Department of Veterans Affairs **VHA DIRECTIVE 2009-055**
Veterans Health Administration
Washington, DC 20420 **November 2, 2009**

STAFFING PLANS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes national policy to assist health care facilities in developing formal plans for staffing levels and staff mix in all disciplines to support patient outcomes, clinical effectiveness, and efficiency.

2. BACKGROUND

a. The Department of Veterans Affairs (VA) must be able to demonstrate that it provides appropriate, high quality health care to Veterans. Given the continuing evolution of the VHA mission, structure, workforce, recruitment, retention issues, and requirements related to accreditation, VA must have a methodology for relating staffing levels and staff mix to patient outcomes, clinical effectiveness, and efficiency.

b. Staffing decisions require evidence-based professional judgment, critical thinking, and flexibility rather than sole use of standardized metrics such as full-time equivalent (FTE) employee. Staffing needs are individualized to specific clinical settings and cannot rely solely on ranges and fixed staffing models, staff-to-patient ratios, or prescribed patient formulas.

c. Information management systems continue to grow in sophistication to support development of standardized data for health care providers in varied care settings. The intent is to then use standardized information data management strategies that facilitate analysis of the relationships among staffing numbers, mix, care delivery models, and patient outcomes for multiple points-of-care. The goal is to develop standardized information for a data-driven and evidence-based approach used in determining staffing plans that support high-quality patient care in the most effective manner possible.

d. **Definitions.** The following definitions apply throughout this Directive:

(1) **Expert Panel.** An expert panel is an inter- and intra-disciplinary advisory group comprised of individuals with in-depth knowledge and evidence-based factors impacting staffing needs at the point-of-care. The panel is best-suited to make judgments to deliver recommendations regarding staffing levels and overseeing outcome analysis and modifications to staffing recommendations.

(2) **Patient Outcomes.** Patient outcomes are measures that describe a patient's health status or level of functioning following or during an episode of health care or components of care delivery.

THIS VHA DIRECTIVE EXPIRES NOVEMBER 30, 2014

(3) **Performance Indicators.** Performance indicators are measurement tools used to monitor and evaluate the quality of important functions. It is numerical information that quantifies input, output, and performance dimensions of programs, projects, and services (see the Office of Quality and Performance Web site at: http://vaww.oqp.med.va.gov). ***NOTE:*** *This is an internal web site and is not available to the public.*

(4) **Performance Measures.** Performance measures are indicators that are used to quantify achievement of established targets.

(5) **Point-of-Care.** Points-of-care are the levels at which distinct units of patient or health services are provided. These units of care delivery can also be described and quantified in nomenclature for treating specialties, resource utilization groupings (RUGs), current procedural terminology (CPT) codes, and stop codes, among others. Examples include: medical and surgical units, mental health clinics, drug treatment programs, inpatient surgery, diagnostic radiology, home care, telecare, neurology, urgent care, community living centers, podiatry service, and outpatient clinics.

(6) **Staffing Plans.** Staffing plans are written documents by service, discipline, and organization that were developed using the guidance contained in Attachment A.

3. POLICY: It is VHA policy that a systematic methodology be used to establish staffing levels and skill mix to ensure that a qualified and competent workforce is available to provide the highest quality health care (See Att. A for a general framework to be used in developing, implementing, and periodically reviewing staffing plans). ***NOTE:*** *Existing national staffing standards, which establish minimum requirements, such as Spinal Cord Injury or Disability Services, are to be applied.*

4. ACTION

a. **Principal Deputy Under Secretary for Health (10A) and Deputy Under Secretary for Health for Operations and Management (10N).** The Principal Deputy Under Secretary and the Deputy Under Secretary for Health for Operations and Management are responsible for standardizing:

(1) Information data management strategies that permit analysis of the relationships among staffing numbers, mix, care delivery models, and patient or resident outcomes for multiple points-of-care.

(2) Evidence-based approaches to staffing and use, in order to provide high-quality patient care in the most efficient manner possible.

b. **VHA's Office of Patient Care Services (11), Office of Nursing Services (108), and Office of Health Information (19).** The Office of Patient Care Services, Office of Nursing Services, and Office of Health Information share responsibility with all other VHA elements to assess trends in workforce and workload measurement systems. They are to work collaboratively to identify and implement additional metrics, information systems, and outcome

measures to further assist Veterans Integrated Service Network (VISN) and facility leadership with determining staffing levels.

c. **The Office of Productivity, Efficiency, and Staffing (OPES).** OPES is responsible for:

(1) Assisting Program Offices in developing effective management tools, systems, and studies to optimize clinical productivity and efficiency; and

(2) Supporting the establishment of staffing guidance that promotes the goals of clinical excellence, access, and the provision of safe, efficient, effective and compassionate care.

d. **VISN Director.** Each VISN Director is responsible for providing oversight to ensure the provision of necessary resources for facilities to implement appropriate staffing plans.

e. **Facility Director.** Each facility Director is responsible for ensuring:

(1) Written facility-wide staffing plans are developed to address tactical and strategic staffing needs.

(2) The necessary resources to implement the staffing plans are provided.

(3) Staffing plans are incorporated into and maintained as part of facility strategic and operational plans.

(4) Staffing plans are reviewed, at least on an annual basis, evaluated, and revised when necessary to address emerging patient care needs.

f. **Chief of Staff and Nurse Executive.** The Chief of Staff and Nurse Executive are responsible for ensuring the development and maintenance of effective staffing plans that are consistent with the provisions of this Directive and the facility strategic plan.

g. **First-line Supervisors, Service Line Managers, and Equivalent Management Positions.** First-line supervisors, service line managers, and equivalent management positions are responsible for ensuring the development and implementation of staffing plans for areas under their direction, to include: analyzing, tracking, and trending variations in patient outcomes; performance indicators; and monitors to assess the effectiveness of the staffing plans.

5. REFERENCES

a. Title 38 United States Code (U.S.C.) §8110, §7421, and §7422.

b. Title 5 U.S.C. §7106(b)(1).

c. VA Directive 5001.

d. VA Directive and Handbook 5005.

6. FOLLOW-UP RESPONSIBILITY: The Workforce Management and Consulting Office (10A2) is responsible for the content of this Directive. Questions may be addressed to (202) 461-7367.

7. RESCISSIONS: None. This VHA Directive expires November 30, 2014.

Gerald M. Cross, MD, FAAFP
Acting Under Secretary for Health

Attachment

DISTRIBUTION: : E-mailed to the VHA Publications Distribution List 11/3/09

ATTACHMENT A

IMPLEMENTATION OF STAFFING PLANS

The following provides a framework for developing, implementing. and reviewing staffing plans.

1. Strategic and Operational Plans are approved.

2. Based on approved Strategic and Operational Plans, decide the scope and level of service to be provided.

3. Managers at the point-of-care make staffing decisions about the appropriate mix and level of staff required based on the following factors:

a. Mandated national staffing levels or methodologies;

b. Recommendations from the team providing the care or services; and

c. Performance measures, patient outcomes, or other indicators or monitors of the accessibility and quality of care provided.

4. As appropriate, managers at the point-of-care implement improvement goals and plans related to the mix and level of staff required, based upon trends in performance measures, patient outcomes, or other indicators or monitors of the accessibility and quality of care provided after seeking input from the employees providing the care or services involved, or from an expert panel.

5. Managers at point-of-care report results to officials responsible for integrating plans at the service or equivalent level.

6. Plans at the service, or equivalent, level are periodically communicated to an advisory group, expert panel, or committee assigned responsibility for reviewing overall staffing plans at the facility. An advisory group, expert panel or committee recommends approval or modification of staffing plans to the facility governing body. Approved or modified plans are communicated to affected managers and employees.

7. Approved staffing plans are incorporated into the facility's Strategic and Operational Plans.

8. Managers at all levels analyze, track, and trend variations in patient outcomes, performance indicators, and monitors to assess the effectiveness of staffing plans, and making appropriate adjustments as indicated.