



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 15-00430-103

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages

January 30, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General (OIG) conducted a determination of Veterans Health Administration (VHA) occupations with the largest staffing shortages as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014.

We interpreted “largest staffing shortage” to encompass broader deliberation than simply the number needed to replace or backfill vacant positions. We performed a rules-based analysis on VHA data to identify these occupations.

We determined that the five occupations with the “largest staffing shortages” were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist.

This determination is the first of several OIG determinations on VHA occupational staffing shortages. We plan to incorporate additional data in future OIG determinations to provide more detailed recommendations.

We recommended that the Interim Under Secretary for Health continue to develop and implement staffing models for critical need occupations.

Comments

The Interim Under Secretary for Health concurred with our recommendation and provided an acceptable action plan. (See Appendix C, pages 12–15 for the Interim Under Secretary's comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

On August 7, 2014, the Veterans Access, Choice, and Accountability Act was signed into law. The law requires the Office of Inspector General (OIG) to annually determine “the five occupations of personnel of this title of the Department covered under section 7401 of this title for which there are the largest staffing shortages throughout the Department as calculated over the five-year period preceding the determination.” The first determination was to be performed within 180 days of the passage of the law with annual determinations by September 30 in subsequent years thereafter.

Background

The Veterans Access, Choice, and Accountability Act of 2014

In May 2014, the OIG reported ongoing concerns regarding access to Veterans Health Administration (VHA) care, VHA scheduling practices, and excessive wait times. In response to these concerns, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, which was signed into law by the President on August 7, 2014 (Public Law 113-146).

Title III of this law addressed healthcare staffing, recruitment, and training. Section 301 requires the OIG to determine the five occupations of “largest staffing shortages.” In addition, the law requires VHA to address “appropriate staffing levels for healthcare professionals to meet the goals of the Secretary for timely access to care for veterans.” The law specifies four clinical areas of heightened concern including primary care, mental health, women’s health, and gastroenterology, as well as other areas as determined by the VA Secretary.

For the purposes of the OIG determination, the phrase “largest staffing shortages” is interpreted to encompass broader deliberation than simply the number needed to replace or backfill vacant positions.

There are many potential ways to assess staffing shortages. Beyond the number of vacancies, considerations might include, but are not limited to, occupations with past and anticipated growth in demand; occupations for which the available labor force is highly competitive; occupations with historically high attrition rates; incorporation of existing or anticipated programmatic growth; geographic and demographic variability; productivity and allocation of staff duties between direct-care, administrative, and research responsibilities; occupations that overlap in their contributions to patient care; and variance from data-driven occupational staffing standards.

VHA’s Workforce Succession Strategic Plan

As part of its workforce planning, VHA annually collects and analyzes system-wide data to determine its workforce needs. This work is summarized in VHA’s Workforce Succession Strategic Plan, which is developed and published annually.

Each VHA facility generates a ranking of up to 10 of the most difficult occupations to recruit and retain as part of its annual submission. VHA's Workforce Management and Consulting Office (WMCO) provides facilities with technical guidance on completing the rankings but does not specify a methodology for determining them. The facilities are asked to provide a narrative that explains the rationale for the ranking.

Individual facility rankings are then submitted to the relevant Veterans Integrated Service Network (VISN). VISN Human Resources staff utilize a tool to assist them in aggregating the facility rankings. WMCO provides guidance to the VISN planners who may modify the results based on their knowledge and analysis of the occupations. However, the specific ranking process is left up to each VISN to determine. Additionally there is a narrative component where VISN Human Resources staff can describe further their selection of top occupations and projections for those occupations.

WMCO uses the VISN level rankings to calculate a score for each occupation. The formula used to calculate the weighted score is the average VISN rank for each occupation multiplied by the number of VISNs that ranked the specific occupation in the top 10 for critical need. The specific formula used is (15-average VISN level rank) X (the number of VISNs ranking the occupation in the top 10). WMCO makes adjustments to the rankings to incorporate feedback from programmatic offices, VHA human resources recruiters, and other relevant VHA offices.

Table 1 displays VHA's determination for occupations of critical need for fiscal years (FYs) 2011–2015 with a ranking of one representing the most critical.

**Table 1. VHA Determination for Occupations of Critical Need
FYs 2011–2015**

Rank	2011	2012	2013	2014	2015
1	Medical Officer	Medical Officer	Medical Officer	Medical Officer	Medical Officer
2	Nurse	Nurse	Nurse	Nurse	Nurse
3	Human Resources	Human Resources	Human Resources	Human Resources	Human Resources
4	Pharmacist	Pharmacist	Physical Therapist	Physical Therapist	Physical Therapist
5	Medical Technologist	Physical Therapist	Medical Technologist	Medical Technologist	Medical Technologist
6	Physical Therapist	Medical Technologist	Pharmacist	Psychologist	Physician Assistant
7	Psychologist	Psychologist	Psychologist	Physician Assistant	Psychologist
8	Diagnostic Radiologic Technician	Diagnostic Radiologic Technician	Occupational Therapist	Occupational Therapist	Occupational Therapist
9	Nurse Anesthetist	Occupational Therapist	Physician Assistant	Pharmacist	Pharmacist
10	Practical Nurse	Nurse Anesthetist	Nurse Anesthetist	Nurse Anesthetist	Diagnostic Radiologic Technician

Source: VHA

OIG Report on VHA's Physician Staffing Levels for Specialty Care Services

In its December 27, 2012 report, *Audit of VHA's Physician Staffing Levels for Specialty Care Services* (report 11-01827-36), to evaluate VHA's progress in implementing a policy on physician staffing levels, OIG assessed whether VHA had an effective methodology for determining staffing levels for 33 of VHA's specialty care services. OIG found that VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. In addition, VHA's lack of productivity standards and staffing plans limited the ability of medical facility officials to make informed business decisions on the appropriate number of specialty care physicians needed to meet patient care needs such as access and quality of care.

OIG recommended the Under Secretary for Health approve a plan that ensures all specialty care services have productivity standards within 3 years and provide medical facility management with specific guidance on the development and annual review of staffing plans.

Scope and Methodology

We interviewed the acting Principal Deputy Under Secretary for Health, the Deputy Chief Officer for WMCO, and the Director of Finance and Business Office, WMCO.

We reviewed relevant VHA data on occupational attrition rates and annual VHA facility ranking of occupations of critical need for FYs 2010 through 2014. We examined rankings at the VISN and National level and the VHA facility level data collection tool used for the annual ranking of occupations of critical need.

We evaluated VHA's methodology for prioritizing occupations of critical need. We reviewed the VHA Workforce Succession Strategic Plan for 2013–2014.

We requested system-wide occupational vacancy data and data on underlying reasons for why staff separated from the system.

We used a rules-based methodology to determine occupations of critical need. We incorporated consideration of previous OIG work in our determination. The OIG methodology focused on facility-level rankings of occupations of critical need. The OIG determination did not include occupations relating to administrative, clerical, physical plant maintenance, or protective services. As VHA did in its determination, we used the Office of Personnel Management (OPM) occupational series.¹ A more detailed discussion of our methodology can be found in Appendix A.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

¹ Handbook of Occupational Groups and Families. May 2009. <http://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/occupationalhandbook.pdf> Accessed 12/11/2014.

Findings

While there are many possible methods to rank direct healthcare occupation staffing shortages, for this initial determination, we chose to focus on facility level rankings of occupations of critical need. We examined and analyzed VHA data from the prior 5 years, placing greater emphasis on the more recent data, as this was felt to better reflect present and future VHA staffing needs compared to data from the earlier years in the timeframe. VHA was able to provide more detailed facility level ranking data for the more recent years. For FY 2011, only partial data was available.

Because 38 US Code Section 7401 excludes administrative positions, we did not include these occupations in our ranking methodology, and we removed human resources management from consideration.

We aggregated facility rankings once to make our determination. By conducting our analysis on a facility level, each facility's ranking carries equal weight in the determination.

Table 2 shows the OIG determination of the five occupations with "largest staffing shortages" for its 2014 initial determination with a ranking of one being most critical.

**Table 2. OIG Determination for 2014
of Five Occupations with Largest Staffing Shortages**

Ranking	Occupational Series
1	Medical Officer
2	Nurse
3 (tied)	Physician Assistant
3 (tied)	Physical Therapist
5	Psychologist

Source: OIG Analysis

In our determination, Psychologist and Medical Technologist were tied. However, factoring in previous OIG work and the emphasis on mental health services as one of four key clinical areas in the Veterans Access, Choice, and Accountability Act of 2014, we ranked Psychologist ahead of Medical Technologist for the purposes of this initial determination.

The data underlying this initial determination relies on ranking by facility leadership and produced a system-wide occupational ranking. While ranking data provides useful information on the relative needs, it does not provide the level of detail required to produce staffing targets. Data such as that generated by implementation of a staffing

model would better facilitate an ongoing process by which VHA could adjust facility staffing. Additionally, this would facilitate comparison of current staffing to staffing model targets, further understanding of facility level barriers, and targeted interventions to address critical staffing needs.

WMCO reported working with mental health, primary care, women's health, and gastroenterology program offices to incorporate staffing models into future assessment of direct care staffing needs. While specialty care staffing models will reportedly factor in the calculation of provider and support staff full time equivalents need, primary care and mental health models reportedly will be driven by treatment team and patient population based considerations. It is our understanding this is a work in process and will be discussed by VHA in its report to Congress as required by sections 301–303 of the Veterans Access, Choice, and Accountability Act of 2014.

In addition to review of developing VHA staffing models, future OIG determinations might include utilization of real-time VHA vacancy data, barriers to hiring and retention, assessing access measures such as wait times, and assessment of the efficiency and effectiveness of staffing and on-boarding processes.

Conclusions

This determination is the first in a series of annual determinations of staffing shortages in VHA. For this initial determination, we focused on those occupations identified by VHA facilities as those of greatest critical need to which we applied a rules-based analysis. VHA is currently developing staffing models that should allow for more objective, detailed, and timely assessment of staffing needs than VHA's current ranking focused methodology.

By utilizing more refined data as it becomes available, future OIG determinations will rely less upon ranking data of what each VHA facility reports as its occupations of critical need versus more objective-based assessment. OIG will continue to develop the data collection process for these determinations both in type of data and scope of the data.

We made one recommendation.

Recommendation

Recommendation 1: We recommended that the Interim Under Secretary for Health continue to develop and implement staffing models for critical need occupations.

OIG Rule-Based Methodology for Ranking Occupations of Critical Need

Discussion of OIG's Methodology

The OIG analysis started with the facility rankings of the top occupations. The table below displays an example of this ranking for an individual facility.

Table 3. Sample Ranking of Critical Need Occupations by a VHA Medical Center

Facility	Occupation	Ranking
Facility 1	Medical Officer	1
Facility 1	Pharmacist	2
Facility 1	Nurse Anesthetist	3
Facility 1	Practical Nurse	4
Facility 1	Nurse	5
Facility 1	Occupational Therapist	6

For each occupation, the average occupational rank was defined as the arithmetic mean of the rank assigned by each facility. For example, if 10 facilities identified an occupation as their number 1 top occupation and 5 facilities rated it as number 4, the average rank would be 2.0.

$$\frac{(10 \times 1) + (5 \times 4)}{(10 + 5)} = \frac{30}{15} = 2.0$$

In addition, for each occupation, the number of times a facility ranked an occupation in the top 10 was also tallied. The number of facilities ranking an occupation in the top 10 and the average occupational rank resulted in a table with a similar format to below. For convenience of analysis and presentation the table is sorted by average occupational rank.

Table 4. Example of OIG Aggregation of Facility Level Rankings

Occupational Series	Average Occupation rank	Number of Facilities Ranking Occupation in Top 10
Medical Officer	1.50	137
Nurse	3.23	132
Physician Assistant	4.96	73
Psychologist	5.10	72
Physical Therapist	5.47	87

For simplicity, we eliminated any occupations from further consideration which were ranked by fewer than 10 facilities as this represents less than ten percent of all facilities.

Appendix A

After compilation and ordering of average occupational rank and the number of facilities ranking that occupation in the top 10, a set of OIG ranking rules were applied.

First OIG Ranking Rule: When comparing two occupations, an occupation with both a higher average rank and more facilities ranking it was ranked higher than a second occupation with both lower average rank and number of facilities ranking that occupation. For example, if Psychologist has an average rank of 5.10 and is ranked by 72 facilities, it would be ranked above Dietician with an average rank of 6 and ranked by 60 facilities.

Second OIG Ranking Rule: In cases where comparing two occupations showed that one had a higher average rank but the other had a greater number of facilities ranking it, the magnitude of the tradeoff between rank and number of facilities was considered and if the difference clearly favored one of those occupations, that occupation was ranked higher. For example, when Physical Therapist was compared to Practical Nurse, although Practical Nurse had a slightly higher average rank score by 0.09 (5.382 versus 5.471), over twice as many facilities ranked Physical Therapists (87 versus 34) in the top 10 and we therefore placed Physical Therapist higher in our determination.

Third OIG Ranking Rule: In cases where the tradeoff between average ranking and number of facilities ranking an occupation was not clear, we considered the relative ranking indeterminate because its ranking would change depending on how much one chooses to emphasize average ranking or number of facilities ranking. We then evaluated the set of all possible ranking orders along the tradeoff between the two variables for the compared occupations.

For example, Physician Assistants were ranked at 4.96 by 73 facilities versus Psychologist, which was ranked at 5.10 by 72 facilities and Physical Therapist was ranked on average 5.47 by 87 facilities. By our first rule, Physician Assistant outranks Psychologist. However, comparison of Physician Assistant and Physical Therapist is indeterminate because the choice between the half-point difference in average rank versus the 14 more facilities ranking it was close enough not to be clear. Likewise, comparison between Physical Therapist and Psychologist is also indeterminate.

With three occupations, at a maximum there would be six possible combinations of rank orders. However, because Physician Assistant outranks Psychologist under our first decision rule, among the six possible combinations only three are consistent with the first rule. This approach generates a set of rankings rather than a single ranking which allows us to consider the range of possible solutions. Table 5 illustrates the six possible combinations of rank orders. Columns 4 through 6 are not consistent with our first ranking rule.

Table 5. Set of All Six Possible Combinations of Rankings Among Three Occupations for which Relative Rankings Were Indeterminate

	1	2	3	4	5	6
1	PA	PT	PA	PT	PSY	PSY
2	PT	PA	PSY	PSY	PA	PT
3	PSY	PSY	PT	PA	PT	PA

PA= Physician Assistant, PT= Physical Therapist, PSY= Psychologist

Source: OIG Analysis

From columns 1 through 3, possible relative rankings for Physician Assistant are 1, 2, and 1; potential relative rankings for Physical Therapist are 2, 1, and 3; and potential relative rankings for Psychologist are 3, 3, and 2. When summing the potential rank orderings for each occupation, Physician Assistant ranks above Physical Therapist which in turn ranks above Psychologist.

However, if there were more than three occupations with indeterminate relative rankings, the number of combinations and resulting rankings would change. With our analysis there were four occupations (Physician Assistant, Psychologist, Physical Therapist, and Medical Technologist) among which the relative rankings were indeterminate prior to application of the third sorting rule.

Application of OIG Ranking Rules to Facility Level Data

Medical Officer had a higher average rank and more facilities ranking it than any other occupation. Therefore, by direct application of the first sorting rule, Medical Officer was our top ranked occupation.

Of the remaining occupations, the Nurse occupation had a higher rank and more facilities than any other occupation. By direct application of the first sorting rule, Nurse was our second ranked occupation.

By application of the first sorting rule, Physician Assistant (rank 4.96, count 73) outranked all the remaining occupations except for being indeterminate with respect to Physical Therapist (rank 5.47, count 87) and Medical Technologist (rank 5.63, count 83). Physical Therapist was indeterminate with Physician Assistant and Psychologist (rank 5.10, count 72) but otherwise outranks all other remaining occupations. After application of the third sorting rule among the 4 occupations with indeterminate relative rankings, Physician Assistant and Physical Therapist were tied for third.

The relative ranking among Physician Assistant, Psychologist, Physical Therapist, and Medical Technologist for spots 3-6 was assessed by looking at all the possible rankings that also preserve the condition that Physician Assistant outranks Psychologist (first rule) and Physical Therapist outranks Medical Technologist (first rule). Six of the 24 possible combinations of ranking orders preserve the above conditions, and in all six, both Physician Assistant and Physical Therapist were in the Top 5 occupations. Psychologist and Medical Technologist were in the number six spot half the time in

Appendix A

these lists. Therefore, we determined that Physician Assistant and Physical Therapist tied for the third spot on the list, while Psychologist and Medical Technologist tied for fifth.

Practical Nurse (rank 5.38, count 34) was outranked by Physician Assistant and Psychologist by the first rule and outranked by Physical Therapist by the second rule (average ranking 0.1 higher, but 34 facilities ranked it versus 87 for Physical Therapist). With at least five other occupations outranking it, Practical Nurse was therefore excluded from the top 5. The occupation Nurse Anesthetist was eliminated due to similar considerations. All other remaining occupations were also outranked by a least 5 other occupations.

Application of our analysis yielded the following determination:

1. Medical Officer
2. Nurse
3. Physician Assistant
3. Physical Therapist
5. Psychologist
5. Medical Technologist

OPM Occupational Series Codes and Definitions²

Medical Officer – OPM Series 0602 – This series covers all classes of positions the duties of which are to advise on, administer, supervise, or perform professional and scientific work in one or more fields of medicine. Positions are classifiable to this series when the nature of duties and responsibilities is such that the degree of Doctor of Medicine or Doctor of Osteopathy is a fundamental requirement. Most positions in this series require a current license to practice medicine and surgery in a State or Territory of the United States or in the District of Columbia.

Nurse - OPM Series 0610 – This series covers positions that require a professional knowledge of nursing. Positions involve providing care to patients in hospitals, clinics, occupational health units, homes, schools and communities; administering anesthetic agents and supportive treatments to patients undergoing surgery or other medical procedures; promoting better health practices; teaching; performing research in one or more phases of the field of nursing; or consulting and advising nurses who provide direct care to patients.

Physician Assistant - OPM Series 0603 – This series covers positions that involve assisting a physician by providing diagnostic and therapeutic medical care and services under the guidance of the physician. The work requires knowledge of specific observation and examination procedures, and ability to perform diagnostic and therapeutic tasks. The work does not include the full scope of interpretation of medical findings requiring the full professional background of the licensed physician. Physician assistants assist in the examination and observation of patients by performing such duties as taking case histories, conducting physical examinations, and ordering laboratory studies during hospital rounds and clinic visits. As directed by a physician, physician assistants carry out special procedures; for example, they give injections or other medication, apply or change dressing, perform lumbar punctures, or suture minor lacerations.

Physical Therapist – OPM Series 0633 – This series covers positions that involve professional work requiring the application of a knowledge of the concepts, principles, and practices of physical therapy for the treatment or prevention of physical disability or disease. Physical therapists plan and carry out treatment utilizing therapeutic exercise, massage, and physical agents such as air, water, electricity, sound, and radiant energy. Therapists perform tests and measurements involving manual or electrical means; and interpret results. Therapists also devise adaptations of equipment to meet the specific needs of patients.

Psychology Series – OPM Series 0180 – This series covers positions involving professional work relating to the behavior, capacities, traits, interests and activities of

² Handbook of Occupational Groups and Families. May 2009. <http://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/occupationalhandbook.pdf> Accessed 12/11/2014

Appendix B

human and animal organisms. This work may involve any one or a combination of the following functions: (1) experimenting with or systematically observing organisms to develop scientific principles or laws concerning the relationship of behavior to factors of environment, experience, or physiology, or to develop practical applications of findings; (2) applying professional knowledge of psychological principles, theories, methods, or data to practical situations and problems; and (3) providing consultative services or training in psycho-logical principles, theories, methods, and techniques to advance knowledge of them and their appropriate use.³

³ For consistency, we used "Psychologist" in this report to refer to OPM's "Psychology Series."

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: January 14, 2015

From: Interim Under Secretary for Health (10N)

Subj: Healthcare Inspection – OIG Draft Report: Determination of VHA Occupational Staffing Shortages (VAIQ 7563888)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft report. The Veterans Health Administration concurs with both the conclusions and the recommendation of this OIG draft report titled, "OIG Determination of VHA Occupational Staffing Shortages."
2. VHA finds that effective workforce succession planning and leveraging continuously-refined clinical staffing models will prove effective in ensuring adequate resources are available to support timely access to care for our Veterans.
3. Staffing models for the critical need occupations cited in the draft report (i.e., Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist) will permit VHA to more accurately project resource requirements for providing Veterans with timely access to health care. With refined clinical staffing projections, VHA can continue to improve on effective management of recruiting and retaining medical professionals, facility by facility.
4. Much work has already been accomplished in the arena of developing clinical staffing models. VHA implemented the Patient Aligned Care Team (PACT) model in 2009, which now forms the national standard for primary care delivery across VHA. PACT is supported by national policy; establishes panel sizes specific to each team; enables specific integrated health care for each patient; and incorporates relevant specialty services and support services to meet patient-centered needs.

5. Likewise, subsequent to OIG's Audit of Physician Staffing Levels for Specialty Care Services (Report 11-01827-36); VHA has developed productivity standards for all of these specialties. This foundational work established a baseline staffing model construct for VHA to build upon and refine. This construct will inform our work on staffing models for the critical need occupations identified in this report.

6. The Veterans Access, Choice, and Accountability Act of 2014 requires the VA OIG to report on the top five VHA staffing shortages at the end of each fiscal year. As such, VHA will be updating OIG regularly on results and progress on our actions relative to the report's recommendations to inform the next iteration of the report. We look forward to continuing our collaborations with OIG on this important work in the months to come.

7. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (1OAR) at VHA 1OARMRS2@va.gov.

(original signed by:)

Carolyn M. Clancy, MD

**VETERANS HEALTH ADMINISTRATION
(VHA)**

Action Plan

**Office of the Inspector General (OIG) Draft Report, OIG Determination
of VHA Occupational Staffing Shortages**

Date of Draft Report: December 18, 2014

Recommendations /Actions	Status	Completion Date
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Recommendation 1. We recommended that the Interim Under Secretary for Health continue to develop and implement staffing models for critical need occupations.

VHA Comment: Concur. To further mature clinical staffing models for the critical occupations cited in the OIG report, VHA will leverage on-going work in three arenas: alignment, benchmarking and implementation:

Alignment: Specifically, VHA seeks to determine if there is a correlation between the factors of facility complexity, characteristics of the local Veteran population, and productivity measurements. To the extent that such a correlation exists, VHA will evaluate the effectiveness of applying additional factors to our existing modeling techniques.

VHA has established a cross-disciplinary clinical staffing working group, with representation from the Primary Care, Specialty Care, Mental Health and Women's Health clinics, along with VHA's operational and policy-making communities. This working group is analyzing where clinical staffing models and team management can be further aligned, leveraging the factors of productivity and population. This working group is addressing both VHA's internal goals of ensuring timely access for Veterans' access to care and also the external requirements of the Veterans Access, Choice, and Accountability Act of 2014, Section 301a.

Benchmarking: Comparing techniques with other health care systems that are national in scale could prove to be useful in terms of validating our current approach, or refining our approach if our peers have successful models that are capable of emulation.

VHA is engaged with the Department of Defense, the National Institute of Health and with our peers in the private sector. These discussions are in various states

of maturity, but have already shown that VHA can learn from (and can teach in turn) external organizations. The results of these conversations are also informing the analyses of our clinical staffing model working group cited above.

Implementation: To improve Veterans' access to care, effective clinical staffing models must be applied to personnel budgeting and workforce succession planning. fy2015 represents the Department's first year of implementing "Manage for Results", establishing an annual cycle of Planning, Programming, Budget and Execution (PPBE).

As the inaugural year for Manage for Results, and in alignment with the Department's initiative, VHA has established a PPBE integration working group. This team is closely aligned with the clinical staffing model working group cited above. The objective is to identify the organizations, activities and information that need to flow in order to 1) project clinical staffing requirements; 2) define, hire and retain the required medical professions at the facility and specialty level); and 3) ensure appropriate physical and financial resources are available to support the staff and the medical facilities.

Timeline for completion: Alignment: VHA will report the results of the analysis to determine to what extent population and productivity factors can and should be integrated within (and applied to) our existing clinical modeling work, along with a plan for a scalable pilot implementation and measurement of results.

Benchmarking: VHA will report on observations and "lessons learned" from our external dialogue. In those cases where a specific external modeling technique can and should be adopted by VHA, we will provide details on the method and timing for doing so. We note that benchmarking (much like clinical staff modeling in general) will not be a "one-time" activity. Rather, we will be continuously engaged with our public and private sector peers for additional refinement.

Implementation: VHA's target for Manage for Results implementation in the context of clinical staffing models for critical occupations will be a multi-year effort. Full establishment of the PPBE process requires both analysis and integration of numerous existing business processes, most notably workforce succession and the annual budget cycle. As the PPBE integration team completes the initial planning, we will be able to provide a specific set of activities and timelines

Status: In Progress

Target Completion Date: June 30, 2015.

OIG Contact and Staff Acknowledgments

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