US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff

Audit	21-03544-111	July 19, 2023

BE A
VOICE FOR VETERANS
REPORT WRONGDOING
va.gov/oig/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more! Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The Veterans Health Administration (VHA) is responsible for providing veterans access to timely, high-quality health care. This includes paying for veterans to receive health care from providers in their local community when certain conditions are met, such as when VHA cannot provide the needed care, the wait time is too long, or the VA medical facility is too far away. VA medical providers use consult referrals to request care in the community for eligible veterans. Each VA medical facility has a community care department whose staff—both clinical and administrative personnel—are responsible for managing, reviewing, authorizing, scheduling, and completing referrals for care in the community.

The VA Office of Inspector General (OIG) and the Government Accountability Office published reports in January and September 2020, respectively, that identified challenges with community care department staffing.[1] The reports concluded that VHA needed to assess community care staffing, adjust staffing levels to effectively manage community care workload, and address staff recruitment and retention challenges. The need to ensure that community care departments are adequately staffed was also emphasized by the expansion of veterans' eligibility for community care under the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 and the subsequent steady increases in community care referrals from fiscal year 2019 to fiscal year 2022.[2]

VHA relies on data from HR Smart—VA's position management system—to analyze and document staffing levels and organizational structure for workforce optimization. Additionally, VHA's Office of Community Care (OCC) developed the community care staffing assessment tool to help VA medical facilities estimate staffing needs.[3] The tool uses facility input and considers average task times, workload data, staff positions involved, and other factors to estimate the number of clinical and administrative staff needed for each VA facility.

The OIG conducted this audit to determine whether VA medical facility leaders identified, authorized, recruited, and retained community care staff to meet increased demand for

[1] VA OIG, *Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities*, Report No. 18-05121-36, January 16, 2020; Government Accountability Office, *Improvements Needed to Help Ensure Timely Access to Care*, GAO-20-643, September 2020.

[2] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

[3] In June 2022, to improve veterans' access to care, VA merged the Office of Veterans Access to Care and OCC into one office called the Office of Integrated Veteran Care. During the scope of this audit, OCC was still functioning as the responsible program office for community care.

community care. The team assessed staffing for nurses and medical support assistants (MSAs) who are responsible for processing community care referrals.[4]

What the Audit Found

The OIG found that VHA does not have reliable data or sufficient tools to assess clinical and nonclinical community care staffing levels and needs at the network or national level. HR Smart has the capability to collect position data by service area—such as primary care or mental health—but not for all community care departments. VHA's Workforce Management and Consulting (WMC) program office provided the audit team with HR Smart staffing data using the organizational code for community care departments.[5] However, these data did not capture community care staff from at least 35 of 140 facilities that had community care departments. Facility leaders told the team that they used different organizational codes for community care based on that service's unique alignment and structure at their respective locations. WMC leaders agreed that consistent organizational codes should be used to identify community care staff across VA medical facilities and that an HR Smart report should be developed to accurately capture this information.

Similarly, the OIG team found that OCC's staffing assessment tool has limited usefulness because it relies on self-reported data that are not effectively verified. The tool is intended to capture positions that are dedicated to processing community care referrals. However, some facility staff erroneously reported authorized and filled positions that were dedicated to supporting other community care operations, such as supervisors and trainers—not just staff dedicated to processing referrals—leading to inconsistent data. These data are also used to populate a mandatory semiannual report to Congress.[6] Due to data entry errors and a lack of consistent validation or quality review, the team found instances where inaccurate information was carried forward into the congressionally mandated reports.

VHA uses staffing data to assess whether facilities have the resources to manage community care responsibilities and prepare for new initiatives. Therefore, it is critical that VA ensures accurate staffing data are available for decision-making, policy updates, and funding allocation to support veterans' access to care in the community.

[4] For more information about the audit's scope and methodology, see appendix A.

[5] Organizational codes identify the service to which an employee is assigned.

[6] VHA is required to send Congress a semiannual report (every 180 days) that contains personnel data by administrative and clinical positions for the community care department at each VA medical facility.

Facility Leaders Reported Confidence in Their Ability to Identify Community Care Staffing Needs

Facility community care leaders reported that they generally identified local staffing needs, and their resource management committees authorized the requested staff. Community care leaders told the audit team that they used a variety of information to justify their staffing requests, including data showing increased workload, referral backlog, internal staffing metrics, the number of referrals and the time to complete them, and the OCC staffing assessment tool. About 69 percent of facility community care leaders reported that the resource management committee generally authorized their staffing requests. Overall, community care leaders were able to identify staffing needs, and the resource management committee approved requests for additional staff.

Community Care Departments Generally Had Enough Nurses to Support Operations but Struggled to Recruit and Retain MSAs

Through interviews and a nationwide survey, the audit team found that most facilities could adequately recruit and retain nurses, but many could not recruit and retain MSAs.[7] The overwhelming majority of community care leaders the audit team surveyed believed that it was not difficult to recruit nurses (84 percent) or retain them (88 percent).[8] Similarly, the staffing assessment tool data reported a nationwide vacancy rate of 11 percent for community care nurses.[9]

However, despite taking steps to request and authorize MSA positions within their community care departments, 56 percent of facility community care leaders and 94 percent of Veterans Integrated Service Network (VISN) business implementation managers believed it was difficult to recruit MSAs, according to the team's survey. Barriers to recruiting MSAs included delays in the hiring and onboarding process, the lack of qualified applicants, and noncompetitive salaries. Facility leaders also stated that the turnover rate made it difficult to keep up with recruitment efforts.

Most facility community care leaders and VISN business implementation managers also believed that it was difficult to retain MSAs. Survey results revealed that 61 percent of community care leaders and 100 percent of business implementation managers reported that it was difficult to retain MSAs for their community care departments. According to these leaders, retaining MSAs

[7] Community care MSAs process referrals for non-VA care for veterans. These tasks include scheduling patient appointments and tracking, reviewing, and responding to electronic orders and referrals.

[8] Figures and averages in this report have been rounded to the nearest whole number.

[9] The audit team could not validate the vacancy rate for community care nurses due to previously noted data reliability concerns. The team presented this information to show that staffing assessment tool data, which are self-reported by VA facilities, did not conflict with the survey results.

is difficult because of burnout, complexity of workload, insufficient staffing to manage workload, and promotions and transfers within VA.

Consolidated Units Assisted Some Facilities in Managing Community Care Referrals

To assist with staffing shortages, five VISNs reported developing a consolidated community care unit to assist their facilities with processing community care referrals. Consolidated community care units allow several facilities in a VISN to share a group of MSAs to address referral backlogs, schedule referrals, retrieve and review veterans' records, and provide telephone support. These units may assist community care departments in processing referrals and mitigate some of the impact staffing shortages have on community care departments.

VA Leaders Reported Leveraging Incentives and Workplace Benefits to Recruit and Retain MSAs

The team learned that facilities used alternative work arrangements and monetary incentives to attempt to reduce MSA vacancies in their community care departments. These approaches included telework and monetary incentives to recruit and retain MSAs. The survey revealed that 108 of 124 community care leaders allowed MSAs to telework, 76 leaders used telework as a recruitment method, and 83 leaders used it to retain MSAs. The OIG survey revealed that nine of the 124 facility leader respondents (7 percent) used at least one type of monetary incentive to recruit or retain MSAs.[10]

Although these approaches could help improve MSA staffing levels, they are not required by VA policy. Additionally, the team could not definitively connect incentives to staffing levels and therefore could not determine the extent to which these incentives affect VHA's ability to recruit and retain MSAs to support community care. Community care leaders also told the team that they did not analyze data that would allow them to assess the impact of alternative work arrangements or monetary incentives on the MSA workforce.

What the OIG Recommended

The OIG made five recommendations to the under secretary for health to improve the reliability of community care staffing data and recruitment and retention of MSAs. The recommendations included implementing consistent data entry and reviews for HR Smart community care data, as well as developing staffing reports that can be searched by service departments to ensure appropriate resources are available. Further, the OIG recommended implementing policy to address the inconsistencies with the community care staffing assessment tool data and review the

[10] Monetary incentives may include special salary rates, recruitment and retention incentives, appointment above the minimum rate, and student loan repayment programs.

data for accuracy. The OIG also recommended assessing whether consolidated community care units would support veterans' access to community care and mitigate staffing shortages within VA medical facilities. Finally, the OIG recommended assessing incentives to determine whether they are effective in recruiting and retaining administrative staff.

VA Management Comments and OIG Response

The under secretary for health concurred or concurred in principle with all the recommendations. Appendix B provides the full text of the under secretary's comments. The proposed corrective measures in VHA's action plans are responsive to recommendations 1, 3, 4, and 5. These include providing training to the responsible VISN staff on the use of proper organizational codes, implementing procedures to improve the accuracy of the staffing assessment tool, assessing whether consolidated community care units should be implemented broadly to help mitigate the impact of staffing shortages, and analyzing incentive data to evaluate their effectiveness in recruiting and retaining administrative staff within community care departments.

The under secretary requested closure of recommendation 2, citing two existing staffing reports within HR Smart that can be searched by service departments to verify resources. However, because HR Smart data remains unreliable due to the continued inconsistent use of organizational codes, the reports cited by the under secretary are not responsive to the intent of the recommendation. The OIG will consider closing this and all other recommendations when VHA provides sufficient evidence that corrective actions have been taken.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

GS	General Schedule
IVC	Integrated Veteran Care
MSA	medical support assistant
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WMC	Workforce Management and Consulting

Introduction

The Veterans Health Administration (VHA) is responsible for providing veterans access to timely, high-quality health care through a nationwide system of medical facilities. VHA also pays for veterans to receive health care from providers in their local community when certain conditions are met, such as when VHA cannot provide the care needed, the wait time is too long, or the VA medical facility is too far away. VA medical facility providers use consult referrals to request care from community providers. If the veteran is eligible for community care, facility staff forward the consult referral to the community care department for scheduling. Each VA medical facility with a community care department has staff—both clinical and administrative personnel—responsible for managing, reviewing, authorizing, scheduling, and completing referrals for care in the community.

In January 2020, the VA Office of Inspector General (OIG) reported that Veterans Integrated Service Network (VISN) 8 experienced challenges with community care department staffing and structure that delayed processing patients' care with community providers.[11] The report concluded that it was critical for VHA to ensure necessary staffing resources were available for effectively managing community care workload. Further, in September 2020, the Government Accountability Office recommended that VHA assess its community care staffing and resource needs, develop strategies to adjust staffing levels to ensure veterans' appointments with community providers are scheduled in a timely manner, and address VA staff recruitment and retention challenges.[12]

The need to ensure adequate staffing in community care departments is also emphasized by the steady increase in community care referrals over the past five years. Figure 1 shows year-to-year increases in referrals from fiscal year 2019 to fiscal year 2022.

[11] VA OIG, *Improvements Are Needed in the Community Care Consult Process at VISN 8 Facilities*, Report No. 18-05121-36, January 16, 2020.

[12] Government Accountability Office, *Improvements Needed to Help Ensure Timely Access to Care*, GAO-20-643, September 2020.

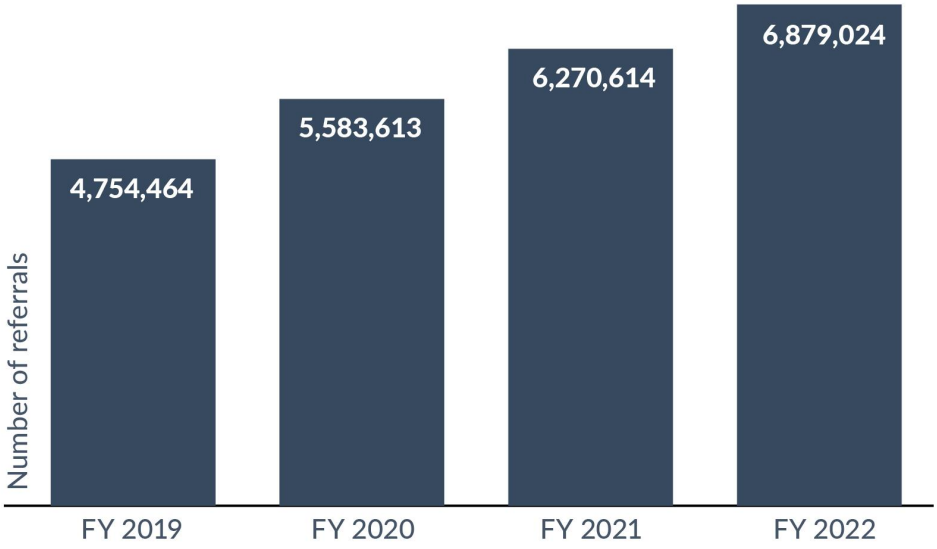

Figure 1. *Community care referrals from fiscal year 2019 through fiscal year 2022. Source: OIG analysis of VHA Support Service Center referral count data obtained October 31, 2022.*

In June 2018, Congress passed the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, which consolidated VHA's community care programs and expanded eligibility for care in the community, leading to an increase in referrals and workload.[13] To assist with implementing the MISSION Act, VHA launched a community care network in December 2018, which consisted of approved community providers administered by contractors in five networks. However, between 2018 and 2020, network providers did not perform all the duties that were completed by the previous contractors, resulting in additional workload for facility community care staff. Added responsibilities at the facility level included providing customer service, referring patients directly to community providers, and directly scheduling community care appointments for patients.

The OIG conducted this audit to determine whether VA medical facility leaders identified, authorized, recruited, and retained community care staff to meet increased demand for community care. The team assessed staffing for nurses and medical support assistants (MSAs) who are responsible for processing community care referrals.[14]

[13] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018); VHA, *MISSION Act Field Guide*, December 2019 release. The field guide implemented designed access standards pursuant to the act that allow patients to use community care if their average drive time is longer than 30 minutes for primary care or 60 minutes for specialty care, if VA cannot provide care within 20 days for primary care and 28 days for specialty care, if community care is in the patients' best medical interest, or if the VA service does not meet certain quality standards.

[14] For this report, the team uses "MSA" as a collective term for administrative staff, including MSAs, advanced MSAs, and program support assistants.

Roles and Responsibilities for Community Care Staffing

VHA's Workforce Management and Consulting (WMC) program office is responsible for manpower management. This requirement-based process ensures that VHA has the right staffing levels and organizational structure to promote the most efficient and economical use of resources. WMC does this by analyzing and documenting staffing levels and organizational structures for efficient use of resources within VHA. WMC also manages and maintains organizational structure and position data in HR Smart, VA's official human resources information system that supports personnel suitability, payroll, and position management. HR Smart organizes data by position, rather than by employee, and allows staff to access real-time human resources data, such as data related to current VA staff, gains and losses, and vacancies.

Regionally, VISN directors provide administrative and clinical oversight of VA medical facilities. VISN human resources departments are responsible for hiring and providing consultative services to VA medical facilities and for creating, updating, and maintaining positions in HR Smart. For example, human resources staff advise on strategies to support staff recruitment and retention, post job announcements, and make qualification determinations.

Locally, VA medical facility resource management committees and directors are responsible for reviewing staffing requests by services and allocating sufficient resources to enable management of referrals and timely delivery of care, including care in the community. In each facility's community care department, nurses and MSAs coordinate non-VA care for veterans:

- **Community care nurses.** Community care nurses are responsible for assessing the veteran's medical records, triaging, documenting clinical activities, and recommending a provider for the care. After the patient receives care from a community provider, the nurses review the returned records, assess the results of care provided, and document the assessment in the veteran's medical records.
- **Community care MSAs.** Community care MSAs process referrals for non-VA care for veterans. These administrative tasks include scheduling patient appointments and tracking, reviewing, and responding to electronic orders and referrals. MSAs must know how to use referral-scheduling software and understand basic medical terminology to ensure patients receive appropriate care. In addition, they are required to record patient messages and must be able to understand physician requests regarding medical care.

  The MSA position, regardless of assignment location, has General Schedule (GS) pay grade levels starting in the range of GS-3 to GS-5 ($11.86–$14.89 per hour).[15] Once the

[15] MSAs are assigned to work in outpatient clinics, inpatient units, call centers, and community care. Data pulled from VHA systems do not categorize MSAs by their work assignment; therefore, data reported on MSAs include all MSAs in the facility unless otherwise noted.

time-in-grade requirement is met, an individual can apply for an advanced MSA, a lead MSA, or a supervisory MSA position, with starting pay grades ranging from GS-6 to GS-8 ($16.60–$20.43 per hour).[16] Competitive appointment to a different occupational series is necessary for promotion above a supervisory MSA.

Community Care Staffing Tool

At the time of the audit, VHA's Office of Community Care (OCC) was responsible for managing nationwide programs that allow veterans to receive care and services from community providers.[17] OCC provides VA medical facilities with tools and metrics, such as the community care staffing assessment tool, to implement and execute community care responsibilities. The community care staffing assessment tool was released in May 2017 to help each VA medical facility estimate staffing needs and was revised in 2019 in light of the MISSION Act of 2018. To assist with meeting the expected increase in workload due to the act's expansion of eligibility for community care, VHA leaders also provided guidance on assessing staffing levels to identify positions that are filled or vacant.[18] As part of the focus on staffing levels, in March 2021, VHA issued a memorandum requiring facilities to complete a community care staffing assessment by March 15, 2021, and every 90 days thereafter.[19]

The staffing assessment tool was revised again in March 2022 to better anticipate staffing needs by position type (administrative and clinical) based on updated average task times, workload data, and other tasks.[20] VA is required by law to review staffing, training, and other requirements needed for the community care program.[21] VISN directors are required to ensure that the data are updated in the staffing tool every 90 days.[22] The updated data in the community care staffing tool are then submitted by VA to Congress in a report every 180 days.[23]

[16] These are the GS hourly basic pay rates for 2022. Pay rates may be higher for employees in some geographic areas due to special rates established by the Office of Personnel Management.

[17] In June 2022, to improve veterans' access to care, VA merged the Office of Veterans Access to Care and OCC into one office called Integrated Veteran Care. During the scope of this audit, OCC was still functioning as the responsible program office for community care.

[18] VHA, *MISSION Act Field Guide*.

[19] VHA assistant under secretary for health operations, "National Implementation of the Community Care Operating Model Staffing Tool," memorandum to the Veterans Integrated Service Network directors, March 1, 2021.

[20] Other tasks include community care work that does not involve processing referrals or coordinating care, such as meetings, training, and congressional research.

[21] Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, Pub. L. No. 116-315, § 3103(a)(1), 134 Stat. 5004 (2020).

[22] VHA assistant under secretary for health operations, "National Implementation of the Community Care Operating Model Staffing Tool," memorandum.

[23] The congressionally mandated report contains personnel data by administrative and clinical positions for the community care department at each VA medical facility.

Community Care Staffing Request Process

Positions in VA medical facilities must be identified, requested, authorized, and funded before recruitment actions can begin. In general, the facility director authorizes and funds current and vacant staff positions—including those in the community care department—at the beginning of the fiscal year. Once positions have been identified, authorized, and funded, the community care department can submit a recruitment package to human resources when positions become vacant throughout the year.

For positions that are not funded at the beginning of the year, community care department leaders must use the following process:

- Submit a request to their supervisor that includes the number of requested staff along with a justification for the additional staff (including staffing levels recommended by the OCC staffing assessment tool, data showing increased workload, referral backlog, and budget data).
- If approved, submit the request to the resource management committee to obtain final approval from the facility director.
- Submit a complete recruitment package validating the hiring need to human resources for recruitment after the facility director approves the request.

Figure 2 illustrates these staffing request processes.

Figure 2. *Community care staffing request processes.*

Source: VHA Time to Hire (T2H) Implementation Guidebook 2.0, VHA Office of Community Care Operating Model, VA Handbook 5005, and interviews with VA community care leaders.

Results and Recommendations

Finding: VHA Lacks Reliable Data to Address System-Wide Community Care Staffing Needs, but Medical Facilities Reported Taking Steps to Address Local Workforce Challenges

VHA does not have reliable data or sufficient tools to assess community care staffing needs. HR Smart—VA's position management system—cannot be used to reliably assess community care staffing levels and needs at the network or national level because facilities did not consistently use the same organizational code to identify community care departments. According to WMC leaders, positions aligned with community care operations should be classified using the same organizational code. Using the same code allows meaningful comparisons across the organization. However, facility leaders stated they use at least five other organizational codes to identify community care staff. This is a persistent problem, and VA is working to implement recommendations from previous OIG reports to address the integrity of HR Smart data.[24]

OCC's staffing assessment tool also has limited usefulness because it relies on self-reported staffing data that are not effectively verified. The team determined that some facilities erroneously included data on positions that were dedicated to supporting other community care operations—not just those dedicated to processing referrals. Importantly, OCC also did not develop and implement an effective process to verify medical facilities' entries and minimize data entry errors.

Despite these nationwide challenges, medical facilities generally took actions within their control to staff their community care departments. Facility community care leaders were able to identify local staffing needs, and resource management committees generally authorized these staffing requests. However, community care leaders who completed the OIG survey believed that filling authorized MSA vacancies was challenging nationwide because of noncompetitive salaries and lack of qualified applicants. According to the survey results, complex workloads and burnout also made it difficult for facilities to retain MSAs once hired.

Some VISNs reported taking steps to address persistent community care staffing shortages. For example, five VISNs established consolidated community care units to support facilities struggling to maintain the MSA staffing levels needed to process community care referrals.[25]

[24] VA OIG, *Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency*, Report No. 20-00541-133, June 10, 2021.

[25] Consolidated community care units allow facilities in a VISN to share a group of MSAs to address referral backlogs, schedule referrals, retrieve and review veterans' records, and provide telephone support. Although consolidated units reported difficulty recruiting and retaining MSAs, the units compensate for staffing vacancies in community care departments and assist in meeting responsibilities by processing community care referrals.

Facility leaders also reported using incentives to recruit and retain MSAs. However, the extent to which these incentives, along with workplace benefits such as telework, measurably affect VHA's ability to retain MSAs to support community care is unknown.

The following determinations formed the basis for this finding and led to the OIG's recommendations:

- Persistent HR Smart data integrity issues limit VHA's ability to determine medical facilities' community care staffing needs.
- OCC's staffing assessment tool data were not consistently reported or validated.
- Facility leaders reported confidence in their ability to identify the number of MSA staff needed to handle the local community care workload.
- Community care departments generally had enough nurses to support operations but struggled to recruit and retain MSAs.
- Some VISNs used a consolidated unit to help facilities manage community care referrals.
- Facility leaders reported leveraging incentives and other available workplace benefits to recruit and retain MSAs.

What the OIG Did

To determine whether VHA had the resources to support community care staffing decisions, the audit team analyzed staffing data from HR Smart and the OCC staffing assessment tool. The team also interviewed community care and VISN leaders about the community care staffing process, the staffing assessment tool, recruitment, retention, and how they compensate for staffing deficiencies. Additionally, the team administered online surveys from May 2022 through June 2022. The online survey had a response rate of 124 out of 140 community care leaders (89 percent) and 18 out of 18 VISN business implementation managers. For more information about the audit's scope and methodology, see appendix A.

Persistent HR Smart Data Integrity Issues Limit VHA's Ability to Determine Medical Facilities' Community Care Staffing Needs

VHA's staffing data cannot be used to reliably assess clinical and nonclinical community care staffing levels and needs, either at the network or national level. According to WMC leaders, HR Smart has the capability to collect data for administrative and clinical positions by service area—such as primary care or mental health—but not for all community care departments. In response to the team's request for aggregate community care staffing data, WMC used the HR Smart organizational code for community care departments to develop an Excel spreadsheet. The team found that the Excel spreadsheet did not include community care staff from at least 35 of 140 VA medical facilities.

When asked about the missing information, facility leaders told the team that they used different organizational codes for community care in HR Smart based on the community care staff's unique organizational alignment and structure at their respective locations. For example, the team found that some community care staff were aligned under elements such as connected care, chief of staff, nursing operations, business office, or health administration services. WMC leaders acknowledged they have not developed a report that can consistently identify community care department staff and recognized that the data were inconsistent due to different organizational codes used by facilities. WMC leaders agreed that consistent organizational codes should be used to identify community care staff across VA medical facilities and that a report should be developed within HR Smart to accurately capture this information. This report would help VHA and VISN leaders identify issues, develop strategies, and assess workforce productivity regarding community care staffing.

A 2021 OIG report identified data integrity issues with HR Smart and concluded that further governance is needed to ensure that VA's staffing position data are consistent and reflect the true status of staff.[26] The OIG recommended VA develop a plan to independently test and validate HR Smart position data to provide greater assurance that VA's staffing needs are accurately represented. Further, the OIG recommended that VA establish standard guidance to ensure staffing positions are consistently approved, created, and maintained and that VA implement oversight mechanisms to monitor position management on a regular basis and ensure the HR Smart position inventory is properly maintained. As of March 2023, VA's corrective actions remain in progress and all report recommendations were open as unimplemented.

OCC's Staffing Assessment Tool Data Were Not Consistently Reported or Validated

The OIG found that VHA relies on self-reported data to estimate staffing needs for community care positions that process referrals. However, these data, populated in the OCC staffing assessment tool, were not consistently reported by VA facility leaders. According to OCC leaders, they did not validate the data. The team found examples where community care leaders were entering information on authorized and filled positions that were dedicated to supporting other community care operations such as supervisors and managers—not just those dedicated to processing referrals.

[26] VA OIG, *Inconsistent Human Resources Practices Inhibit Staffing and Vacancy Transparency*.

OCC has issued new guidance in response to changes to the community care program. Specifically, OCC updated guidance over a four-year period:

- In 2019, OCC updated the staffing tool and issued guidance to account for new community care responsibilities. The guidance stated staff who do not complete community care tasks should not be included in staffing totals.
- In 2021, OCC guidance stated all staff within the community care department, except supervisors, should be included in staffing totals. However, according to an OCC leader, only staff who process referrals should be captured on the staffing assessment tool.
- In March 2022, OCC issued new guidance that stated if supervisors process referrals, they should also be included in these numbers; otherwise, they should be excluded from the count. An OCC leader told the team that the community care staffing assessment tool should capture contractor staff who are onboard and who process community care referrals. In contrast, although OCC guidance noted the tool captures the current number of detailed or contracted staff, it did not specifically state to count only the ones who were actively processing referrals.

In short, despite these guidance updates, facility community care leaders inconsistently captured information for the number of staff approved and onboard in the staffing tool, hindering the usefulness of this information to support staffing level decisions.

For instance, the OIG team found that all eight of the VISN 1 facilities reviewed had miscounted staff in their February 2022 staffing assessment tool data entry. This resulted in VA reporting 248 authorized administrative staff for VISN 1 collectively, even though facility community care leaders told the team that there were only 199 authorized staff responsible for community care referrals. The team determined that community care leaders misunderstood which staff to count at that time.

In another example, a VISN 19 community care department had a contract for 20 MSAs and counted all 20 as onboard staff who processed community care referrals on the staffing assessment tool. However, a community care department leader told the team that at the time the data were collected, there were four contract vacancies. The team concluded only 16 of the 20 contracted staff should have been included in the count.

Staffing assessment tool data are also used to populate the mandatory semiannual report to Congress.[27] An OCC leader stated they spot-check the data, and if something looks like an outlier, they follow up with the VISN point of contact. The OCC leader also told the audit team that the VISN business implementation managers should validate the data in conjunction with

[27] VHA is required to send a semiannual report to Congress (every 180 days) including personnel data by administrative and clinical positions for the community care department at each VA medical facility.

OCC. However, the team found instances in which facility staff made data entry errors, and OCC did not identify the errors in the congressionally mandated reports. For example, in the December 2021 report, one VISN 2 community care department reported that it did not have any community care staff working during the reporting period.[28] However, the facility's community care leaders told the team that they had 21 MSAs and 11 clinical staff onboard. In the same report, a VISN 1 facility reported having no clinical staff working, even though community care leaders confirmed they had 10 clinical staff onboard during this period.

The team also identified errors in congressionally mandated reports that appeared to result from a lack of quality review. For example, the June 2022 report stated that one VISN 8 facility required 1,011 administrative staff rather than 101 staff. This error appeared to be a typo that was not corrected before the report was released. Another example in the same report was a VISN 23 facility that reported having 36 administrative staff approved but 355 staff onboard, suggesting that there were 319 additional staff processing referrals above the approved amount. In both instances, the team confirmed that the data published in the report were inaccurate.

As shown in the previous examples, the data provided by VHA, at least in some instances, were not validated and were inaccurate. Staffing data are used to assess whether facilities have the resources to manage community care responsibilities and prepare for new initiatives.[29] Having sufficient community care staff is integral to providing veterans access to community care. Therefore, it is critical that VA ensure accurate staffing data are available for decision-making, policy updates, and funding allocation to support veterans' access to care in the community.

Facility Leaders Reported Confidence in Their Ability to Identify the Number of MSA Staff Needed to Handle the Local Community Care Workload

According to interviews and survey results, facility community care leaders reported that they generally identified local staffing needs, and their resource management committees authorized the requested staff. For instance, about 69 percent of facility community care leaders reported on the OIG's survey that the resource management committees authorized their latest staffing requests.[30] Community care leaders told the team that they used a variety of information to justify their staffing requests, including data showing increased workload, referral backlog, internal staffing metrics, the number of referrals and the time to complete them, and the OCC

[28] VA, *Congressionally Mandated Report: Report on the Administration of Non-Department of Veterans Affairs Health Care (B)*, December 2021.

[29] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014. According to these standards, managers should use quality information to achieve the entity's objectives to make informed decisions and evaluate the entity's performance in achieving key objectives and addressing risks.

[30] Figures and averages in this report have been rounded to the nearest whole number.

staffing assessment tool.[31] Community care leaders also developed a timeline specific to their internal community care process to determine how long referral tasks should take, which helped them identify the number of staff needed in their respective departments.

Community Care Departments Generally Had Enough Nurses to Support Operations but Struggled to Recruit and Retain MSAs

Although facility community care leaders generally identified staffing needs, they were not consistently able to recruit and retain personnel for all the needed positions. Through interviews with community care leaders at 16 facilities in VISNs 1 and 19 as well as a nationwide survey, the audit team found that facilities could generally recruit and retain nurses but not MSAs.

Overall, most community care leaders believed that it was not difficult to recruit and retain nurses in their community care departments. Of the 124 community care leaders who responded to the survey, 84 percent believed that it was not difficult to recruit nurses, and 88 percent believed it was not difficult to retain nurses. Similarly, the staffing assessment tool reported a nationwide vacancy rate of 11 percent for community care nurses.[32]

However, VHA had difficulty recruiting and retaining MSAs. Despite facilities taking steps to request and authorize positions for their community care departments, staffing assessment tool data from June 2022 showed that 47 of 140 facilities (34 percent) had a vacancy rate of 25 percent or greater for administrative staff, with some facilities experiencing vacancy rates as high as 64 percent. These numbers could be overstated or understated due to data integrity and validation concerns discussed previously in this report.

Beyond the nationally reported data, facility community care leaders and VISN business implementation managers reported that it was difficult to recruit MSAs. When interviewed about barriers encountered in recruiting MSAs, five of 16 leaders (31 percent) stated it was difficult to recruit qualified applicants because the MSA position requires specialized experience, such as knowledge of medical terminology. For example, a VISN 19 facility leader stated they had 15 candidates for an MSA GS-6 position, but only three candidates were qualified and eligible for interviews. Additionally, six of 16 leaders (38 percent) stated that noncompetitive salaries make it difficult to recruit MSAs. They cited examples such as local healthcare systems paying wages up to an additional $4 per hour or offering sign-on bonuses up to $6,000.

The OIG survey results showed that 56 percent of community care leaders and 94 percent of business implementation managers believed it was difficult to recruit MSAs. Community care

[31] Even though 83 percent of community care leaders surveyed believe the staffing tool may not accurately represent the needs of their department, 77 percent of respondents reported using the tool as part of their justification.

[32] The audit team could not validate the vacancy rate for community care nurses due to previously noted data reliability concerns. The team presented this information to show that staffing assessment tool data, which are self-reported by VA facilities, did not conflict with the survey results.

leaders were also asked to select the top five reasons why it was difficult to recruit MSAs. About 83 percent of these leaders identified delays in the hiring and onboarding process as a barrier to recruitment. For example, one respondent stated that it takes two months on average after a candidate was selected to receive a final offer, and several candidates declined the offer as a result. The overall time-to-hire was also frequently cited. For instance, the year-to-date average time needed to hire an MSA at a VISN 19 VA medical facility was 130 days, as of May 2022.[33] Facility community care leaders also stated that the lack of qualified applicants, noncompetitive salaries, and the turnover rate made it difficult to keep up with recruitment efforts.
Figure 3 shows the top five barriers to recruiting MSAs reported by community care leaders.

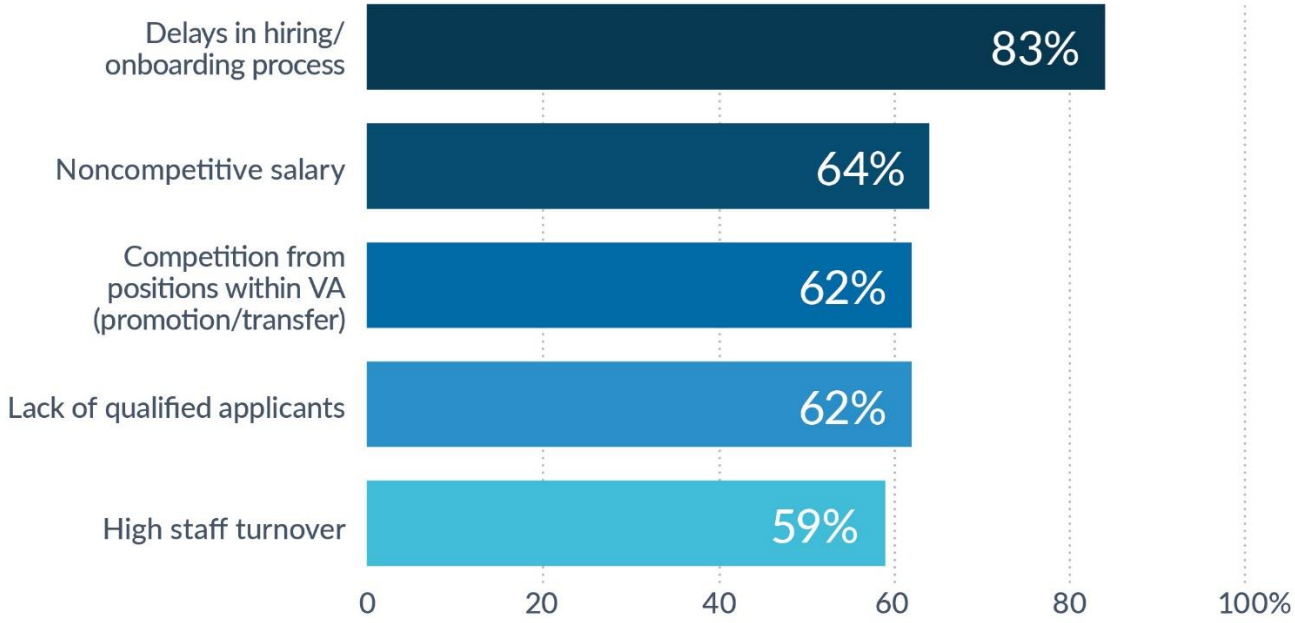

Figure 3. *Top five reasons for MSA recruiting difficulties.*

Source: OIG analysis of community care staffing survey results.

Another reason facility and VISN community care leaders believed they did not have enough MSAs to manage referrals is because they had difficulty retaining staff. From fiscal year 2018 through fiscal year 2022, VHA experienced an 11 percent loss rate for all MSAs regardless of assignment location.[34] This exceeded the five-year growth rate of about 7 percent during the same period. During interviews with the audit team, facility leaders stated that one cause of the retention problem is that staff learn the job, gain experience, and progress to

[33] Time-to-hire is the period from when the need to fill a position is verified to when a newly hired employee begins their first day of work. The time-to-hire target is 80 days.

[34] The loss rate and growth rate were extracted from a WMC-created dashboard within VA's Power Business Intelligence software. The audit team accepted VHA's data and did not perform additional substantive analyses or testing for accuracy. Further, the data include all MSAs across VA medical facilities, not just facility community care departments.

higher-paying positions outside of the community care department after they meet time-in-grade requirements. According to community care leaders, these positions are often internal to the medical facility or at nearby Veterans Benefits Administration offices.

The OIG survey results revealed that 61 percent of community care leaders and 100 percent of business implementation managers expressed that it was difficult to retain MSAs for their community care departments. As reflected in the survey, community care leaders identified burnout, insufficient staffing to manage workload, complexity of workload, competition from positions within VA (promotions/transfers), and lack of promotion opportunities as the top five barriers to retaining MSAs. According to a VISN 19 medical facility community care leader, their community care department had 14 MSA vacancies within a one-year period. They had hired internal MSAs who worked in the clinical setting, but these employees often go back to their original jobs because of the high volume of referrals, the complexity of the workload, and the fast pace of work in the community care department. Figure 4 depicts the top five barriers to retaining MSAs reported by community care leaders.

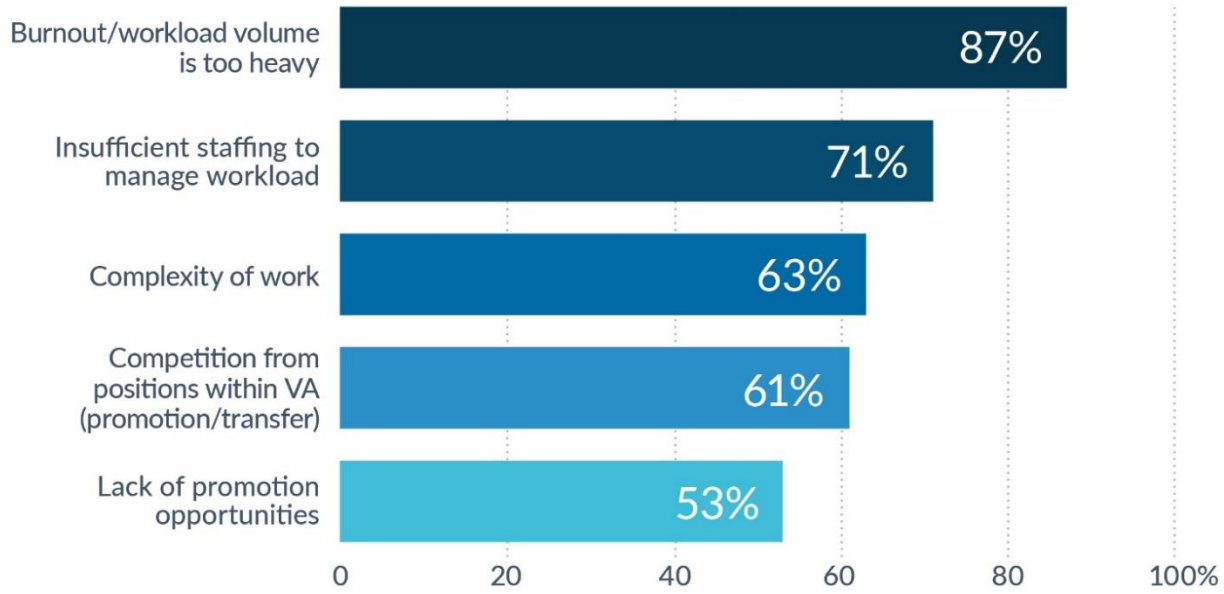

Figure 4. *Top five reasons for MSA retention difficulties.*

Source: OIG analysis of community care staffing survey results.

Some VISNs Used a Consolidated Unit to Help Facilities Manage Community Care Referrals

Some VISNs reported taking steps to address the challenges posed by community care staffing shortages. Of the 18 business implementation managers surveyed, five reported that VISNs 4, 5, 16, 19, and 20 used consolidated community care units in addition to local facility staff to mitigate staffing shortages and assist community care departments in reducing referral backlogs, scheduling referrals, retrieving and reviewing medical records, and providing

telephone support. Although these consolidated units may not assist directly with recruiting and retaining staff at each medical facility, they indirectly affect staffing because they assist community care departments in processing community care referrals.

For example, the VISN 19 community care manager reported the consolidated unit had 27 staff onboard as of October 2022. Typically, the unit assists multiple facilities at the same time and uses a different number of staff depending on the facility's needs. For example, the VISN 19 consolidated unit assisted a facility community care department from January 31 through February 11, 2022. During that period, the consolidated unit focused on processing active referrals. According to the facility's community care chief, the active referrals improved, dropping from 10,408 to 8,678. The community care chief stated that the active referrals began increasing after the consolidated unit's assistance was completed, reaching 11,260 active referrals as of May 2022.

VISN leaders may want to consider whether a consolidated community care unit could help mitigate the impact of staffing shortages and help improve veterans' access to care in the community.

Facility Leaders Reported Leveraging Incentives and Other Available Workplace Benefits to Recruit and Retain MSAs

During the audit, the team learned that several facilities used alternative work arrangements and monetary incentives to attempt to reduce vacancies in their community care departments. For example, telework arrangements allow employees to work part of the time from an alternative location (i.e., from a telework site or from home). Telework is not a universal employee benefit, right, or entitlement, and agency leaders determine who or what positions are appropriate for telework. The survey revealed that 108 of 124 community care leaders allowed MSAs to telework, 76 leaders used telework as a method to recruit, and 83 leaders used it to retain MSAs. Since the onset of the COVID-19 pandemic, VA medical facilities are increasingly offering telework to administrative staff. With the pandemic easing, some facilities have continued to offer telework, citing that this flexibility has assisted with recruiting and retaining staff.

The team also learned that noncompetitive salaries and competition from positions within VA and local markets are top challenges affecting the recruitment and retention of MSAs. Once all recruitment and retention considerations have been exhausted, monetary incentives such as special salary rates can be used to move toward adequate staffing levels at VA medical facilities. Requests for monetary incentives must clearly identify the nature and extent of any recruitment and retention problems and the effect on patient care. Facility directors are responsible for reviewing requests to ensure there is a need for monetary incentives, approving incentives up to a certain threshold, and canceling incentives when no longer appropriate.

According to the OIG survey, nine of 124 facility leader respondents (7 percent) used at least one type of monetary incentive to recruit or retain MSAs, such as special salary rates, appointment

above the minimum rate, and student loan repayment programs.[35] Facilities that implemented monetary incentives have collectively increased their MSA staff from 282 to 363 (29 percent) from October 2021 to June 2022. However, the team could not definitively connect monetary incentives to this increase in staff.

Although these approaches could assist with MSA staffing levels, they are not required by VA policy, and the team could not determine the extent to which particular incentives affect VHA's ability to recruit and retain MSAs to support community care. Further, staff from 16 facilities told the team that they do not analyze data that would allow them to determine the impact of incentives or workplace flexibilities on their MSAs. Without assessing the use and success of incentives or workplace flexibilities, VHA cannot make informed decisions for future use or the need for other tools to assist with recruiting and retaining staff.

Conclusion

The OIG found that the system and tools used to support staffing assessments and make policy decisions for community care are unreliable. Accurately identifying and capturing the number of authorized and onboard personnel in facility community care departments are fundamental to ensuring VHA leaders can make informed management decisions and resolve program weaknesses. Until formal policy, procedures, and effective oversight are established, VHA cannot ensure the accuracy of community care position data and make strategic personnel decisions that reflect the true staffing needs of its facilities.

Despite these challenges, VA medical facilities generally took actions within their control to staff their community care departments. Community care leaders identified staffing needs, and facility resource management committees generally authorized staffing requests submitted by the community care department leaders. However, community care department leaders experienced difficulty recruiting and retaining MSAs after positions were authorized. VISN and facility leaders used methods such as consolidated units, telework, or monetary incentives to mitigate staffing vacancies. VA should assess whether consolidated community care units could be more broadly used to offset staffing needs, and facility leaders could assess whether incentives, such as telework and special salary rates, could help recruit and retain qualified MSAs and support veterans' access to care in the community.

Recommendations 1–5

The OIG made the following recommendations to the under secretary for health:

[35] VA Handbook 5007, "Authorization of Individual Appointments Above the Minimum Rate of the Grade," part 2, chap. 3 in *Pay Administration*, December 6, 2007. The handbook states that authorized officials may appoint VHA GS patient-care personnel at rates of pay above the minimum rate of the appropriate grade based on higher or unique qualifications or special needs of VA.

1. Implement consistent data entry, standardized organizational codes, and periodic reviews for HR Smart community care data.
2. Develop staffing reports that can be searched by service departments to ensure appropriate resources to meet their assigned missions.
3. Improve usability of the staffing assessment tool by implementing policy to address the inconsistencies with staffing data entry and review the reported data for accuracy.
4. Assess whether consolidated community care units would more broadly support veterans' access to community care and help mitigate the impact of staffing shortages, and, if so, develop a project management plan for implementing those units.
5. Assess the use of monetary and nonmonetary incentives to evaluate whether they are effective in recruiting and retaining administrative staff within community care departments.

VA Management Comments

The under secretary for health concurred with recommendations 1, 2, 4, and 5 and concurred in principle with recommendation 3. The under secretary provided action plans for four of the five recommendations, stating that no further action was needed to address recommendation 2. Appendix B provides the full text of the under secretary's comments.

In response to recommendation 1, the under secretary stated that WMC's Workforce Strategy and Standardization team has implemented standardized organizational codes and plans to provide training to the responsible VISN staff to ensure use of the proper codes. Additionally, the WMC team will require a full review by VISN Manpower to ensure that all community care staff are assigned the correct organizational code and that these staff are performing community care functions. After the initial training and mandatory review, staff will receive training on a regular basis, and an annual review will be required. The under secretary provided a target completion date of July 2023.

Regarding recommendation 2, the under secretary stated that two staffing reports already exist in HR Smart that can be searched by service departments to verify resources. The reports include all active positions, both vacant and encumbered, and allows for review of the approved full-time equivalent positions for the community care function. The under secretary further stated that since these reports already exist, new reports do not need to be developed. The under secretary requested closure of this recommendation.

For recommendation 3, the VHA Office of Integrated Veteran Care (IVC) recognized there are opportunities for improvement with the current staffing tool and how the tool is used by staff in the field. To improve the staffing assessment tool and the accuracy of data entry, IVC will implement standard operating procedures. The under secretary provided a target completion date of September 2023.

To address recommendation 4, WMC will partner with IVC to assess existing consolidated community care units and determine whether a broader implementation of such units would better support veterans' access to community care and help mitigate the impact of staffing shortages. Based on that assessment, WMC and IVC will develop a report along with recommendations and, if warranted, a project plan to further implement consolidated community care units. The under secretary provided a target completion date of March 2024.

For recommendation 5, VHA agreed that an analysis of the available incentive data is warranted. However, VHA stated that it is difficult to make definitive judgments about the value of incentives without a controlled study. WMC will match incentive use data with recruitment and retention data, evaluate the effectiveness of and need for incentives in recruiting and retaining administrative staff with community care departments, develop an action plan to educate the field on the use of incentives, and deliver a report on their findings. The under secretary provided a target completion date of September 2023.

OIG Response

The OIG considers the corrective action plans provided by the under secretary to be responsive to the intent of recommendations 1, 3, 4, and 5. Regarding recommendation 1, the OIG acknowledges that VHA had established an organizational code for community care and that this is a step toward standardizing consistent code usage across VA medical facilities. The OIG will close this recommendation once VHA provides sufficient evidence showing the community care organizational code is consistently used and the data is periodically reviewed. The OIG will monitor the implementation of the planned actions for the other recommendations and will close them once VHA has provided sufficient evidence of corrective action.

However, the OIG does not consider the under secretary's comments to be fully responsive to the intent of recommendation 2. As discussed previously in this report, WMC leaders and staff told the audit team that HR Smart does not possess the capability to provide a summary report of community care department employees due to the inconsistent use of organizational codes. Further, the spreadsheet provided by WMC to the audit team used HR Smart data and did not include community care staff from at least 35 of 140 VA medical facilities. Because HR Smart data remains unreliable due to inconsistent use of organizational codes, the reports cited by the under secretary do not meet the intent of the recommendation. The OIG acknowledges that, if given reliable data, HR Smart's existing report-generating capabilities may be sufficient to produce a searchable, accurate report that identifies community care department staff; however, because the OIG cannot confirm that this is the case until VHA produces such a report, recommendation 2 will remain open.

Appendix A: Scope and Methodology

Scope

The team conducted its work from December 2021 through April 2023. The audit focused on whether VA medical facility leaders identified, authorized, recruited, and retained staff to meet increased demands in community care. The team assessed staffing for nurses and medical support assistants (MSAs) who were responsible for processing community care referrals. The team conducted interviews with staff from Veterans Integrated Service Network (VISN) 1, VISN 19, and the following affiliated facilities:

- VISN 1, Bedford, Massachusetts
  - VA Connecticut Healthcare System, West Haven, Connecticut
  - VA Maine Healthcare System–Togus, Augusta, Maine
  - Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts
  - VA Boston Healthcare System, Jamaica Plain, Massachusetts
  - VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts
  - Manchester VA Medical Center, Manchester, New Hampshire
  - Providence VA Medical Center, Providence, Rhode Island
  - White River Junction VA Medical Center, White River Junction, Vermont
- VISN 19, Glendale, Colorado
  - VA Eastern Colorado Health Care System, Aurora, Colorado
  - VA Western Colorado Health Care System, Grand Junction, Colorado
  - Fort Harrison VA Medical Center, Fort Harrison, Montana
  - Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
  - Oklahoma City VA Health Care System, Oklahoma City, Oklahoma
  - VA Salt Lake City Health Care System, Salt Lake City, Utah
  - Cheyenne VA Medical Center, Cheyenne, Wyoming
  - Sheridan VA Medical Center, Sheridan, Wyoming

The team used multiple sources of information, including applicable directives, Veterans Health Administration (VHA) policies and procedures, and community care staffing data. The team obtained testimonial and documentary information from program officials and staff in various

offices across the country, including the Office of Community Care (OCC), the Workforce Management and Consulting (WMC) office, VISNs, and medical facilities.

Methodology

To determine whether VA medical facility leaders identified, authorized, recruited, and retained community care staff to meet increased demands in community care, the team reviewed staffing data for nurses and MSAs; these data were obtained from facilities, OCC, and WMC. The team also reviewed and evaluated testimonial and documentary evidence from VISNs, OCC, and WMC to determine their responsibilities and oversight of VHA community care staffing. The team reviewed and evaluated testimonial and documentary evidence obtained from medical facilities to identify processes for requesting and approving staff, barriers to recruiting and retaining staff, and strategies for addressing those barriers.

The team conducted an online survey of 140 VA medical facility community care leaders and 18 VISN business implementation managers to gather and quantify information and leaders' opinions on community care staffing.[36] As of June 2022, 124 community care leaders and 18 business implementation managers responded, for a response rate of 89 percent and 100 percent, respectively, and the team reviewed and analyzed the responses.

Internal Controls

The team assessed the internal controls of community care staffing significant to the audit objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[37] During this audit, the team identified internal control weaknesses significant to the objective for the following components and principles and proposed three recommendations specific to them:[38]

- Component: Information and Communication
    - Principle 13: Management should use quality information to achieve the entity's objectives.
- Component: Monitoring
    - Principle 16: Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.

[36] The audit team used the community care staffing assessment tool to identify the number of VA medical facilities that have community care departments.

[37] Government Accountability Office, *Standards for Internal Control in the Federal Government.*

[38] Because this audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators but did not identify any instances of fraud during this audit.

Data Reliability

The team assessed the reliability of community care staffing data across VA medical facilities obtained from OCC. To test the data, the team reviewed and compared the staffing data to survey results, congressional reports, and inquiries with VA medical facility leaders. Because the team identified potential errors within the staffing data, the team could not verify the reliability and accuracy of the data. These results are discussed in the finding of this report.

The team also assessed the reliability of computer-processed data obtained from WMC. Specifically, the team obtained a list of community care staff across VA medical facilities from WMC. To test the data, the team reviewed and compared the staffing data to organizational charts from VA medical facilities. The team could not determine whether the list provided by WMC matched the organizational charts obtained from the VA medical facilities. Therefore, the team could not verify that the data were reliable, as discussed in this report.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objective.

Appendix B: VA Management Comments, Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: May 24, 2023

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff (2021-03544-AE-0177)

To: Assistant Inspector General for Audits and Evaluations (52)

Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff. The Veterans Health Administration (VHA) concurs and concurs in principle with the recommendations and provides an action plan in the attachment.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal. M.D., MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Community Care Departments Need Reliable Staffing Data to Help

Address Challenges in Recruiting and Retaining Staff

(2021-03544-AE-0177)

Recommendation 1: Implement consistent data entry, standardized organizational codes, and periodic reviews for HR Smart community care data.

VHA Comments: Concur. A standardized organizational code (org code) is already established for the function of Community Care (org code 2455), with the description reading "Community Care." For those community care positions aligned outside the organizational function of Community Care, there is also a special population code of "Community Care" that is used as an identifier. These two codes were put in place in June 2021. These codes then come together as a Department ID which is labeled "Community Care" for the Department Description.

VHA has already completed several steps to ensure standardized org codes. Specifically, the Workforce Management and Consulting (WMC) Workforce Strategy and Standardization (WSS) team has implemented standardized org codes and organizational titling that are to be used in department creation. The WMC Workforce Data Systems (WDS) team manages the submission of any requests for new departments to ensure that the established codes and titles stay consistent. This ensures that any departments created conform to the specific titling and functions of the department.

In the near future, WMC WSS will provide training to the Veterans Integrated Service Network (VISN) Manpower staff to ensure they are using the proper codes and require a full review by VISN Manpower to ensure that all community care staff are coded with org code 2455 or the special population code of "Community Care" and that all staff who are coded with org code 2455 or the special population code of "Community Care," are performing community care functions. After the initial training and mandatory review, training will be provided on a regular reoccurring basis and an annual review will be required.

Status: In Progress Target Completion Date: July 2023

Recommendation 2: Develop staffing reports that can be searched by service departments to ensure appropriate resources to meet their assigned missions.

VHA Comments: Concur. The staffing reports in the recommendation already exist, therefore, they do not need to be developed. There are two staffing reports within HR Smart that can be searched by service departments to verify resources. These reports have been available in HR Smart for more than a year. They are the POSN report, which includes all active positions, both vacant and encumbered, and the Workforce Roster, which identifies only encumbered positions. These reports allow for review of the approved Full Time Equivalent (FTE) positions for the Community Care or any other function and allow facility leaders and others to assess the FTE that have been approved in their facilities to ensure that the necessary resources have been approved. As these reports already exist, this work is complete, and we are requesting that OIG consider this recommendation for closure.

Status: Complete

Completion Dates:

Workforce Roster March 20, 2018

POSN Report April 3, 2020

Recommendation 3: Improve usability of the staffing assessment tool by implementing policy to address the inconsistencies with staffing data entry and review the reported data for accuracy.

VHA Comments: Concur in Principle. The VHA Office of Integrated Veteran Care (IVC) recognizes there are opportunities for improvement with the current staffing tool and how the tool is used by staff in the field. To improve the staffing assessment tool and the accuracy of data entry, IVC will be implementing strong standards through a Standard Operating Procedure. We do not feel the need to create a directive, therefore, we concur in principle with the recommendation.

In March 2022, an improved staffing tool was deployed by IVC. This improved tool reduces the unreliability of some of the self-reported data by pre-populating workload data. These pre-populated fields no longer allow for adjustments that previously impacted the accuracy of recommended staffing levels. IVC intends to continue our work of improving the usability of the staffing tool by continuing to review and improve on current processes, developing data reports, and implementing a standardized adoption of the tool. The target completion date has been set accordingly

Status: In Process Target Completion Date: September 2023

Recommendation 4: Assess whether consolidated community care units would more broadly support veterans' access to community care and help mitigate the impact of staffing shortages, and, if so, develop a project management plan for implementing those units.

VHA Comments: Concur. WMC will partner with IVC to assess existing consolidated community care units and whether a broader implementation of consolidated community care units would better support veterans' access to community care and help mitigate the impact of staffing shortages. Based on that assessment, WMC and IVC will develop a report along with recommendations and, if warranted, a project plan to further implement consolidated community care units.

Status: In Progress Target Completion Date: March 2024

Recommendation 5: Assess the use of monetary and nonmonetary incentives to evaluate whether they are effective in recruiting and retaining administrative staff within community care departments.

VHA Comments: Concur. VHA concurs that an assessment of the effectiveness of monetary and non-monetary incentives for recruitment and retention of administrative staff in community care departments is needed. It is extremely difficult, however, to make definitive judgments about the value of incentives without a controlled study. Incentive usage is at the discretion of facilities based on their budget and specific needs and therefore does not lend itself to a robust analysis in a controlled study design. Previous efforts to analyze the effectiveness of incentives have often found that the usage of incentives may not appear to have a large impact on recruitment or retention, but it is impossible to know if recruitment or retention would have been worse without the incentives. With those caveats, VHA agrees that an analysis of the available data is warranted.

WMC has pulled the data for monetary and non-monetary incentive use in Community Care for the past three years.

Next Steps:

Match incentives use data with recruitment and retention data.

Analyze the data to evaluate the effectiveness of and need for incentives in recruiting and retaining administrative staff within community care departments.

Review findings with Community Care program office and if needed, develop an action plan to educate the field on the effective use of incentives.

Deliver a report on findings.

Status: In Progress Target Completion Date: September 2023

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Audit Team	Shawn Steele, Director Chris Carrera Scott Godin Jennifer Leonard Elaina Parman LeAnne Weakley
Other Contributors	Marnette Dhooghe Dyanne Griffith Jill Russell Kotwoallama Reine Zerbo

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.va.gov/oig.