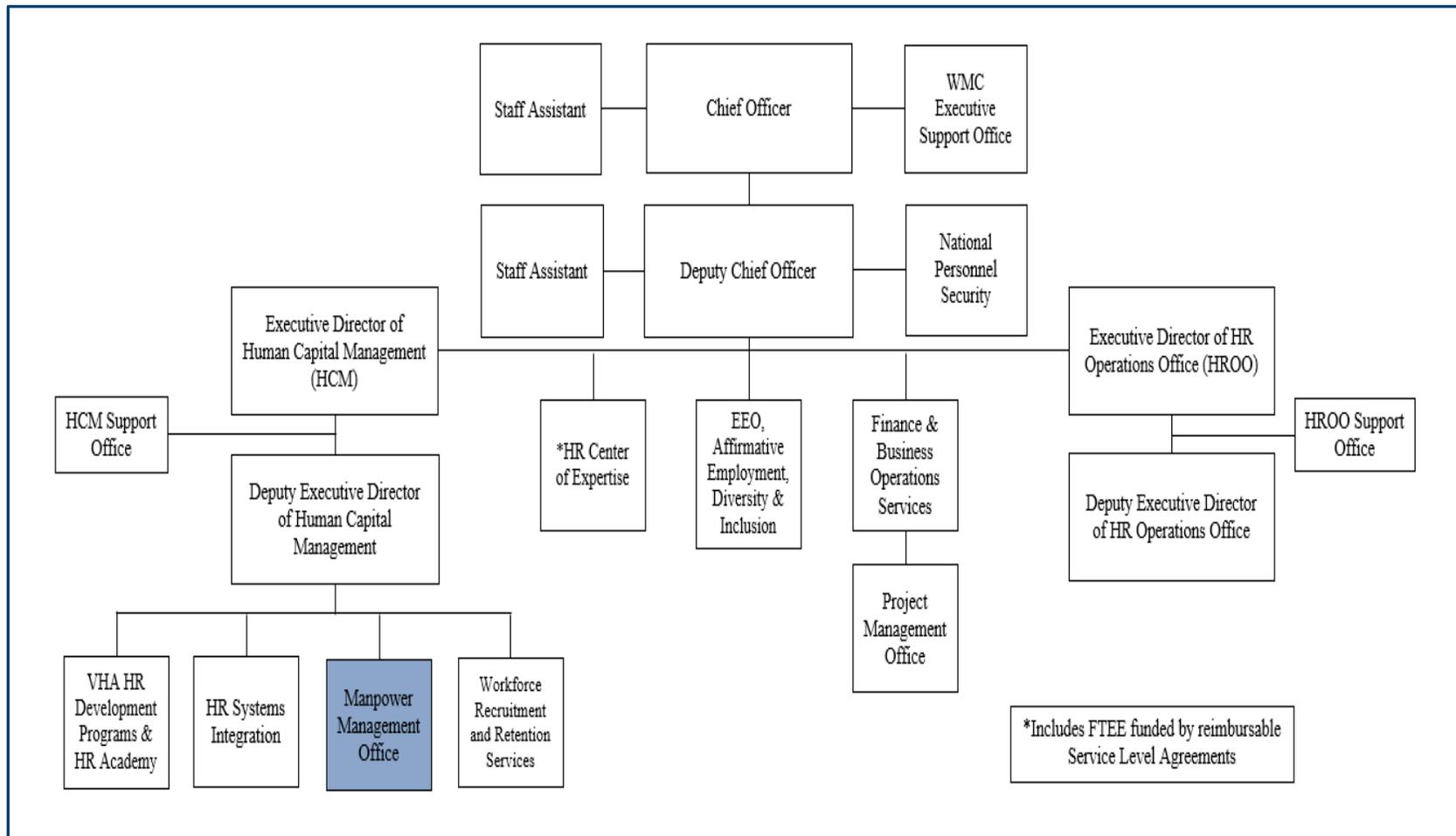
U.S. Department of Veterans Affairs, Veterans Health Administration¹⁴⁹



Source: U.S. Department of Veteran's Affairs VA Functional Organization Manual Version 6.0

¹⁴⁹ The OIG modified the organizational chart to remove names, ensure consistent formatting, and highlight the program offices relevant to this review.

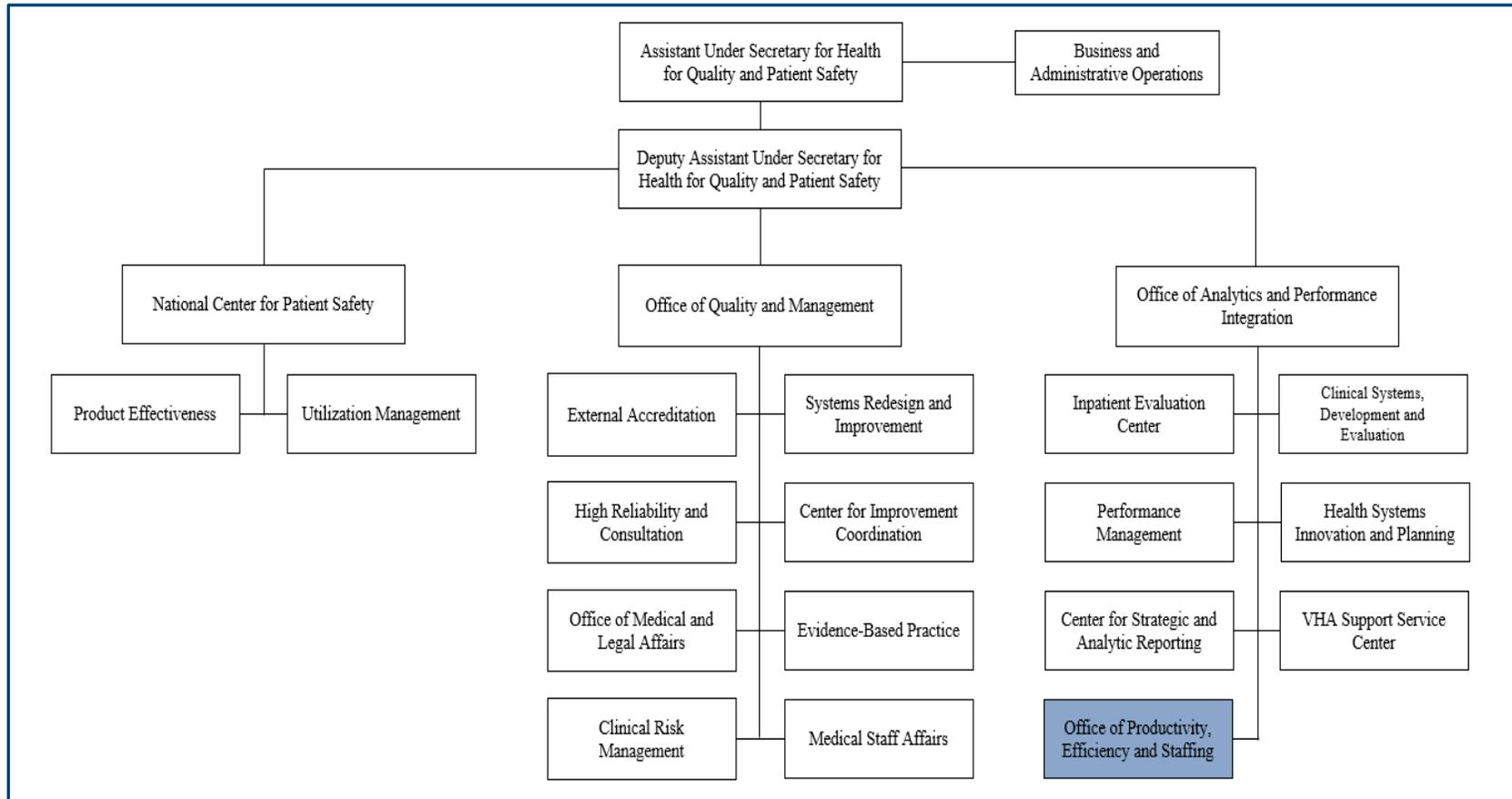
VHA Manpower Management Office, Office of Workforce Management and Consulting¹⁵⁰



Source: VHA Office of Workforce Management and Consulting website, link "About WMC"

¹⁵⁰ The OIG modified the organizational chart to remove names, ensure consistent formatting, and highlight the program offices relevant to this review.

VHA Office of Productivity, Efficiency and Staffing, Office of Analytics and Performance Integration, Office of Quality and Patient Safety¹⁵¹



Source: Email submission from Director of the Office of Productivity, Efficiency and Staffing

¹⁵¹ The OIG modified the organizational chart to remove names, ensure consistent formatting, and highlight the program offices relevant to this review.

Appendix B: Status of Recommendations Made in Prior OIG Reports

Report	Recommendations	Status
<i>OIG Determination of Veterans Health Administration's Occupational Staffing Shortages</i> , Report No. 15-00430-103, January 30, 2015	1. We recommended that the Interim Under Secretary for Health continue to develop and implement staffing models for critical-need occupations.	1. Closed October 15, 2015
<i>Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists</i> , Report No. 13-03917-487, August 25, 2015	<p>1. We recommended the Under Secretary for Health ensure Veteran Integrated Service Networks and medical facilities incorporate the Office of Mental Health Operations staffing model to determine the appropriate number of psychiatrists needed for outpatient care, and work with those facilities to attain appropriate staffing levels or identify alternative options to meet veteran demand for psychiatrists.</p> <p>2. We recommended the Under Secretary for Health develop clinic management business rules to ensure facilities consistently monitor the use of clinical time and number of veterans per psychiatrist, in conjunction with monitoring psychiatrists' productivity.</p> <p>3. We recommended the Under Secretary for Health reassess the appropriateness of the Veterans Health Administration's productivity target for psychiatrists.</p> <p>4. We recommended the Under Secretary for Health develop a mechanism to monitor the variance in which psychiatrists code encounters and determine appropriate coding guidance and training to ensure consistency.</p>	<p>1. Closed September 21, 2016</p> <p>2. Closed August 1, 2016</p> <p>3. Closed August 1, 2016</p> <p>4. Closed July 10, 2015</p>
<i>OIG Determination of Veterans Health Administration's Occupational Staffing Shortages</i> , Report No. 15-03063-511, September 1, 2015	<p>1. We recommended that the Under Secretary for Health ensure that the Veterans Health Administration further develops staffing models for critical-need occupations.</p> <p>2. We recommended that the Under Secretary for Health review the data on regrettable losses in this report and Veterans Integrated Service Network Workforce Succession Strategic Plans and, if appropriate, consider implementing measures to reduce such losses.</p>	<p>1. Closed September 28, 2016</p> <p>2. Closed September 28, 2016</p>
<i>OIG Determination of VHA Occupational Staffing Shortages</i> , Report No. 16-00351-453, September 28, 2016	1. We restated our previous recommendation that the Under Secretary for Health ensure that Veterans Health Administration develops staffing models for critical-need occupations, and we further recommended that Veterans Health Administration sets forth milestones and a timetable for further	<p>1. Closed January 4, 2018</p> <p>2. Closed January 4, 2018</p> <p>3. Closed January 4, 2018</p> <p>4. Closed January 4, 2018</p>

Report	Recommendations	Status
	<p>critical-need occupations' staffing model development, piloting, and implementation.</p> <p>2. We restated our previous recommendation that the Under Secretary for Health review data on regrettable losses and consider implementing measures to reduce such losses.</p> <p>3. We recommended that the Under Secretary for Health consider incorporating data that predicts changes in veteran demand for health care into its staffing model.</p> <p>4. We recommended that the Under Secretary for Health assess Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.</p>	
<p><i>OIG Determination of VHA Occupational Staffing Shortages FY 2017</i>, Report No. 17-00936-385, September 27, 2017</p>	<p>1. We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical-need occupations.</p> <p>2. We recommended that the Acting Under Secretary for Health review the Veterans Health Administration report on regrettable losses and implement effective measures to reduce such losses.</p> <p>3. We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model.</p> <p>4. We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.</p>	<p>1. Closed August 19, 2020</p> <p>2. Closed August 2, 2020</p> <p>3. Closed August 19, 2020</p> <p>4. Closed November 5, 2019</p>
<p><i>OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018</i>, Report No. 18-01693-196, June 14, 2018</p>	<p>1. The Under Secretary for Health refines and formalizes VHA's position categorization of individuals (clinical and nonclinical) who are necessary to VHA's mission of delivering health care by looking at various dimensions of each occupation, including staff skill set and function, enabling identification of positions based on the specific role a person would fill.</p> <p>2. The Under Secretary for Health ensures the consistent implementation and use of the position categorization approach across all facilities.</p>	<p>1. Closed August 19, 2020</p> <p>2. Closed October 28, 2019</p>
<p><i>Inadequate Governance of the VA Police Program at Medical Facilities</i>, Report No. 17-01007-</p>	<p>1. Clarify program responsibilities between the Veterans Health Administration and the Office of Operations, Security, and Preparedness, and evaluate the need for a centralized management entity for the security and law enforcement program across all medical facilities.</p>	<p>1. Open</p> <p>2. Open</p> <p>3. Open</p> <p>4. Open</p> <p>5. Open</p>

Report	Recommendations	Status
01, December 31, 2018	<ol style="list-style-type: none"> 2. Ensure police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities. 3. Make certain medical facilities use strategies to address police staffing challenges such as having documented recruitment plans for police officer positions that include a determination of the need for special salary rates and incentives. 4. Assess the staffing levels for the Office of Security and Law Enforcement police inspection program, and authorize and provide sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues. 5. Ensure procedures are developed for appropriately handling VA police investigations of medical facility leaders. 	
<i>Staffing and Vacancy Reporting under the MISSION Act of 2018</i> , Report No. 19-00266-141, June 25, 2019	<ol style="list-style-type: none"> 1. Ensure VA vacancy data are reported by occupation as required by Section 505(a)(1)(C) of the MISSION Act 2. Make certain that VA staffing gains and losses data are reported by quarter as required by Section 505(a)(1)(B) of the MISSION Act. 3. Annotate limitations clearly within the staffing and vacancy data to improve transparency and usability of the data, to include changes from HR Smart data-cleansing efforts. 4. Ensure that the staffing and vacancy reporting website maintains historical information on the data elements required by the MISSION Act. 5. Update the methodology for collecting and reporting on VA staffing and vacancy data to ensure consistency in future quarters. 	<ol style="list-style-type: none"> 1. Closed November 14, 2019 2. Closed November 14, 2019 3. Closed June 22, 2020 4. Closed November 14, 2019 5. Closed June 22, 2020
<i>OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2019</i> , Report No. 19-00346-241, September 30, 2019	<ol style="list-style-type: none"> 1. The Under Secretary for Health ensures completion of all open action plans related to recommendations from previous iterations of this report. The Under Secretary for Health ensures completion of all open action plans related to recommendations from previous iterations of this report. 2. The Under Secretary for Health identifies a plan of action that will address the underlying causes of severe occupational staffing shortages identified in this report. 	<ol style="list-style-type: none"> 1. Closed August 19, 2020 2. Closed March 10, 2020
<i>VA Improved the Transparency of Mandatory Staffing and Vacancy Data</i> , Report No. 20-00541-149, June 3, 2020	<ol style="list-style-type: none"> 1. Ensure VA time-to-hire percentages are reported using the OPM's target as required by Section 505(a)(1)(D) of the MISSION Act. 2. Confer with the VA Office of General Counsel to ensure that changes to the reporting methodology comply with Section 505 of the MISSION Act. 	<ol style="list-style-type: none"> 1. Closed December 8, 2020 2. Closed January 5, 2021
<i>Review of Veterans Health Administration's</i>	No Recommendations	

Report	Recommendations	Status
<i>COVID-19 Response and Continued Pandemic Readiness, Report No. 20-03076-217, July 16, 2020</i>		
<i>OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2020, Report No. 20-01249-259, September 23, 2020</i>	No Recommendations	

Source: OIG analysis of status of recommendations for prior OIG reports.

Appendix C: VA's Manpower Management Service Staffing Model Definition¹⁵²

Requirements determination processes can be used for individual programs (i.e., caregivers or police), organizational components (i.e., a VAMC [VA Medical Center] or VA staff office), or an occupational series or specialty (i.e., specialty care providers). Manpower requirements determination processes are not intended to replace resource management processes or decisions on resource allocations. Validated workload manpower requirements should be used to inform those resource decisions.

The analytic approach used depends on the focus of the analysis and the availability of administrative data (transactional data collected as products are delivered). There are a variety of approaches used, ranging in rigor from subjective judgment (qualitative) to manpower management engineering (quantitative). However, the inputs, outputs, and steps used are fundamentally the same regardless of the approach. Inputs are workload factors needed to accomplish missions, required functions, and tasks measured by the amount of work produced, per accomplishment times, and manpower availability factors. Outputs are estimates for the minimum essential number of people, competencies, and experience needed for that level of workload given the appropriate man-hour availability factor (MAF).

Manpower requirements analysis is the process of objectively determining and quantifying manpower requirements for improved cost-efficiency and effectiveness within an organization. This analytic process answers a standard set of questions:

- Workload—What are the required output(s) (products or services)?
- Mission (i.e., Legislation, Strategic Plan, Policies) —What requires the work to be done?
- Process Analysis—How are the work/functions/tasks performed to produce the output?
- Workload Driver—What are the inputs that affect the amount work to be done?
- Frequency and Per Accomplishment Time—How often is the work performed and how long does it take?
- Process Driver—What impacts or influences the time of the process?
- Study or Model; Benchmark—How many sites perform this work – single location or multiple locations?
- Organizational Structure—What is the most efficient and effective design?

All manpower requirements determination reviews follow a five-step process to ensure analytic rigor is maintained. These steps are:

¹⁵² This information is verbatim from VA's Manpower Management Service Director. The OIG added text in brackets to define acronyms not previously used.

- Planning: Determine methodology and approach
- Front end analysis: Conduct process mapping (how, when, and where), organizational analysis, develop data collection plan, and identify possible process improvements for additional review
- Data collection: Finalize data collection plan, collect data, conduct analysis, and assess workforce requirements
- Study outcomes and recommendations: Review with subject-matter experts to obtain functional validation of analysis
- Approval and documentation: Decision brief and record final decisions in source system

There are three fundamental approaches to determining staffing requirements: staffing models, staffing studies, and benchmarks. In general terms, both staffing models and studies use a basic approach of determining the amount of workload multiplied by a per accomplishment time or productivity standard, divided by a standard MAF to determine the full-time equivalent (FTE) employees needed to meet the workload requirements. Benchmarks are used to compare like functions across multiple similarly structured organizational components using the number of employees performing the service relative to an appropriate workload indicator. Regardless of the approach, findings should be reviewed with the subject-matter experts responsible for the functions to obtain a “functional validation” to ensure that the analysis accurately captures nuances not known to the analyst.

Productivity (Staffing) Standard: Staffing standards are approved quantitative and qualitative expressions of manpower requirements needed to perform prescribed tasks at varying levels of workload. Productivity standards are based on the projected workload, or other demand indicator, and the level of staffing needed to meet that workload demand. All productivity standards must be approved by the appropriate Manpower Management Office. The objective of developing staffing standards is to articulate the mathematical relationship between a work center's requirements and its workload.

Staffing models are generally used for similar functions across many components of the organizations (for example, primary care is a function across all medical treatment facilities). Ideally, staffing models use transactional workload data to determine the amount of workload performed, or projected to be performed, and industry or internal benchmarks to determine productivity standards or per accomplishment times. If transactional data are not available, workload data must be collected. Staffing models usually cover a greater percentage of the positions more quickly than staffing studies. The ability to cover these positions more quickly is due to the relative availability of workload data and the number of positions covered in the model. Applying productivity standards developed by the Office of Productivity, Efficiency, and Staffing (OPES) to current and projected workload measured by relative value units is a good example of the inputs for a staffing model.

Staffing studies are generally used for estimating workload requirements for a single organization with multiple functions (for example, headquarters activities). Unlike staffing models, transactional workload data are not usually available, and the functions and tasks are not clearly defined. This makes staffing studies far more labor-intensive to complete. Data are collected through a time-intensive interview process with subject-matter experts, review of policy documents, and/or process mapping.

Generally, benchmarks are used when work centers or functions are comparable and operate in a similar fashion. Central factors to successful internal benchmarking across functions include standardized organizational structures, clear policies, and consistent processes. Benchmarking provides an approximate range to guide staffing requirements that should be followed up with a staffing model or study to yield deterministic outcomes. Ideally, benchmarks should consider appropriate workload indicators to help refine the results (i.e., square footage of a facility) for facility and environmental management. In limited circumstances, a ratio-based approach for benchmarking can be used if the workforce productivity and processes are expected to remain constant or if there is enough empirical evidence to support use of a ratio-based approach. Nurse staffing assessments using number of patients is a good example of ratio-based benchmarking where there is significant research and standardization to support this approach.

Appendix D: VHA’s Manpower Management Office in Coordination with the Office of Productivity, Efficiency and Staffing Model Definition¹⁵³

What Is a Staffing Model?

The term “staffing model” is used to represent different concepts ranging from prospective workforce management to day-to-day operations and scheduling. For large integrated healthcare organizations, where staffing needs are a complex interrelationship of many variables, a staffing model is a set of reports, charts, graphs, and measures that are used identify and describe work activity, labor hours, employee utilization, and overall cost. The general purpose of a staffing model is to provide information on staffing: the process of acquiring, deploying and retaining a workforce of sufficient quantity and quality to create positive impacts on the organization’s effectiveness.

For health care organizations in particular, a staffing model requires understanding the relationship between the healthcare providers, the patient population, workload volume and variation, the complexity of the workload, facility mission (including research and education), local facility dynamics, and specific practice management measures. Because healthcare staffing requires understanding the relationships between each of these disparate pieces of information, staffing models are rarely as straightforward as they are in other disciplines like manufacturing.

VHA’s staffing models are a set of interrelated reports designed to use data relating to workforce supply, workload volume, and workload demand to provide a comprehensive picture of the existing workforce, existing workload, internal benchmarks, external benchmarks, and related measures that help the individual healthcare systems understand how facility specific measures relate to staffing requirements.

Overview of VHA’s Staffing Model for Specialty Care Group Practice

Within health care, approaches exist to model staffing requirements; however, there is no consensus on a definitive methodology or technique. Recent literature suggests that an integrated approach that combines elements of supply and demand with that of benchmarking. One accepted industry approach for addressing staffing needs is to compare staffing against workload using benchmarks internal to the organization. VA accomplishes this comparison using its extensive data systems. VHA maintains a comprehensive database of the provider workforce

¹⁵³ This information is verbatim from VHA’s Manpower Management Office Director in coordination with the Office of Productivity, Efficiency and Staffing Director. The OIG added text in brackets to define acronyms not previously used.

with near real-time reporting (by pay period) of staffing levels, clinical workload and productivity by specialty and practice setting.

VHA's staffing model for specialty care group practice is summarized in VHA Directive 1065. OPES defines appropriate staffing through the lens of an appropriately productive workforce. The below text summarizes VHA's approach to staffing models through the analytic tools developed based on existing data from VHA's electronic health record.

Provider Productivity

Within the health care context, there is a generally accepted approach to calculating productivity of physician practices that is used in the private sector both in operations and in academic literature: specialty practice workload measured in wRVUs [work relative value unit] divided for physician FTE totals. VHA mirrors this approach through its productivity measurement and guidance (workload in wRVUs divided by clinical FTE).

Workload

VHA uses an industry accepted metric of a work relative value unit (wRVU) to measure provider productivity (clinical work per provider). Provider clinical workload, measured in wRVUs, adjusts for the differences in time, intensity and complexity of medical services. RVUs are assigned to VHA workload by extracting Current Procedural Terminology (CPT) coding from the electronic health record (EHR). Capture of workload incorporates all inpatient and outpatient reported workload with CPT coding that passes workload capture data checks. Workload is assigned to the provider who completed the workload as noted on the encounter. Specialty/discipline classification of the workload is derived from the specialty/discipline group practice provider active person class code/taxonomy assignment of the workload-completing provider.

Workforce

The number of hours of clinical worked time (defined as Provider FTE(C)) is calculated based on the provider's actual hours worked are reported on a pay period basis in the VHA payroll system. Only worked hours are included in the productivity calculation; hours associated with annual leave, sick leave or leave without pay are excluded from the worked hour count. Only the clinical portion of the hours worked are considered. Hours associated with administration, research and education are excluded.

Non-VA PAID [personnel accounting integrated data system] providers (including in-house fee providers, contract staff and without compensation (WOC) providers) are not covered in the process of productivity measurement because while workload information is available (in wRVUs completed), there is no source of data for clinical hours worked.

VHA imputes the FTE total of work received through in-house fee, contract staff and WOC workload by comparing the total work completed by the contract staff divided by the VHA national average productivity for VA PAID staff for the specialty of the providers. The imputed workforce estimates are included in the Provider Clinical FTE estimates in the Office of Productivity, Efficiency and Staffing (OPES) tools relating to counts of the provider workforce.

Productivity Standards

VHA productivity benchmarks rely on internal performance data. Specialty group practices are compared based on VHA internal peer groupings to ensure that similar practices are compared against each other. Thresholds both low and high for Specialty/Discipline Group Practice Productivity. This is generally referred to as the acceptable range of productivity for the specialty. Minimum productivity thresholds are established at the median group practice provider productivity minus 1.25 standard deviations for the specialty's peer group.

Productivity standards are re-evaluated as needed by the Assistant Deputy Under Secretary for Health for Clinical Operations and the Assistant Deputy Under Secretary for Health for Patient Care Services. Re-evaluation must take place because as health care evolves over time, RVU [relative value unit] values change and relative workloads shift. Productivity standards consist of the acceptable group practice range of productivity, the peer grouping and the minimum productivity threshold for the specialty. The productivity data used to establish the productivity standards is the same data developed by OPES as a part of their ongoing productivity reporting.

Specialty Group Practice Productivity Standard Outlier Reports

The Specialty Provider Productivity Standards Performance & Outlier Review report provides information on historic productivity in comparison to established productivity standards for the standards established for the selected fiscal year. Additionally, the outlier review report provides fiscal year to date (FYTD) productivity levels with a projection of whether the specialty group practice is on track to meet existing productivity standards or fail to meet existing minimum productivity thresholds. The outlier report also provides the full set of specialty group practice productivity standards and the list of specialty group practices in need of remediation plans or productivity review.

Specialty Staffing Profiles

Existing specialty workforce and support staff are described by the amount of clinical time dedicated to the specialties at the facility. Specialty staffing profiles are based on the data from the provider productivity calculations in combination with staffing data relating to different types of staff required for running a specialty clinic (e.g. residents, advanced practice providers, administrative support staff, and clinical support staff). Using this data on staffing in conjunction with specialty workload data, specialty practices can get a picture of how specialty specific

staffing at a site compares with VHA, Veterans Integrated Service (VISN) and peer VA medical facility staffing for a given specialty.

The Specialty Provider Workforce Report delivers system level staffing norms by geographic location (Veterans Integrated Service (VISN)) and practice setting (MCG [medical center] group). Staffing levels per population (core facility unique patients and specialty specific patients treated) are included in this report as well as provider productivity levels. VA medical facility managers should contextualize these data to their potentially unique characteristics such as patient reliance and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

Comparison of Productivity of Existing Staff to Demand

OPES publishes a Specialty Provider Group Practice Productivity Access Report and Quadrants (SPARQ) tool that compares specialty group practice productivity to access. b. [a was not in the original document.] The SPARQ tool combines practice-level productivity and access metrics into an Importance-Performance Analysis (IPA) framework. This identifies four potential staffing states:

- Specialties with above-average productivity with above-average access (optimized),
- Specialties with above-average productivity and below-average access (possibly under-resourced – i.e., the practice is productive, but even with a productive staff, the current demand cannot be handled without an above-average wait time),
- Specialties with below-average productivity and above-average access (possibly over-resourced – i.e., demand for the service is satisfied such that wait times are low, but the staff have below-average productivity indicating an area that may require fewer resources to fill the demand),
- Specialties with below-average productivity and below-average access potentially inefficient – i.e., the wait times may be able to be addressed by increasing the throughput/productivity of the existing staff).

Comparison of Specialty Practice Groups to Peer Groups

The SPARQ tool also aggregates practice management data designed to provide VA medical facility specialty Service Chiefs and clinical leadership with views of various measures known to have a relationship with specialty group practice productivity, including:

1. Facility level specialty utilization.
2. Workforce supply.
3. Workforce per population.
4. Procedure suite-based workforce (for applicable specialties).
5. Office-based clinic support staff.
6. Advanced practice provider workforce.

7. Provider productivity.
8. Teaching mission.
9. Practice management measures.
10. Specialty workload measures.
11. Employee turnover.
12. Physician compensation.

Specialty Provider Productivity Benchmarking Reports

VHA reports both internal and external benchmarks for understanding the relative productivity of its workforce at the group practice specialty level.

Internal Benchmarks

The Physician Productivity Standards Reports provide a management tool for the systematic, longitudinal measurement and reporting of clinical productivity, efficiency and staffing in VHA. The productivity benchmarking tools show the average, range and variation in productivity across specialties at the national, VISN, complexity group and administrative parent level. This information can be used to identify areas of need or improvement within relevant comparison groups.

External Benchmarks

The benchmarking report specifically provides the descriptive statistics of productivity performance at the VA medical facility level with comparisons to existing productivity standards, current year moving statistics and private-sector benchmarks in the form of the Medical Group Management Association (MGMA) Academic and Private Practice Mean and Median specialty group practice productivity measures.

The benchmarking report additionally provides productivity data at the subspecialty level, VA medical facility rankings for specialty productivity, trends in specialty productivity over time summarized at the national, MCG [medical center group] group and VA medical facility level and comparisons between VHA's productivity performance and MGMA's benchmarks over time.

Provider Productivity Leadership Dashboard

The Provider Productivity Leadership Dashboard provides detailed information about the staffing levels, clinical workload and provider productivity for each VA medical facility at the specialty level. This analytic tool assists VHA managers and leadership in effectively managing their specialty provider practices toward the goal of ready access to quality specialty services. VHA tracks specialty care practice and provider level productivity performance for over 30 areas of specialization as well as advanced practice providers.

The leadership dashboard provides a Chief of Staff dashboard with views of specialty provider productivity at the aggregate specialty level, views of APP [advanced practice provider] productivity, views of rehabilitation provider specialty productivity and social work provider productivity at the facility level.

Detailed workload reports provide trend information on year-over-year specialty workload growth in key practice management metrics like total workload (RVU sum), unique encounters per unique Veteran, RVU sum per unique Veteran and RVU sum per encounter. The dashboard also provides time-level detail to identify when during the day workload is happening for the given specialty

Detailed workforce reports provide trend information on key practice management metrics like year-over-year changes in physician workforce labor mapping distribution, Full-Time Equivalent (FTE) growth over time and FTE counts by aggregate specialty.

A Note on Prescriptive Staffing Models

Sometimes the term “staffing model” is used in conjunction with a prescriptive approach to staffing (e.g. to produce 1,000 vehicles per year at an automotive plant, requires 200 assembly line workers, 15 quality control staff, etc.) VHA’s approach to date is not prescriptive. This is intentional. Prescriptive staffing requires three conditions that are not present in VHA’s healthcare system:

1. A link between funding or revenue and the staff
2. A simple process that can be readily described as a function of staff to time commitments
3. Quality measurement that can be readily linked to staffing output

While the first requirement could be met (and is at times met via specific purpose funding) within the context of VHA, the latter two requirements are unlikely to ever be met in a health care context.

Health Care Is Not A Simple System

As noted previously, health care is not a simple system. Appropriate staffing depends on many inputs and those many inputs have interrelationships that are not readily describable. Examples of the list of inputs into appropriate staffing levels are the following:

- Volume of patients (current and projected)
- Complexity of care provided (current and projected)
- Patient risk (current and projected)
- Patient reliance (on the existing VA system, on Non-VA care paid by Medicare, on Non-VA care provided by private insurance, and on Non-VA care paid by VA in addition to future states)
- Nonclinical mission-required time (e.g. education, research, and fourth mission time)

- Clinical time required per patient or procedure
- Available space for providing health care
- Changes in the healthcare marketplace
- Changes in populations covered (e.g. changing regulations)
- Specific facility-level variation (e.g. geographic variation, potential available staffing pools, etc.)

The above list is not exhaustive. While VHA is on the path to providing standardized definitions and measurements of the current state of these variables, accurate projection of these variables into the future is unlikely to be more than directionally accurate. As a result, VHA recommends allowing facility directors to be able to use the data at their disposal to make educated staffing decisions based on the information about their local facility.

Health Care Lacks Quality Measures That Link to Staffing Profiles

VHA is dedicated to providing a workforce of sufficient quantity and quality to create positive impacts on the organization's effectiveness. However, there is little consensus, either within VHA or outside the VHA on how "quality" should be defined and measured. For any given quality indicator, there is a high level of uncertainty about the effect of specific interventions. There is additional uncertainty about whether the quality measure is actually measuring the quality sought by the care. There are virtually no studies in the clinical literature that link outcome-oriented measures of quality to the intensity of physician staffing.

VHA is dedicated to the continual measurement of quality and to the provision of high-quality care. As quality measurement methods advance, there may eventually be an available link between quality and the intensity of physician staffing, but to date, that link eludes both VHA and non-VHA healthcare organizations alike.

Appendix E: Office of Productivity, Efficiency and Staffing Reports

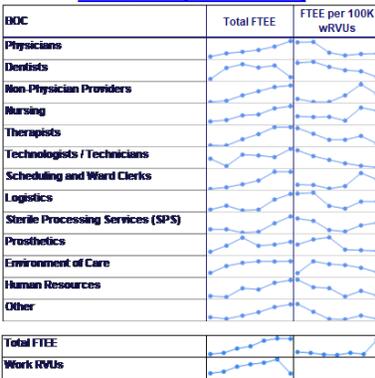
Operational Workforce Report



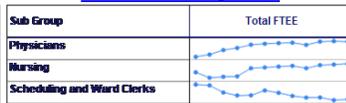
- Data Definitions
- Help Desk
- Rate Report

FY 2019 - (V##) (###) Sample Facility Name

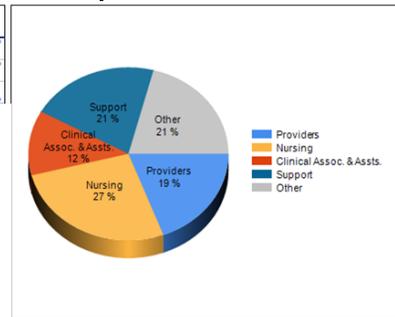
Annual Trends (FY2014 - FY2020)



Current Year Monthly Trends



Operational Workforce Distribution



Group	Sub Group	Budget Object Code (BOC)	Cost Center	Total FTEE	Inpatient FTEE	Outpatient / HBPC FTEE	Total FTEE per 100K wRVUs	MCG Average FTEE	MCG FTEE per 100K wRVUs
Total FTEE				5,523.88	2,207.29	3,316.59	231.19	3,630.53	246.24
Providers	Physicians	All BOCs	All	374.68	67.77	306.92	15.68	281.36	19.08
	Dentists	All BOCs	All	14.25	0.48	13.76	0.60	12.00	0.81
	Non-Physician Providers	All BOCs	All	678.07	125.30	552.77	28.38	487.97	33.10
Nursing	Nursing	All BOCs	All	1,473.24	799.41	673.83	61.66	915.42	62.09
Associates & Assistants	Therapists	All BOCs	All	189.79	77.75	112.04	7.94	110.21	7.48
	Technologists / Technicians	All BOCs	All	479.69	129.69	350.00	20.08	339.68	23.04
Support	Scheduling and Ward Clerks	All BOCs	All	636.45	151.60	484.85	26.64	401.93	27.26
	Logistics	All BOCs	All	98.21	34.74	63.47	4.11	71.17	4.83
	Sterile Processing Services (SPS)	All BOCs	All	58.01	19.97	38.04	2.43	35.96	2.44
	Prosthetics	All BOCs	All	38.15	1.40	36.76	1.60	31.08	2.11
	Environment of Care	All BOCs	All	240.37	86.90	153.48	10.06	102.42	6.95
	Human Resources	All BOCs	All	85.35	30.20	55.15	3.57	58.49	3.97
Other	Other	All BOCs	All	1,157.63	682.09	475.54	48.45	782.82	53.10

Highlighted FTEE per 100K wRVUs indicates +/- 1 St Dev above or below the MCG Average at the SubGroup level.

Highlighted FTEE per 100K wRVUs indicates +/- 2 St Dev above or below the MCG Average at the SubGroup level.

2019 Data current through:
 Outpatient Encounters Date: 2019 - SEP
 ARC: MFCR3 : 2019 - SEP

Specialty Workforce Report



Specialty Provider Workforce Report

Note: Physician Productivity Cube data is current through PP 14 (ending July 31, 2020)

- Data Definitions
- Help Desk
- Rate Report
- OPES Support Staff White Paper

Workforce Report | Provider FTE Breakdown Trends | Observed Staffing Level Benchmarks | Observed Staffing Trends | Facility Maps

FY 2019 MCG/VHA Comparisons

Note: Counts of Physicians Included in this report include All Specialty and Outpatient as well as Clinicians, Optometrists, Podiatrists, and Psychologists.

Specialty	Comparison Group	Facility Count	Facility Average Physician FTE	Facility Average Residents	Productivity (P YTD)	Annual Productivity Target	Physician Clinical FTE per 100K Specialty Inpatient	Physician Clinical FTE per 100K Core Facility Inpatient	Residents per Clinical Physician	Associate Providers per Physician Clinical FTE	Admin Support Staff per Physician Clinical FTE	Clinical Support Staff per Physician Clinical FTE	Total Support Staff per Physician Clinical FTE
Allergy and Immunology	(VHA) (###) Sample Facility Name	25	0.53	1.40	3,926	3,375	7.71	0.44	1.05	0.21	0.96	2.17	3.13
	1a-High Complexity	57	0.45	1.04	3,871		8.28	0.40	0.89	0.22	0.93	2.26	3.10
Cardiology	(VHA) (###) Sample Facility Name	31	10.63	11.00	7,468	7,886	4.10	8.00	1.04	0.91	0.46	0.95	3.41
	1a-High Complexity	39	6.69	7.08	8,536	7,886	4.81	8.54	1.06	0.63	0.54	0.93	1.48
Chiropractic	(VHA) (###) Sample Facility Name	1	4.49		4,658	3,025	15.42	3.38	0.00	0.05	0.39	0.10	0.49
	1a-High Complexity	24	1.86	1.00	3,465	3,025	14.98	1.46	0.07	0.02	0.41	0.11	0.53
Critical Care / Pulmonary Disease	(VHA) (###) Sample Facility Name	1	4.81	4.25	6,710	5,709	6.89	3.62	0.88	0.63	0.86	0.88	1.74
	1a-High Complexity	39	4.69	5.28	7,421	5,709	6.88	5.99	1.13	0.39	0.75	1.26	2.02
Dermatology	(VHA) (###) Sample Facility Name	1	2.74	9.00	10,335	8,988	3.87	2.06	3.29	0.98	1.00	3.26	4.26
	1a-High Complexity	39	2.52	5.02	8,961	8,988	3.70	3.22	1.94	0.55	1.44	2.30	3.74
Emergency Medicine	(VHA) (###) Sample Facility Name	1	113	1.60	4,027	7,791	3.88	2.82	1.64	0.56	1.45	2.40	3.85
	1a-High Complexity	39	11.70	2.22	4,829	8,241	18.97	16.55	0.05	0.21	1.29	3.95	4.85
Endocrinology	(VHA) (###) Sample Facility Name	1	124	7.54	2.10	4,406	10.29	14.55	0.09	0.27	1.24	3.74	4.98
	1a-High Complexity	39	3.29	1.50	3,853	3,844	8.72	2.47	0.46	1.04	1.46	1.77	3.23
Gastroenterology	(VHA) (###) Sample Facility Name	39	2.09	2.18	4,421	3,844	8.22	2.67	0.99	0.57	0.77	1.11	1.87
	1a-High Complexity	111	1.41	1.98	4,191	3,844	8.39	2.44	0.92	0.62	0.91	1.51	2.32
Geriatric Medicine	(VHA) (###) Sample Facility Name	1	9.34	7.00	4,662	7,141	10.66	7.02	0.75	0.24	0.55	0.84	1.50
	1a-High Complexity	39	4.81	4.57	7,764	7,141	7.84	6.14	0.95	0.57	0.54	0.76	1.30
Hematology/Oncology	(VHA) (###) Sample Facility Name	1	2.68	5.00	6,862	5,257	7.46	2.01	1.87	0.67	0.60	1.61	2.21
	1a-High Complexity	39	3.28	3.71	5,409	5,257	12.46	4.19	1.07	0.58	0.74	1.29	2.04
Infectious Disease	(VHA) (###) Sample Facility Name	1	1.48	3.00	3,361	3,618	8.71	1.11	2.03	0.88	1.13	1.52	2.66
	1a-High Complexity	39	1.99	2.28	4,069	3,618	13.43	2.54	1.12	0.28	0.43	0.68	1.10
Internal Medicine	(VHA) (###) Sample Facility Name	1	118.62	68.00	3,501	2,798	13.12	88.89	0.48	0.18	0.53	1.55	2.06
	1a-High Complexity	39	64.29	54.67	3,984	2,798	13.49	82.10	0.85	0.28	0.95	1.72	2.58
Nephrology	(VHA) (###) Sample Facility Name	1	139	40.09	31.36	2,838	13.28	86.68	0.71	0.35	0.95	1.91	2.86
	1a-High Complexity	39	3.33	3.00	9,838	5,292	11.32	2.51	0.90	0.23	0.97	0.64	1.31
Neurological Surgery	(VHA) (###) Sample Facility Name	39	2.56	2.68	6,111	5,292	14.72	3.26	1.02	0.42	0.48	0.45	0.91
	1a-High Complexity	119	1.71	2.18	5,507	5,292	14.24	3.17	0.73	0.34	0.42	0.58	0.99
Neurology	(VHA) (###) Sample Facility Name	1	1.20	1.00		5,370	34.84	0.90	0.83	2.24	1.94	0.82	2.76
	1a-High Complexity	39	1.28	1.40	5,820	5,370	13.29	1.63	0.87	0.61	0.62	0.68	1.30
Obstetrics & Gynecology	(VHA) (###) Sample Facility Name	65	0.97	1.18	4,895	4,895	12.31	0.88	0.84	0.85	0.64	0.76	1.41
	1a-High Complexity	119	2.09	3.18	4,872	4,846	13.12	88.89	0.11	0.11	0.39	0.73	1.56
Ophthalmology	(VHA) (###) Sample Facility Name	39	5.00	6.60	4,438	4,648	10.21	6.38	1.36	0.13	0.43	0.51	0.94
	1a-High Complexity	137	2.75	5.22	4,202	2,587	10.08	5.86	1.03	0.13	0.44	0.61	1.05
Optometry	(VHA) (###) Sample Facility Name	39	1.69	0.82	3,232	2,587	13.07	11.99	0.40	0.19	0.48	0.96	1.44
	1a-High Complexity	115	0.77	0.81	2,873	2,587	14.14	12.65	0.36	0.25	0.50	0.95	1.44
Orthopaedic Surgery	(VHA) (###) Sample Facility Name	1	6.83	6.50	9,907	8,355	4.62	5.14	0.95	0.89	2.01	2.91	2.91
	1a-High Complexity	39	5.19	4.81	8,556	8,355	6.36	6.63	0.93	0.10	0.87	1.93	2.79
Otolaryngology	(VHA) (###) Sample Facility Name	123	2.96	3.95	6,215	6,215	6.81	5.70	0.84	0.07	0.79	1.83	2.62
	1a-High Complexity	39	6.91		8,234	5,231	3.42	4.46	0.90	0.98	0.92	0.63	0.76
Pain Medicine	(VHA) (###) Sample Facility Name	39	7.45	3.77	5,432	5,231	4.40	9.52	0.34	0.02	0.45	0.70	1.14
	1a-High Complexity	137	5.10	3.00	5,503	5,231	4.48	10.86	0.32	0.02	0.47	0.67	1.34
Pathology	(VHA) (###) Sample Facility Name	1	2.23	3.00	4,101	5,489	10.33	1.68	1.35	2.24	1.74	0.68	2.42
	1a-High Complexity	39	3.34	4.16	5,051	5,489	9.82	4.26	1.21	1.01	0.74	1.06	1.80
Physical Medicine & Rehabilitation	(VHA) (###) Sample Facility Name	125	2.39	3.49	5,194	5,194	10.11	4.65	0.83	0.88	0.79	1.21	2.00
	1a-High Complexity	39	1.72	3.00	7,893	6,010	8.16	1.29	1.74	0.46	0.92	1.34	2.28
Plastic Surgery	(VHA) (###) Sample Facility Name	39	2.03	2.77	6,288	6,010	7.73	2.59	1.30	0.52	0.78	1.24	2.02
	1a-High Complexity	104	1.54	2.54	5,631	5,631	7.99	2.49	1.00	0.43	0.73	1.22	1.95
Podiatry	(VHA) (###) Sample Facility Name	22	1.55	1.46	4,424	3,792	10.74	1.12	0.94	1.32	2.11	3.72	5.83
	1a-High Complexity	74	1.14	1.46	3,866	3,792	11.77	1.32	0.57	0.95	1.89	3.11	5.01
Primary Care	(VHA) (###) Sample Facility Name	1	5.07	4.00	6,750	5,866	0.47	3.81	0.79	0.11	0.41	1.81	22.94
	1a-High Complexity	39	3.95	3.26	5,844	5,866	0.72	5.04	0.74	0.01	2.49	14.59	17.08
Psychiatry	(VHA) (###) Sample Facility Name	134	2.23	2.86	5,549	5,549	0.64	4.65	0.55	0.00	2.68	16.38	19.06
	1a-High Complexity	1	9.47	8.00	3,932	3,299	13.97	7.13	0.84	0.14	0.39	0.11	0.40
Radiation Oncology	(VHA) (###) Sample Facility Name	38	6.87	6.78	4,000	3,299	15.83	8.54	0.70	0.15	0.23	0.14	0.37
	1a-High Complexity	127	3.45	4.84	3,697	3,299	14.45	6.22	0.60	0.15	0.31	0.18	0.50
Surgery	(VHA) (###) Sample Facility Name	1	1.55	1.50	3,740	4,243	12.68	1.17	0.97	1.13	1.22	2.34	2.34
	1a-High Complexity	39	1.34	1.92	4,370	4,243	13.75	1.71	1.21	0.53	0.52	0.72	1.24
Thoracic Surgery	(VHA) (###) Sample Facility Name	85	1.00	1.59	4,377	4,377	13.32	1.32	1.01	0.52	0.56	0.93	1.49
	1a-High Complexity	111	1.00	1.76	3,757	4,377	9.87	1.65	0.86	0.21	0.53	0.81	1.44
Urology	(VHA) (###) Sample Facility Name	39	4.29	6.69	5,664	5,347	6.25	5.48	0.78	0.06	0.53	0.91	1.44
	1a-High Complexity	137	3.10	6.32	5,190	5,190	6.71	6.61	0.55	0.06	0.53	1.10	1.84
Vascular Surgery	(VHA) (###) Sample Facility Name	1	85.23		3,449	3,910	7.72	64.12	0.00	0.73	2.15	2.88	3.85
	1a-High Complexity	39	54.42		3,910	3,910	8.89	69.49	0.00		1.02	2.04	3.06
Psychology	(VHA) (###) Sample Facility Name	139	39.17		2,954	2,954	9.15	80.38	0.00		1.03	2.06	3.09
	1a-High Complexity	1	45.36	24.00	3,666	3,844	17.87	34.13	0.53	0.35	0.95	0.78	1.72
Radiology	(VHA) (###) Sample Facility Name	39	29.12	18.82	3,901	3,844	22.87	37.18	0.65	0.39	0.89	0.71	1.60
	1a-High Complexity	139	16.56	19.83	3,766	3,766	22.60	35.82	0.54	0.45	1.01	0.84	1.85
Rheumatology	(VHA) (###) Sample Facility Name	39	48.11	17.50	4,465	2,364	33.68	36.96	0.36	0.32	1.13	0.82	1.96
	1a-High Complexity	39	44.11	16.00	2,263	2,364	43.05	56.32	0.36	0.28	0.74	0.67	1.31
Surgery	(VHA) (###) Sample Facility Name	139	26.58	9.53	2,292	2,292	45.05	57.47	0.32	0.28	0.78	0.63	1.40
	1a-High Complexity	1	27.54	1.00	6,899	6,084	4.48	29.79	0.04	0.69	1.59	2.30	3.88
Surgery	(VHA) (###) Sample Facility Name	39	14.06	7.01	6,405	6,084	4.52	17.06	0.49	0.07	1.49	3.53	5.02
	1a-High Complexity	139	7.82	5.36	6,354	6,354	4.08	16.91	0.35	0.05	1.48	3.82	5.30
Surgery	(VHA) (###) Sample Facility Name	1	3.17	4.00	3,366	4,137	10.45	2.39	1.26	0.30	0.68	1.10	1.78
	1a-High Complexity	39	1.60	1.93	3,921	4,137	9.82	2.04	1.15	0.25	0.62	0.61	1.23
Surgery	(VHA) (###) Sample Facility Name	111	1.00	1.76	3,757	4,137	9.87	1.65	0.86	0.21	0.53	0.81	1.44
	1a-High Complexity	1	4.86	13.50	7,742	4,731	13.72	3.66	2.78	1.09	1.18	1.27	2.46
Surgery	(VHA) (###) Sample Facility Name	39	4.25	9.36	4,767	4,731	18.16	5.42	2.20	0.46	0.56	1.16	1.72
	1a-High Complexity	129	2.99	6.66	4,294	4,294	16.26	6.01					

Specialty Productivity Access Report and Quadrant Tool¹⁵⁴



Specialty Productivity - Access Report and Quadrant Tool (SPARQ)

Note: Please note data is only as current as each data source. See Data Connect Through list.

- Data Definitions
- Help Desk
- Rate Report
- Additional Resources

Specialty Quadrant | Facility Quadrant | Key Practice Indicators | Table | Trends

Fiscal Year: FY 2019 Facility: (V#) (###) Sample Facility Name	Allergy and Immunology		Cardiology		Chiropractic		Critical Care / Pulmonary Disease		Dermatology		Endocrinology	
	Not Available		4 - Over-Resourced		1 - Optimal Practice		3 - Inefficient		2 - Under-Resourced		Grey Zone	
	Facility Value	1a-High Complexity 10th - 50th - 90th	Facility Value	1a-High Complexity 10th - 50th - 90th	Facility Value	1a-High Complexity 10th - 50th - 90th	Facility Value	1a-High Complexity 10th - 50th - 90th	Facility Value	1a-High Complexity 10th - 50th - 90th	Facility Value	1a-High Complexity 10th - 50th - 90th
Measures												
Core Facility Uniques	132,910	58,045 - 73,456 - 112,014	132,910	58,045 - 73,456 - 112,014	132,910	58,045 - 73,456 - 112,014	132,910	58,045 - 73,456 - 112,014	132,910	58,045 - 73,456 - 112,014	132,910	58,045 - 73,456 - 112,014
Pro-Rated Patients	122,800	43,556 - 57,412 - 101,680	122,800	43,556 - 57,412 - 101,680	122,800	43,556 - 57,412 - 101,680	122,800	43,556 - 57,412 - 101,680	122,800	43,556 - 57,412 - 101,680	122,800	43,556 - 57,412 - 101,680
Community Care - Average Days to Appt Created	33.86	17.22 - 29.89 - 43.67	33.86	17.22 - 29.89 - 43.67	33.86	17.22 - 29.89 - 43.67	33.86	17.22 - 29.89 - 43.67	33.86	17.22 - 29.89 - 43.67	33.86	17.22 - 29.89 - 43.67
Core Facility Uniques - 3 yr Change	5.8%	(2.1%) - 2.0% - 0.4%	5.8%	(2.1%) - 2.0% - 0.4%	5.8%	(2.1%) - 2.0% - 0.4%	5.8%	(2.1%) - 2.0% - 0.4%	5.8%	(2.1%) - 2.0% - 0.4%	5.8%	(2.1%) - 2.0% - 0.4%
Pro-Rated Patients - 3 yr Change	4.6%	(2.5%) - 1.9% - 0.8%	4.6%	(2.5%) - 1.9% - 0.8%	4.6%	(2.5%) - 1.9% - 0.8%	4.6%	(2.5%) - 1.9% - 0.8%	4.6%	(2.5%) - 1.9% - 0.8%	4.6%	(2.5%) - 1.9% - 0.8%
Specialty Uniques - 3 yr Change	(100.0%)	(55.4%) - 7.1% - 30.2%	12.1%	(15%) - 0.3% - 17.6%	(109.6%)	(13.3%) - 4.8% - 55.6%	8.4%	(3.3%) - 13.8% - 32.0%	10.8%	(5.0%) - 0.3% - 25.0%	8.2%	(5.3%) - 0.4% - 24.7%
Trend Data												
Physician Clinical FTE	--	16.63	3.04 - 6.53 - 8.94	4.49	0.77 - 1.66 - 2.96	4.81	2.77 - 4.22 - 6.83	2.41	1.38 - 2.58 - 3.83	3.29	1.17 - 1.82 - 3.37	5.24
MD FTE (C)	--	--	8.73	3.73 - 6.26 - 9.60	1.82	0.73 - 1.59 - 2.47	4.82	2.49 - 4.09 - 6.32	2.88	1.83 - 2.80 - 3.53	3.16	1.13 - 2.10 - 3.16
Imputed Fee & Contract MD FTE	--	--	1.80	0.00 - 0.14 - 0.69	2.87	0.01 - 0.12 - 1.74	0.78	0.00 - 0.10 - 0.78	0.66	0.03 - 0.30 - 1.27	0.13	0.00 - 0.06 - 0.33
% MD FTE (C)	--	--	12.9%	55.3% - 91.5% - 100.0%	100.0%	78.0% - 67.4% - 81.9%	78.0%	53.3% - 67.3% - 81.9%	78.1%	47.5% - 76.3% - 80.1%	100.0%	44.3% - 63.9% - 87.1%
% Admin FTE	--	--	18.9%	7.6% - 11.1% - 21.0%	--	3.1% - 0.8% - 25.8%	25.3%	7.1% - 14.9% - 25.7%	7.8%	5.4% - 12.1% - 24.8%	4.6%	4.9% - 12.1% - 24.8%
% Education FTE	--	--	3.8%	1.6% - 3.9% - 11.9%	--	5.5% - 7.5% - 9.5%	--	1.1% - 5.1% - 12.1%	2.6%	1.2% - 0.6% - 15.0%	--	2.3% - 5.1% - 13.0%
% Research FTE	--	--	2.8%	1.2% - 7.4% - 18.2%	--	11.2% - 14.2% - 17.2%	4.1%	1.7% - 11.7% - 24.9%	18.4%	5.6% - 28.5% - 44.4%	--	10.3%
% Total Bedday FTE	--	--	--	7.1% - 18.6% - 29.6%	--	--	--	19.8% - 37.4% - 62.1%	--	1.2% - 4.8% - 7.8%	--	4.9% - 17.9% - 37.4%
Physician Clinical FTE per 10K Specialty Patients	--	--	4.10	3.08 - 4.74 - 7.42	15.42	8.82 - 15.51 - 22.95	6.89	4.41 - 7.37 - 12.06	3.87	2.84 - 3.80 - 5.16	8.72	5.78 - 8.22 - 11.53
Physician Clinical FTE per 100K Core Facility Uniques	--	--	8.80	5.19 - 8.21 - 11.72	3.38	0.89 - 1.84 - 4.20	3.62	3.78 - 5.78 - 7.94	2.06	1.78 - 3.15 - 5.29	2.47	1.61 - 2.47 - 3.76
Cardiac Cath or Endoscopy Admin Support Staff per 10,000 RVUs	--	--	1.84	0.57 - 1.46 - 3.75	--	--	--	--	--	--	--	--
Cardiac Cath or Endoscopy Clinical Support Staff per 10,000 RVUs	--	--	4.81	2.25 - 5.05 - 8.32	--	--	--	--	--	--	--	--
Cardiac Cath or Endoscopy Total Support Staff per 10,000 RVUs	--	--	5.95	3.65 - 6.36 - 11.91	--	--	--	--	--	--	--	--
Cardiac Cath or Endoscopy Support Staff per Physician Clinical FTE	--	--	1.41	0.72 - 1.41 - 2.60	0.49	0.00 - 0.37 - 0.90	1.74	0.93 - 1.98 - 3.28	4.26	2.31 - 3.70 - 6.84	3.23	0.80 - 1.63 - 3.16
APP Workforce per Physician Clinical FTE	--	--	0.91	0.32 - 0.64 - 0.96	0.85	0.01 - 0.08 - 0.16	0.63	0.09 - 0.38 - 0.92	0.98	0.19 - 0.59 - 1.44	1.84	0.25 - 0.57 - 1.33
APP Workforce per 10K Specialty Patients	--	--	3.73	1.40 - 2.87 - 4.98	0.77	0.11 - 0.60 - 2.28	4.37	0.48 - 2.25 - 8.81	3.78	0.95 - 2.88 - 8.01	9.88	2.85 - 4.25 - 13.01
APP Workforce per 100K Core Facility Uniques	--	--	7.29	2.32 - 4.74 - 8.60	0.17	0.03 - 0.14 - 0.45	2.38	0.49 - 2.01 - 4.81	2.01	0.74 - 1.82 - 3.84	2.57	0.78 - 1.48 - 2.83
Productivity Measure	--	--	7.68	6.74 - 8.25 - 10.60	4.68	2.79 - 3.25 - 4.64	6.18	5.24 - 7.58 - 11.84	10.85	6.38 - 8.63 - 14.40	3.83	3.20 - 4.28 - 5.99
Operating Room												
Average OR Time (hrs) per Week	--	--	--	--	--	--	--	--	--	--	--	--
Average OR Time (hrs) per Physician Clinical FTE	--	--	11.80	3.43 - 7.80 - 9.60	--	--	--	--	--	--	--	--
Resident Slots	--	--	13.38	10.35 - 38.80	17.84	13.85 - 19.78 - 28.45	21.57	13.88 - 22.83 - 43.30	34.07	15.13 - 26.40 - 43.57	31.80	9.47 - 18.88 - 30.19
Average Wait - New Patient from Create Date	--	--	8.81	4.78 - 12.80 - 35.77	16.67	9.38 - 16.61 - 25.67	8.58	8.58 - 18.43 - 41.45	23.63	10.93 - 18.43 - 38.54	41.94	7.42 - 14.88 - 33.42
Average Wait - Established Patient from Patient Indicated Date	--	--	8.95	3.21 - 10.01	11.91	6.88 - 11.03 - 16.73	4.64	2.74 - 4.64 - 8.38	9.70	7.18 - 11.70 - 25.29	8.95	3.22 - 7.52 - 12.97
Average Wait - All Patient from Patient Indicated Date	--	--	2.04	4.74 - 13.15	12.87	7.38 - 11.26 - 18.11	5.38	4.58 - 7.28 - 12.38	13.51	8.59 - 12.98 - 26.86	13.61	4.38 - 8.68 - 16.40
Average Days to Appointment Created	--	--	6.77	10.23 - 26.74	11.81	5.78 - 8.75 - 13.47	8.35	6.09 - 8.78 - 13.47	22.64	6.81 - 10.92 - 20.59	17.80	4.94 - 8.19 - 13.87
Average Total Days Waiting (All Aug Wait - Days to Appt Created)	0.00	0.00 - 0.54 - 32.90	23.88	14.25 - 21.23 - 30.33	14.73	8.06 - 7.35 - 22.84	36.15	15.45 - 23.58 - 41.84	30.89	8.28 - 17.27 - 28.94	35.45	13.52 - 19.59 - 32.59
Average Days to 3rd Next Available Appointment	--	--	25.91	21.87 - 37.58 - 66.64	28.39	5.78 - 18.58 - 32.41	52.19	24.21 - 44.33 - 80.32	62.46	13.89 - 27.86 - 43.48	35.55	28.16 - 40.11 - 57.42
Average Days to Three Consecutive Date	--	--	47.65	34.72 - 58.28 - 82.86	33.52	16.38 - 23.59 - 45.11	68.48	34.57 - 61.60 - 98.88	82.31	28.87 - 42.56 - 82.80	55.18	31.83 - 51.13 - 78.82
% of Routine Consults Elapsed greater than 30 Days	--	27.0%	40.5%	76.9%	48.1%	17.4%	27.9%	41.4%	46.8%	28.3%	48.0%	88.3%
EMM Established to New Encounters	--	0.77 - 2.78 - 6.61	5.25	1.16 - 2.56 - 4.74	1.57	0.21 - 0.93 - 4.92	0.45	0.63 - 1.69 - 3.33	6.29	1.14 - 2.98 - 6.15	3.42	1.18 - 2.18 - 4.05
Physician EMM Est to New Encounters	--	0.91 - 2.57 - 6.60	5.90	1.87 - 2.94 - 4.27	1.57	0.21 - 0.93 - 4.92	0.64	0.63 - 1.69 - 3.33	6.29	1.14 - 2.98 - 6.15	3.42	1.18 - 2.18 - 4.05
APP EMM Est to New Encounters	--	0.81 - 2.28 - 29.67	4.78	0.88 - 4.17 - 24.87	0.11	0.18 - 1.16 - 5.67	4.28	0.71 - 4.09 - 16.58	4.28	0.71 - 4.09 - 16.58	4.58	0.93 - 5.27 - 24.55
Cancelled by Clinic Prior to Appointment Rate	--	--	7.7%	5.9% - 8.2% - 11.1%	6.6%	1.1% - 3.4% - 6.6%	6.6%	3.0% - 7.9% - 12.5%	7.5%	3.9% - 7.1% - 11.4%	4.5%	3.9% - 6.6% - 9.2%
Missed Opportunity Rate	--	--	12.0%	8.7% - 18.5% - 16.9%	13.0%	7.3% - 10.9% - 16.3%	11.3%	9.3% - 12.5% - 18.7%	8.8%	7.7% - 10.6% - 13.4%	12.4%	11.4% - 14.5% - 18.9%
Total RVUs												
Total RVUs	--	87,385	34,158 - 48,725 - 117,777	111,597	2,275 - 5,742 - 11,278	36,884	14,679 - 26,511 - 43,588	412,219	14,177 - 25,839 - 33,515	18,671	5,658 - 8,743 - 15,741	46,819
Annual % Change in PPC RVUs	--	--	3.3%	(6.1%) - 4.9% - 13.5%	3.9%	(5.1%) - 0.8% - 13.5%	18.2%	(8.8%) - 8.4% - 28.9%	(3.3%)	(20.3%) - 1.0% - 12.9%	23.9%	(6.0%) - 1.0% - 33.8%
VA Paid RVUs (% of Total)	--	--	62.2%	75.7% - 18.1% - 96.0%	45.5%	63.0%	100.0%	73.3%	65.1%	107.7%	100.0%	65.2%
Non-VA Paid Fee & Other RVUs (% of Total)	--	--	34.5%	8.0% - 2.9% - 8.0%	54.5%	8.4%	0.1%	23.8%	34.9%	1.1%	10.0%	34.8%
Resident Only RVUs (% of Total)	--	--	1.1%	0.0% - 0.2% - 0.5%	--	0.0%	0.0%	0.5%	0.0%	0.0%	0.1%	0.4%
APP RVUs (% of Total)	--	--	17.2%	1.2% - 0.2% - 17.5%	--	0.0%	0.0%	13.1%	32.0%	0.2%	0.1%	34.2%
RVU Sum per Encounter	--	--	1.85	0.73 - 1.08 - 1.75	1.28	1.81 - 1.32 - 1.64	0.45	1.13 - 1.57 - 2.28	1.74	1.31 - 1.66 - 2.21	1.72	1.28 - 1.54 - 1.80
Billable RVU Sum per Encounter	--	--	0.77	0.67 - 0.91 - 1.25	0.87	0.86 - 0.91 - 1.43	0.39	0.95 - 1.30 - 1.80	1.80	1.28 - 1.56 - 2.13	1.35	1.28 - 1.37 - 1.57
% of Encounters with an APP	--	--	42.4%	6.7% - 4.0% - 13.5%	0.0%	0.0%	0.1%	0.1%	1.1%	0.0%	0.4%	22.4%
(Physician) Calculated Average Weekly Inpatient Consults	--	--	98.85	1.41 - 13.35 - 29.75	8.13	0.84 - 0.11 - 0.27	9.21	1.87 - 3.92 - 11.93	2.25	0.87 - 1.12 - 2.11	8.63	0.25 - 2.91 - 5.90
(Physician) Average Outpatient VA Encounters per Day per FTE	7.25	14.98 - 21.51	10.68	13.51 - 25.65 - 45.85	16.38	7.95 - 8.65 - 19.16	7.90	9.87 - 17.18 - 28.35	25.34	15.22 - 22.70 - 36.59	7.29	7.89 - 10.73 - 17.49
(Physician) Average Outpatient VA Encounters per Day per FTE (VA or Other)	7.14	14.97 - 21.51	10.52	13.20 - 25.49 - 45.60	16.38	7.95 - 8.65 - 19.16	7.74	8.78 - 16.87 - 27.16	25.33	14.67 - 22.55 - 36.58	6.47	6.78 - 10.20 - 15.15
(Physician & APP) Average Outpatient VA Encounters per Day per FTE	5.19	18.82 - 19.77	8.21	9.23 - 14.14 - 26.68	14.38	7.38 - 8.54 - 17.81	7.32	6.90 - 12.84 - 17.81	17.85	10.26 - 15.68 - 21.62	5.75	5.78 - 7.23 - 12.92
Employee Utilization												
VA Physician Loss Rate	--	--	4.4%	3.4% - 0.5% - 22.4%	8.7%	2.7% - 5.9% - 11.7%	11.1%	8.9%	13.1%	23.4%	13.6%	28.3%
Facility Average Total Compensation	--	\$26,887	\$29,838 - \$29,138 - \$24,624	\$11,937	\$88,217 - \$112,319 - \$153,387	\$251,189	\$248,989 - \$274,299 - \$389,369	\$280,973	\$291,387 - \$296,975 - \$353,876	\$212,854	\$211,825 - \$227,784 - \$245,329	\$319,849
Total Compensation per RVU	--	\$40	\$38 - \$38 - \$47	\$24	\$25 - \$33 - \$54	\$38	\$24 - \$37 - \$54	\$27	\$22 - \$37 - \$48	\$35	\$22 - \$37 - \$48	\$38
Facility Average Total Compensation (% Clinical)	--	\$245,882	\$144,938 - \$295,135 - \$258,820	\$111,177	\$75,408 - \$183,314 - \$122,233	\$177,762	\$59,387 - \$116,303 - \$195,306	\$236,601	\$151,443 - \$237,644 - \$293,849	\$212,654	\$88,856 - \$116,646 - \$172,929	\$280,290
Clinical Compensation per RVU	--	\$33	\$15 - \$24 - \$36	\$24	\$24 - \$25 - \$28	\$26	\$8 - \$15 - \$28	\$22	\$14 - \$24 - \$40	\$35	\$14 - \$24 - \$40	\$39

¹⁵⁴ This screen shot was truncated to fit on the page. The full report includes the following specialties: Gastroenterology, Geriatric Medicine, Hematology-Oncology, Infectious Disease, Internal Medicine, Nephrology, Neurological Surgery, Neurology, Obstetrics & Gynecology, Ophthalmology, Optometry, Orthopaedic Surgery, Otolaryngology, Pain Medicine, Physical Medicine & Rehabilitation, Plastic Surgery, Podiatry, Psychiatry, Psychology, Radiation Oncology, Radiology, Rheumatology, Surgery, Thoracic Surgery, Urology, and Vascular Surgery.

Appendix F: Staffing Guidance Identified by the OIG

Guidance	Date Published	Occupation/Service Line
<i>A Staffing Model Approach: VHA Administrative Staffing Model</i>	May 20, 2019	Administration
<i>VHA Directive 1101.05(2) Emergency Medicine</i>	September 2, 2016 (Amended March 7, 2017)	Emergency Department and Urgent Care
<i>VHA Directive 1140.11 Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics</i>	October 11, 2016	Geriatrics and Extended Care
<i>Environmental Programs Service Staffing Guide</i>	October 2006	Housekeeping
<i>VHA Handbook 1160.01 Uniform Mental Health Services in VA Medical Centers and Clinics</i>	September 11, 2008 (Amended November 16, 2015)	Mental Health
<i>VHA Directive 1161 Productivity and Staffing in Clinical Encounters for Mental Health Providers</i>	April 28, 2020	Mental Health
<i>VHA Handbook 1160.06 Inpatient Mental Health Services</i>	September 16, 2013	Mental Health
<i>VHA Directive 1351 Staffing Methodology for VHA Nursing Personnel</i>	December 20, 2017	Nursing
<i>VHA Directive 1064 Pathology and Laboratory Medicine Services (P&LMS) Productivity and Staffing</i>	September 17, 2018	Pathology and Laboratory Medicine
<i>VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook</i>	February 5, 2014 (Amended May 26, 2017)	Patient Aligned Care Team
<i>VHA Handbook 1108.11 Clinical Pharmacy Services</i>	July 1, 2015 (Amended June 29, 2017)	Pharmacy
<i>VHA Directive 1406 Patient Centered Management Module (PCMM) For Primary Care</i>	June 20, 2017	Primary Care
<i>VHA Directive 1411 Home-Based Primary Care Special Population Patient Aligned Care Team Program</i>	June 5, 2017 (Revised September 20, 2017)	Primary Care
<i>VHA Handbook 1065 Productivity and Staffing Guidance For Specialty Provider Group Practice</i>	December 22, 2020	Specialty Provider Group Practice (Excludes Mental Health and Emergency Medicine)

Guidance	Date Published	Occupation/Service Line
<i>Social Work Staffing and Clinical Practice Committee, Sub-Committee Staffing Model Guide, VA Care management and Social Work Services, Social Work Staffing and VA Complexity Level</i>	2007	Social Work
<i>VHA Directive 1176(2) Spinal Cord Injuries and Disorders System of Care</i>	September 30, 2019 (Amended February 7, 2020)	Spinal Cord Injuries and Disorders
<i>VHA Handbook 1160.04 VHA Programs for Veterans with Substance Use Disorders (SUD)</i>	March 7, 2012	Substance Use Disorders
<i>VHA Directive 1330.01(3) Health Care Services for Women Veterans</i>	February 15, 2017 (Amended June 29, 2020)	Women's Health

Source: OIG analysis of VHA publications.

Note: The OIG identified 18 different instances of staffing guidance across 14 occupation/service lines.

Appendix G: Facility Director Awareness of VHA Staffing Models by OPM Occupational Series

Table G.1. Frequency of Facility Awareness of VHA Staffing Model for Psychology

Psychology	Number of Facilities (130)	Percentage of Facilities
No	54	42
Yes*	76	58
Yes, National	30	39
Yes, at the VISN	1	1
Yes, Local	12	16
Yes, Mix	33	43

Source: OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.

**Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mixed responses. Percentage of facilities that responded Yes (n=76).*

Table G.2. Frequency of Facility Awareness of VHA Staffing Model for Medical Officer¹⁵⁵

Medical Officer	Number of Facilities (130)	Percentage of Facilities
No	50	38
Yes*	80	62
Yes, National	36	45
Yes, at the VISN	3	4
Yes, Local	8	10
Yes, Mix	33	41

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

* *Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=80).*

Table G.3. Frequency of Facility Awareness of VHA Staffing Model for Nurse¹⁵⁵

Nurse	Number of Facilities (130)	Percentage of Facilities
No	23	18
Yes*	107	82
Yes, National	60	56
Yes, at the VISN	1	1
Yes, Local	10	9
Yes, Mix	36	34

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

* *Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=107).*

¹⁵⁵ The OIG did not intend the response *NA* as a survey response. The OIG received and reviewed *NA* responses from San Diego VA Medical Center, California determining the response was in regard to OPM occupational series and VHA assignment codes they do not hire. The OIG assigned *Yes, National* as the OPM occupational series and VHA assignment codes indicated this level of awareness.

Table G.4. Frequency of Facility Awareness of VHA Staffing Model for Practical Nurse

Practical Nurse	Number of Facilities (130)	Percentage of Facilities
No	43	33
Yes*	87	67
Yes, National	37	43
Yes, at the VISN	2	2
Yes, Local	13	15
Yes, Mix	35	40

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

*Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=87).

Table G.5. Frequency of Facility Awareness of VHA Staffing Model for Medical Technologist

Medical Technologist	Number of Facilities (130)	Percentage of Facilities
No	70	54
Yes*	60	46
Yes, National	17	28
Yes, at the VISN	2	3
Yes, Local	13	22
Yes, Mix	28	47

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

*Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=60).

Table G.6. Frequency of Facility Awareness of VHA Staffing Model for Police

Police	Number of Facilities (130)	Percentage of Facilities
No	50	38
Yes*	80	62
Yes, National	42	53†
Yes, at the VISN	3	4†
Yes, Local	13	16†
Yes, Mix	22	28†

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

*Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=80).

Table G.7. Frequency of Facility Awareness of VHA Staffing Model for Medical Support Assistance

Medical Support Assistance	Number of Facilities (130)	Percentage of Facilities
No	61	47
Yes*	69	53
Yes, National	21	30
Yes, at the VISN	3	4
Yes, Local	14	20
Yes, Mix	31	45

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

*Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=69).

Table G.8. Frequency of Facility Awareness of VHA Staffing Model for General Engineering

General Engineering	Number of Facilities (130)	Percentage of Facilities
No	77	59
Yes*	53	41
Yes, National	19	36
Yes, at the VISN	3	6
Yes, Local	10	19
Yes, Mix	21	40

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

*Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=53).

Table G.9. Frequency of Facility Awareness of VHA Staffing Model for Custodial Worker

Custodial Worker	Number of Facilities (130)	Percentage of Facilities
No	60	46
Yes*	70	54
Yes, National	29	41
Yes, at the VISN	4	6
Yes, Local	11	16
Yes, Mix	26	37

Source: *OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.*

*Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=70).

Table G.10. Frequency of Facility Awareness of VHA Staffing Model for Food Service Worker

Food Service Worker	Number of Facilities (130)	Percentage of Facilities
No	81	62
Yes*	49	38
Yes, National	15	31
Yes, at the VISN	1	2
Yes, Local	13	27
Yes, Mix	20	41

Source: OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey.

**Aggregation of Yes, National; Yes, at the VISN; Yes, Local; and Yes, Mix responses. Percentage of facilities that responded Yes (n=49).*

Appendix H: Medical Officer VHA Assignment Codes Used for Facility Director Awareness of Specialties

Table H.1. Medical Officer VHA Assignment Codes Used for Facility Director Awareness of Specialties

VHA Assignment Code and Title*
1 Anesthesiology
2 Surgery
3 Gynecology
5 Medical Oncology
6 Ophthalmology
7 Orthopedic Surgery
8 Otolaryngology
9 Plastic Surgery
10 Colon & Rectal Surgery
11 Thoracic Surgery
12 Urology
13 Physiatry
16 Emergency Medicine
18 Hematology
19 Infectious Diseases
20 Dermatology
21 General Internal Medicine
23 Allergy & Immunology
25 Gastroenterology
26 Pulmonary Diseases
27 Nephrology
28 Rheumatology
29 Endocrine and Metabolism
30 Neurology
31 Psychiatry
32 Anatomic Pathology
33 Clinical Pathology
36 Preventive Medicine
38 Radiology-Diagnostic
39 Radiology-Therapeutic
40 Geriatrics
43 Pathology
44 Physical Medicine & Rehabilitation

VHA Assignment Code and Title*
45 Radiology-Interventional
46 Nuclear Medicine
49 Family Practice
67 Oral Surgery
68 Periodontics
CA Cardiology Non-Invasive
CE Palliative Care
E4 Cardiovascular/Thoracic Surgeon
E5 Neurosurgery
E6 Cardiology Non-Interventionist
E7 Radiology (Nuclear)
G9 Radiation Oncology
K6 Hospitalist
K8 Critical Care
N9 Cardiac Electrophysiology
P1 Primary Care
P9 Orthopedic
R3 Hematology/Oncology
R4 Vascular Surgery

Source: OIG review of selected VHA assignment codes within the Medical Officer occupation.

** VHA assignment codes and titles within the OPM occupational series and title, 0602 Medical Officer.*

Appendix I: Source of Method Used to Determine Staffing Requirements for the Top Five Clinical and Top Five Nonclinical Severe Shortage Occupations

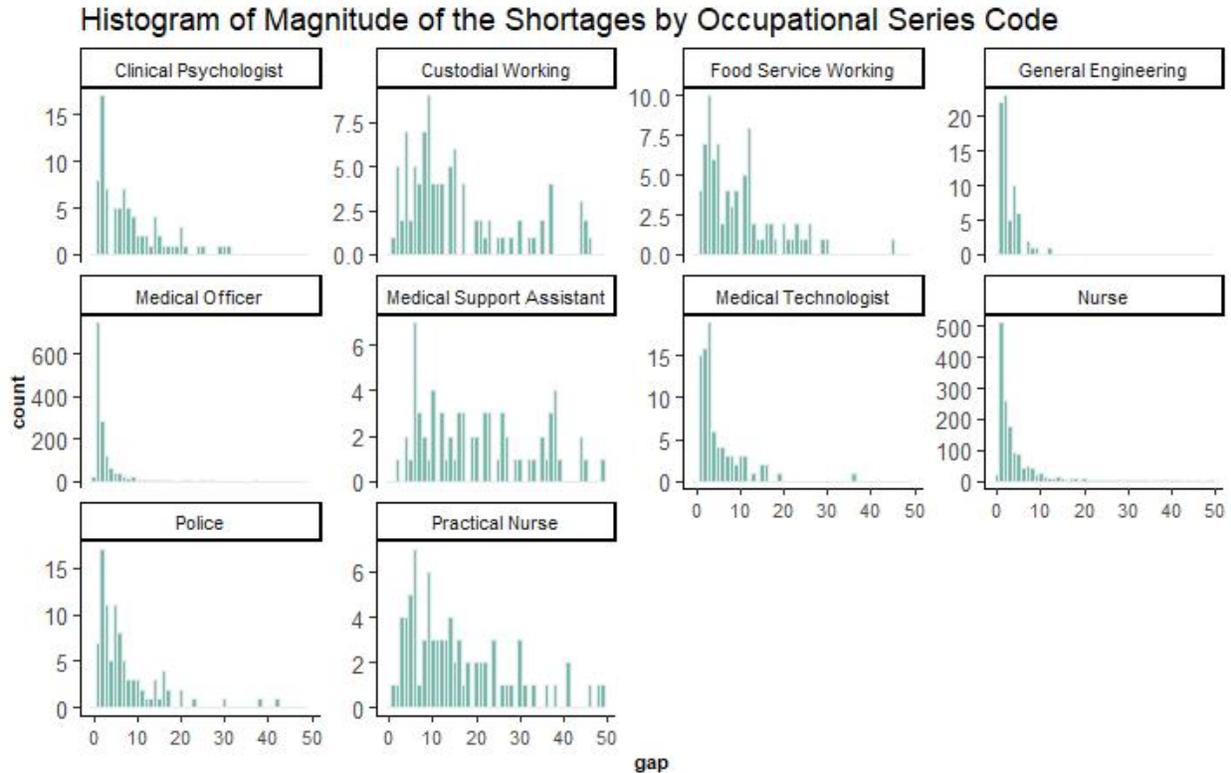
Table I.1. Source of Method for the Top Five Clinical and Top Five Nonclinical Occupations

Occupation	VHA (%)	VISN (%)	Facility-Developed (%)	External (%)	Mix (%)	Other (%)	Assorted* (%)
Psychology	17 (13)	1 (1)	57 (44)	0 (0)	43 (33)	2 (2)	10 (8)
Medical Officer	5 (4)	1 (1)	26 (20)	0 (0)	95 (73)	0 (0)	3 (2)
Nurse	12 (9)	1 (1)	33 (25)	0 (0)	79 (61)	0 (0)	5 (4)
Practical Nurse	20 (15)	2 (2)	57 (44)	0 (0)	37 (28)	0 (0)	14 (11)
Medical Technologist	7 (5)	1 (1)	73 (56)	0 (0)	40 (31)	2 (2)	7 (5)
Police	18 (14)	1 (1)	60 (46)	1 (1)	38 (29)	2 (2)	10 (8)
Medical Support Assistance	7 (5)	2 (2)	64 (49)	0 (0)	38 (29)	4 (3)	15 (12)
General Engineering	10 (8)	5 (4)	67 (52)	2 (2)	32 (25)	2 (2)	12 (9)
Custodial Worker	15 (12)	3 (2)	68 (52)	0 (0)	32 (25)	2 (2)	10 (8)
Food Service Worker	7 (5)	1 (1)	77 (59)	0 (0)	29 (22)	4 (3)	12 (9)

Source: OIG analysis of VHA facilities' responses to the FY 2020 Staffing Determination and Staffing Model survey

** Includes facility director responses that were not included in the drop-down menu and responses where the number of staff needed for the occupation is unknown. Additionally, every occupation is not hired at every facility; this category counts the number of facilities indicating they do not hire for this occupation.*

Appendix J: Histogram of Magnitude of Shortages



Source: *OIG Analysis of Survey Data.*

The bar charts in appendix J show the histograms of the magnitude of the gap (number of staff required – number of staff on hand) data for each occupational series. The size of the gap is represented on the x-axis and the number of responses is on the y-axis. The histograms where bars group on the left side are those where the gaps are smaller. For example, the gap size for Medical Officer is for most responses is less than two and the numbers of responses drops off quickly as gap size increases. In contrast, Medical Support Assistant remain similar until the gap size reaches 40. Of note, the scale on the y-axis is different for the histograms to best appreciate the distribution of the gap sizes. The x-axis scale is the same in all histograms to allow for comparison of gap sizes. The limit of the y-axis was set to 50, so these distributions are truncated on the right. This was done to reduce the white space that results if tails of the distribution were fully represented.

Appendix K: VHA Onboard Levels for the Top Five Clinical and Top Five Nonclinical Severe Shortage Occupations

Table K.1. Changes in VHA Onboard Levels for the Top Five Clinical Severe Shortage Occupations

Occupation	Onboard Levels as of March 28, 2020	Onboard Levels as of October 10, 2020	Net Change	
			Number	Percent
Psychology	6,038	6,258	220	3.6
Medical Officer	26,713	27,150	437	1.6
Nurse	73,900	76,721	2,821	3.8
Practical Nurse	15,298	15,501	203	1.3
Medical Technologist	4,543	4,599	56	1.2
Overall	126,492	130,229	3,737	3.0

Source: OIG analysis of VHA-provided HR Smart data.

Table K.2. Changes in VHA Onboard Levels for the Top Five Nonclinical Severe Shortage Occupations

Occupation	Onboard Levels as of March 28, 2020	Onboard Levels as of October 10, 2020	Net Change	
			Number	Percent
Police	3,838	3,876	38	1.0
Medical Support Assistance	27,856	29,086	1,230	4.4
General Engineering	1,008	1,066	58	5.8
Custodial Worker	11,834	12,237	403	3.4
Food Service Worker	4,749	4,933	184	3.9
Overall	49,285	51,198	1,913	3.9

Source: OIG analysis of VHA-provided HR Smart data.

Appendix L: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: July 16, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Veterans Health Administration Staffing Models

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Review of Veterans Health Administration (VHA) Staffing Models. VHA concurs with recommendations 1-3 and provides an action plan in the attachment.
2. I will continue to support the roles, responsibilities, and number of staff needed for VHA offices involved in the development, validation, and implementation of staffing models to ensure that staffing model-related efforts are prioritized and supported. VHA will complete organizational assessments of staffing, roles, and responsibilities using the Manpower Estimation Model tool to ensure adequate staffing assignments for these important functions.
3. VHA has completed the initial development, internal validation, and implementation of most staffing models for VHA and will provide a current listing and documentation of these models to OIG. VHA will also provide OIG documentation of a project timeline for development, validation, and implementation of any remaining staffing models.
4. VHA is in the process of completing standard operating procedures for all manpower processes within HR Smart and a standardized process for the identification and communication of positions approved by facility resources committees and a standardized format for manning documents.
5. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health coordinates with VA to review the roles, responsibilities, and number of staff required for the VA and Veterans Health Administration offices involved in the development, validation, and implementation of staffing models, and ensure that staffing model-related efforts are prioritized and supported.

Concur.

Target date for completion: March 2022

VHA Comments

VA OIG, at the outset of this report, defines staffing models as: “analytic tools that provide workload-based staffing data to support workforce optimization.” Under this definition and other common definitions of a staffing model, VHA’s Office of Productivity, Efficiency and Staffing (OPES) has already developed and validated staffing models for most if not all occupations and functional areas and made those available for implementation at VA Medical Centers nationwide. OPES will continue to adjust processes to keep pace with emerging and changing healthcare dynamics.

To ensure staffing model-related efforts are prioritized and supported, VHA Workforce Strategy and Standardization (WSS, formerly VHA Manpower Management) office will complete an organizational assessment using the Manpower Estimation Model which will help determine if OPES and WSS are appropriately staffed to continue the work of staffing model development and validation. WSS will support OPES in the continued work of staffing model development and implementation.

To close this recommendation VHA will provide:

1. The completed Manpower Estimation Model results for OPES and WSS; and
2. Documentation of sufficient staffing levels for the development, validation, and implementation of staffing models in VHA.

Recommendation 2

The Under Secretary for Health coordinates with VA to evaluate the status of, and provide a timeline for, the development, validation, and implementation of Veterans Health Administration staffing models for all occupations.

Concur.

Target date for completion: December 2021

VHA Comments

VA Directive 5010 identifies benchmarking as an acceptable approach to establishing staffing models. Using this definition, VHA has completed the initial development, internal validation, and implementation of most staffing models for VHA. OPES will continue to adjust processes to keep pace with emerging and changing healthcare dynamics in the creation of these models. WSS will work collaboratively with OPES to identify any models that may be missing or needed and will develop a timeline for development, validation, and implementation of identified models.

To close this recommendation VHA will provide:

1. A current listing of VHA staffing models and the definition and supporting documentation used for development; and
2. Timeline for development, validation, and implementation of missing or needed models.

Recommendation 3

The Under Secretary for Health coordinates with VA to evaluate the status of, and provide a timeline for, the implementation of HR Smart-related requirements referenced in VA and Veterans Health Administration policy, with a specific focus on the authorizations, vacancies, budgeted positions, and unbudgeted requirements at the facility, Veterans Integrated Service Network, and national levels.

Concur.

Target date for completion: October 2021

VHA Comments

Two VHA efforts are underway to address this recommendation. The first is a workgroup comprised of representation from VHA's Workforce Management and Consulting and field subject-matter experts to finalize the standard operating procedures for all manpower processes within HR Smart. VHA also established a national Transparency Integrated Project Team (IPT) comprised of Finance and Manpower staff from all levels of the organization to develop a standardized process to identify and communicate positions approved by facility resources committees and to develop a standardized format for manning documents.

To close this recommendation VHA will provide:

1. The final standardized processes developed by the IPT for facility implementation; and
2. The standardized format for manning documents together with a communication and training plan for implementation.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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