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Office of Healthcare Inspections

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OIG Determination of VHA Occupational Staffing Shortages FY 2017

September 27, 2017

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Executive Summary

The VA Office of Inspector General (OIG) conducted its fourth 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 (VACAA).

We analyzed VHA facility rankings of critical occupations¹ to identify “largest staffing shortages.” This is a broader, and in our opinion more appropriate, deliberation than simply the number needed to replace or backfill vacant positions. We performed an OIG developed rules-based analysis on VHA data to identify these occupations, analyzed data on gains and losses for occupations with the largest staffing shortages, and assessed VHA’s progress with implementing staffing models.

We determined, based on data provided by VHA, that the largest critical need occupations were Medical Officer, Nurse, Psychologist, Physician Assistant, and Medical Technologist. In each of our previous three rankings of staffing shortages, Medical Officer and Nurse have been the two largest critical need occupations. Administrative positions were not included in our ranking methodology due to VACAA excluding administrative positions; therefore, we removed Human Resource Management from the VHA ranking when conducting the rules-based analysis. If included, Human Resource Management would rank in the Top 10 in VA and OIG determinations since fiscal year (FY) 2011.

Our analysis of the staffing gains and losses for this year’s report shows that for critical need occupations, a significant percentage of the total gains continues to be offset by staff losses. We also determined that the percentage of regrettable losses to total onboard staff in many critical need occupations was high relative to overall increases in onboard staff.

Throughout the years in these reports, we have noted the relatively long onboarding process and challenges in finding suitable candidates. Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and FTE allocation at the individual facility level. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures to address the above concerns.

OIG reported on the need for staffing models for critical need occupations in the first report of this series over 2 years ago. At the time of the writing of this report, VHA still does not have operational staffing models that comprehensively cover critical need occupations. VHA has made progress in developing a Specialty Care (SC) provider staffing model; however, this model is not operational and is unlikely to be operational within a year. In the absence of facility-specific staffing targets or an operational staffing model, determining whether facilities are making meaningful progress in filling critical

¹ VHA refers to these as mission critical occupations; VA OIG refers to these as critical need occupations.

staffing shortages is challenging. Without staffing models, VA leadership is unable to ensure that staffing is consistent and sufficient.

VHA reported that it incorporates Enrollee Health Care Projection Model (EHCPM) data into staffing model development, and the SC staffing model incorporates demand projection data. We noted VHA's efforts with internal reviews of its staffing models and refinement of staffing terminology as well as efforts with external consultation for the development of staffing models.

VHA chartered a work group to review data on regrettable losses and consider ways that these numbers could be reduced. The group compiled a report on regrettable losses and submitted it to VHA leadership. The report focused on the need for additional studies to determine causative and other factors related to regrettable losses. The work group reported issuing a follow-up report in September 2017.

In an effort to better understand staffing processes and identify staffing barriers, we conducted a survey of 141 VHA facilities in May 2017. We received a request from Senator Thom Tillis to evaluate staffing requirements and demand for select non-physician professionals. We included questions in the survey related to those professionals (optometrists, pharmacists, and medical technicians).

The survey was designed to gather information and not measure compliance with VHA guidance on staffing (see Appendix A).

We recommended that the Acting Under Secretary for Health:

- Ensure that the Veterans Health Administration implements staffing models for critical need occupations.
- Review the Veterans Health Administration report on regrettable losses and implement effective measures to reduce such losses.
- Continue incorporating data that predict changes in veteran demand for health care into its staffing model.
- Continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.

Comments

The Acting Under Secretary for Health concurred with the report and provided acceptable action plans. (See Appendix B, pages 21–26, for the full text of the Acting Under Secretary for Health’s comments.) For recommendation 2, with a target completion date of September 2017, we will follow up on the recently implemented actions to ensure that they have been effective and sustained. For the remaining recommendations, we will follow up on the planned actions until they are completed.



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Purpose

On August 7, 2014, the Veterans Access, Choice, and Accountability Act (VACCA), Public Law (PL) 113-146 was signed into law. PL 113-146 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 [2] of this title for which there are the largest staffing shortages throughout the Department as calculated over the five-year period preceding the determination." As specified, the first determination was performed and published within 180 days of the passage of the law on January 30, 2015.³ Annual determinations were completed by September 30 in subsequent years thereafter.⁴⁵

In compliance with the VACCA, the purpose of our fourth review is to determine the five occupations of Veterans Health Administration (VHA) personnel for which there are the largest staffing shortages based on data from fiscal year (FY) 2016. In addition, during this review, we determined VHA's progress in implementing OIG recommendations made in our September 28, 2016 report, *OIG Determination of VHA Occupational Staffing Shortages* (Report No. 16-00351-453). In response to a request made by Senator Thom Tillis, we conducted a survey of facilities (see Appendix A) and reviewed the survey data related to select non-physician professionals.

Background

Largest Staffing Shortages

For the purposes of this report, we analyzed VHA facility rankings of critical occupations to identify "largest staffing shortages." We determined the phrase "largest staffing shortages" encompassed a broader deliberation than simply the number needed to replace or backfill vacant positions for an occupation. Because of this interpretation, we referred to occupations from our determination as critical need occupations. VHA makes a similar determination and refers to these occupations as mission critical occupations.⁶

² Section 7401, 38 U.S. Code § 7401. <https://www.gpo.gov/fdsys/granule/USCODE-2011-title38/USCODE-2011-title38-partV-chap74-subchapI-sec7401>. Accessed August 11, 2017. Section 7401 specifically excludes certain classes of occupations relating to administrative, clerical, or physical plant maintenance and protective services.

³ OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages*, (Report No. 15-00430-103, January 30, 2015).

⁴ OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages*, (Report No. 15-03063-511, September 1, 2015).

⁵ OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages*, (Report No. 16-00351-453, September 28, 2016).

⁶ VHA Workforce and Succession Strategic Plan 2016.

Occupational staffing shortages may be assessed in many ways. Criteria for assessment might include but are not limited to:

- The number of vacancies
- 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 which overlap in their contributions to patient care
- Variance from data-driven occupational staffing standards

Determining the appropriate staffing of critical need occupations is complex as suggested by the number of ways that shortages can be assessed. VHA staffing needs will also be affected by the ability to obtain non-VA care through programs such as Choice Program⁷ (Choice) or other purchased care arrangements. Another factor that also affects the ability to staff facilities is the availability of the local labor force. Facility-specific factors such as the available local labor force emphasize the importance of examining staffing needs in a facility- and specialty-specific fashion.

VHA's Workforce Succession Strategic Plan

VHA annually collects and analyzes system-wide data to determine its workforce needs. This work is summarized in VHA's Mission Critical Occupation Report, which is developed and published annually.⁸ The VHA Workforce Management and Consulting Office (WMC) generates a ranking of the 10 most difficult occupations to recruit and retain. WMC submits individual facility rankings to the relevant Veterans Integrated Service Network (VISN). WMC amended the criteria that facilities should use when determining critical need occupations to include workforce need and recruitment and retention.

⁷ The Veterans Choice Program was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of third-party administrators.

⁸ <http://vaww.va.gov/wmc/index.asp>. Accessed July 20, 2017.

Office of Productivity, Efficiency and Staffing

The VHA Office of Productivity, Efficiency and Staffing (OPES)⁹ assists VHA leadership in developing effective management tools, systems, and studies to optimize clinical productivity and efficiency so that informed staffing decisions are made. The OPES staff produce a variety of studies, products, and tools related to productivity and efficiency that are designed to assist VHA leaders in optimizing resources.

VHA reported to OIG that the Specialty Productivity Access Report and Quadrant Tool (SPARQ),¹⁰ is a staffing tool they use that provides for a relative value unit (RVU) based model to measure specialty provider group practice productivity and staffing.

Summary of Prior VA OIG Reports Responsive to the VACCA

In OIG's first report, published on January 30, 2015, we determined the top five critical need occupations were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist.¹¹ We recommended the Interim Under Secretary for Health (USH) continue to develop and implement staffing models for these and other critical need occupations.

In OIG's second report, published on September 1, 2015,¹² we determined the top five critical need occupations were unchanged from our initial January 2015 determination. We recommended that the USH ensure VHA further develops staffing models for critical need occupations and review the data on regrettable losses noted in the report and VISN Workforce Succession Strategic Plans and, if appropriate, consider implementing measures to reduce such losses.

In OIG's third report, published on September 28, 2016,¹³ we determined the top five critical need occupations for FY 2016 were Medical Officer, Nurse, Psychologist, Physician Assistant, Physical Therapist, and Medical Technologist.¹⁴ We restated our prior September 1, 2015 recommendations and recommended that VHA set forth milestones and a timetable for further critical need occupations' staffing model development, piloting, and implementation. We also recommended that the USH:

- Consider incorporating data that predicts changes in veteran demand for health care into its staffing model.

⁹ <http://opes.vssc.med.va.gov/Pages/AboutOPES.aspx>. Accessed July 20, 2017.

¹⁰ <http://opes.vssc.med.va.gov/Pages/Default.aspx>. Accessed July 20, 2017.

¹¹ OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages* (Report No.15-00430-103, January 30, 2015).

¹² OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages*, (Report No.15-03063-511, September 1, 2015).

¹³ OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages*, (Report No.16-00351-453, September 28, 2016).

¹⁴ Because of a tie for 5th place, we had six occupations in our determination.

- Assess VHA's resources and expertise in developing staffing models and determine whether exploration of external options to develop the staffing model is necessary.

We discuss VHA's progress in implementing actions for these recommendations in Issue 3.

Scope and Methodology

We interviewed the VHA Deputy Principal Deputy Under Secretary for Health; Chief Nursing Officer and staff; Chief Financial Officer; Director of Enrollment and Forecasting; Director, Finance and Business Operations, Office of Workforce Management and Consulting and staff; Director of OPES; and National Director of Surgery.

We reviewed VHA mission critical occupation rankings within the context of OIG-defined critical need occupations. We examined VHA rankings at the national level as well as the facility level. We reviewed and analyzed relevant VHA onboarding data (number of people in an occupation working at a facility) for FY 2011 through FY 2016 and VHA gains and loss data for FY 2014 through FY 2016. We requested and analyzed VHA data on reasons for losses, for example, retirements and voluntary separations. We reviewed VHA updated submissions in response to our prior staffing reports, work group charter documents, and National Leadership Council Workforce Committee meeting and Health Services Committee minutes.

Occupational Staffing Shortages and Rules-Based Methodology

We 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.

We compared our determination of five critical need occupations using an OIG rules-based methodology to VHA's determination as well as to our previous determinations. A more detailed discussion of our methodology can be found in the OIG 2016 staffing report.¹⁵

In an effort to better understand staffing processes and identify staffing barriers we conducted a survey of 141 VHA facilities in May 2017. We received a request from Senator Thom Tillis to evaluate staffing requirements and demand for select non-physician professionals. We included questions in the survey related to those professionals (optometrists, pharmacists, and medical technicians). We asked that an individual knowledgeable about staffing processes complete the survey.

¹⁵ OIG report, *Determination of Veterans Health Administration's Occupational Staffing Shortages*, (Report No. 16-00351-453, September 28, 2016).

The survey was designed to gather information and not measure compliance with VHA guidance on staffing.

We reviewed the responses using a thematic analysis approach¹⁶ and extracted representative examples of identified themes. The themes were the basis for our analysis of the survey responses. Teams of two individuals independently categorized the facility responses into themes for each question and subsequently reconciled their responses through discussion. All three teams reviewed these results to produce the final analysis.

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.

¹⁶ Thematic analysis is a method to analyze the free-text survey responses. We identified the major themes for each question after reading through the responses. Two independent raters then classified the all of the responses for each question by themes and reconciled their responses through discussion.

Results

Issue I: OIG Determination of Critical Need Occupations

We determined that VHA’s five occupations with the largest staffing shortages were, in ranked order: (1) Medical Officer, (2) Nurse, (3) Psychologist, (4) Physician Assistant, and (5) Medical Technologist.

Table 1 displays OIG’s determination of the five occupations with the largest staffing shortages for its 2017 determination with a ranking of “1” being the most critical. In order to maintain consistency, determination of rankings is based on the OIG developed rules-based methodology utilized in prior reports.¹⁷ VACAA excludes administrative positions, and as such, we did not include those occupations in our ranking methodology. Had VHA also excluded those occupations in its determination of mission critical occupations, the rankings below would be identical to VHA’s most recent rankings.

Table 1: OIG Determination for FY 2017 of Five Occupational Series with Largest Staffing Shortages

2017 Ranking	Occupational Series
1	Medical Officer
2	Nurse
3	Psychologist
4	Physician Assistant
5	Medical Technologist

Source: VA OIG analysis of facility rankings of critical occupations submitted to WMC

¹⁷ The OIG Rule-Based Methodology for Ranking Occupations of Critical Need can be found in Appendix A of VAOIG, *OIG Determination of VHA Occupational Staffing Shortages*, (Report No. 16-00351-453, September 28, 2016), *OIG Determination of Veterans Health Administration Occupational Staffing Shortages*, (Report No.15-03063-511, September 1, 2015), and *OIG Determination of Veterans Health Administration Occupational Staffing Shortages* (Report No.15-00430-103, January 30, 2015).

Table 2 displays a comparison of the five occupations with the largest OIG-determined staffing shortages over the last 4 years.

Table 2: OIG Summary Determination of Five Occupational Series with Largest Staffing Shortages, FYs 2014–2017

Occupational Series	2014 Ranking	2015 Ranking	2016 Ranking	2017 Ranking
Medical Officer	1	1	1	1
Nurse	2	2	2	2
Psychologist	5	3	3 (tied)	3
Physician Assistant	3 (tied)	4 (tied)	3 (tied)	4
Medical Technologist			5 (tied)	5
Physical Therapist	3 (tied)	4 (tied)	5 (tied)	6

Source: VA OIG analysis of facility rankings of critical occupations submitted to WMC

Since our initial determination in 2014, four of the five occupational series with the largest staffing shortages have not changed:

- Medical Officer and Nurse have been the top two critical need occupations.
- Psychologist and Physician Assistant were determined to be in the top five, but their relative order changed with respect to the initial determination.

For this year, Physical Therapist was sixth following Medical Technologist, one of the top five staffing shortages for the 2nd year in a row.

Human Resources: VHA’s rankings back to 2011 included Human Resource Management as the number three ranked occupation. Due to VACAA excluding administrative positions, we did not include this occupation in our ranking methodology, and we removed Human Resource Management from the VHA ranking for this comparison. Based partly on the review’s survey findings (see Issue 4) of the need to process and onboard potential employees in a timely fashion, the shortage in Human Resource Management personnel might be implicated in other staffing shortages. If included, Human Resource Management would rank in the Top 10 in VA and OIG determinations since FY 2011.

Issue II. Gains and Losses for Critical Need Occupations

VHA increased the absolute numbers of staff (that is, net onboard) in four of the top five critical need occupations (Medical Officer, Nurse, Psychologist, and Physician Assistant) during FY 2016, which moved VA closer to its goal of improving staffing levels. However, most of the gains in FY 2016 staffing replaced existing losses and did not significantly impact availability of staff in critical needs occupations.

We requested VHA data on gains and losses for FY 2016 and had previous data from FY 2011 through FY 2015. We analyzed the number of staff onboard and full-time employee equivalents (FTE) from FY 2011 through FY 2016.

Although VHA provided information on hires, that data could not be used to accurately determine staffing at VHA medical facilities as some personnel actions that increase onboard staff are not considered hires.¹⁸

VHA also reports onboard numbers, which more accurately reflect the number of individuals working in each occupation. We calculated the gains in staffing using losses and net increases in onboard staff.¹⁹ In this report, we define the gains to be the number of additional people working in VHA, the losses to be the number of people who are no longer working in VHA, and the net increase or decrease in onboard staff to be the change in the overall number of staff in an occupation.

FY 2016 Medical Officer gains were 3,034 and total losses were 2,290. This resulted in a net increase (gains – losses) in onboard Medical Officers of 744. (See Table 3.)

We noted that only 25 percent of the gains represented a net increase in VHA's workforce given the offsetting losses. Most of the gains in staffing replaced existing losses rather than providing additional capacity to deliver health care. (See Table 3.) However, VHA did increase the absolute numbers of staff (that is, net onboard) in four of the top five critical need occupations, moving VHA closer to its goal of improving staffing levels.

Table 3 displays the requested data for the top 10 critical occupations from VHA's most recent ranking. Human Resource Management has been removed from our ranking methodology due to VACAA excluding administrative positions, and was not included in the top 10 listing this year. Therefore, data for only nine occupations are included in the table.

¹⁸ For example, the change in employment status of an individual who was a resident at the facility and then hired as an attending physician could be classified as a promotion rather than a hire.

¹⁹ The gains were calculated using this method because the number of hires did not capture all additions to staff.

Table 3. Top VHA Critical Occupations Gains, Losses, and Changes in Onboard Staff in FY 2016

Occupation	Total Gains	Losses	Net Increase in Onboard (Total Gains–Losses)	Total Onboard
0180 Psychologist	783	566	217	5,448
0602 Medical Officer	3034	2290	744	25,000
0603 Physician Assistant	305	218	87	2,222
0610 Nurse	7223	5371	1852	65,262
0620 Practical Nurse	1358	1313	45	14,747
0631 Occupational Therapist	138	106	32	1,254
0633 Physical Therapist	271	171	100	2,077
0644 Medical Technologist	382	410	(28)*	4,459
0660 Pharmacist	666	438	228	7,658

Source: VAOIG analysis of VHA data

**Number in parenthesis represents net loss.*

VHA categorizes staffing losses into three broad categories—voluntary retirements, regrettable losses or “voluntary quits,”²⁰ and other losses. (See Table 4.) Regrettable losses are defined as those individuals who resign from the VHA or who transfer to another government agency. Regrettable losses are staff that potentially could have stayed on at VHA and represent a missed opportunity for VHA to retain staff.

For Medical Officer, we noted that regrettable losses represent 60 percent of the total losses in FY 2016, while 30 percent were due to voluntary retirement, and 10 percent from other causes. For the other critical need occupations, regrettable losses comprised between 40 and 60 percent of loss, and voluntary retirements ranged between 16 and 45 percent of loss. (See Table 4.)

²⁰ While VHA now refers to regrettable losses as “voluntary quits,” OIG continues to use the term regrettable losses to be consistent with prior staffing determination reports.

Table 4. Reasons for Losses (in percent) for Top VHA Critical Occupations in FY 2016

Occupation	Voluntary Retirements	Regrettable Losses	Other
Psychologist	17.7%	43.6%	38.7%
Medical Officer	30.2%	59.7%	10.0%
Nurse	38.2%	54.9%	6.9%
Practical Nurse	30.0%	58.0%	12.0%
Physician Assistant	27.1%	58.3%	14.7%
Physical Therapist	15.8%	40.4%	43.9%
Occupational Therapist	33.0%	51.9%	15.1%
Medical Technologist	44.9%	44.9%	7.6%
Pharmacist	37.4%	42.2%	20.0%

Source: VAOIG analysis of VHA data

Because the total losses for an occupation may only represent a fraction of the entire occupation, it is also important to compare total occupational losses to the number of people onboard in an occupation. For example, Medical Officer total losses compared to the total number of Medical Officers onboard was 9.2 percent, and regrettable losses compared to the total number onboard was 5.5 percent. To put these numbers in perspective, the annualized net gain for Medical Officers over the past 4 years was 4.5 percent. (See Table 5.)

Table 5. Total Losses and Regrettable Losses as a Percentage of Total Onboard Staff in Top VHA Critical Occupations in FY 2016 Compared to the Annualized Net Increase in Onboard Staff in FYs 2012–2016

Occupation	FY 2016 Total Losses to Onboard	FY 2016 Regrettable Losses to Onboard	Annualized Net Increase in Onboard FYs 2012–2016
Psychologist	10.4%	4.5%	7.2%
Medical Officer	9.2%	5.5%	4.5%
Nurse	8.2%	4.5%	4.5%
Practical Nurse	8.9%	5.2%	2.2%
Physician Assistant	9.8%	5.7%	4.3%
Physical Therapist	8.2%	3.3%	7.3%
Occupational Therapist	8.5%	4.4%	4.9%
Medical Technologist	9.2%	4.1%	0.6%
Pharmacist	5.7%	2.4%	4.4%

Source: VAOIG analysis of VHA data

Issue III. Review of VHA's Progress with Previous OIG Recommendations

In prior staffing reports, we have noted the relatively long onboarding process and challenges in finding suitable candidates. Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and FTE allocation at the individual facility level. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures.

This section looks at VHA's current progress with respect to the recommendations made in prior reports. While VHA has taken steps to study and develop staffing models, there is still an absence of established staffing targets and an absence of means for determining whether VHA is making meaningful progress in filling the critical staffing shortages.

Staffing Model Development

VHA chartered a work group to develop staffing models for Specialty Care (SC) providers. The work group's January 2017 report included²¹ three SC provider staffing models, as follows:²²

- Policy Based Model reflects the baseline SC provider staffing as required by VHA complexity policies, VHA Directive 2010-018²³ and VHA Directive 2011-037.²⁴
- OPES Multivariable Model reflects an actual demand based model employing statistical analysis related to patient care needs in the SC areas of medicine and surgery.
- Enrollee Demand Based Model reflects references to the median SC provider staffing per enrollee population with a defined surplus or deficiency.

The work group examined the three SC provider staffing models, and noted strengths and weaknesses in each model. During an interview with one of the work group co-chairs, he stated that the three SC provider staffing models will need continued refinement.

On February 12, 2017, the report was presented to VHA leadership with 10 recommendations. An updated charter extending the work group to continue development of the SC provider staffing model is pending USH approval.

²¹ VHA defines Specialty Provider Group Practice Practitioner (SC provider) as a practitioner that is a Medicine, Surgery or other specialty practitioner outside of Primary Care. VHA Directive 1065, *Productivity and Staffing Guidance for Specialty Provider Group Practice*, May 4, 2015.

²² Department of Veterans Affairs, *Staffing Model for the Delivery of Specialty Care Work Group: Final Report*, January 27, 2017.

²³ VHA Directive 2010-018, *Facility Infrastructure to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

²⁴ VHA Directive 2011-037, *Facility Infrastructure Requirements to Perform Invasive Procedures in an Ambulatory Surgery Center*, October 14, 2011.

We also spoke with the Chief Nursing Officer for VHA who outlined that other clinical areas, such as coordination of community care, may be assessed for potential development of staffing models.

VHA Regrettable Losses Work Group

VHA chartered a work group in 2016 to review the data on regrettable losses and consider ways that these numbers could be reduced.

This work group completed a regrettable losses report that was presented to the National Leadership Council Workforce Committee in March 2017. The report focused on the need for additional studies to determine causative and other factors related to regrettable losses. VHA also completed a review of turnover intentions, exhaustion, and burnout indicators from the All Employee Survey, and a review of physician loss rates by specialty.

In an interview, the Director, Finance and Business Operations, Office of Workforce Management and Consulting, and staff reported different national level initiatives, such as the primary care physician summit to address burn-out indicators.

Incorporating Data for Demand for Health Care into Staffing Model

VHA reported that it incorporates the Enrollee Health Care Projection Model (EHCPM)²⁵ data into staffing model development. EHCPM is a health care demand projection model which uses actuarial methods and approaches to project veteran demand for VA health care. The SC staffing model incorporates demand projection data.

VHA highlighted that part of the demand for healthcare is veterans' reliance on VA services as veterans may have options for health care coverage, such as private insurance, in addition to the VA. During an interview, a Work Group co-chair outlined that changes in veterans' reliance on VA healthcare services may change over time.

VHA outlined that it reviews the OPES SPARQ formula, data, and execution. The goal is to evolve SPARQ in terms of both reliability and applicability as a critical aid towards informing staffing decisions.

Assessment of VHA's Expertise and External Options to Develop Staffing Models

We noted VHA's efforts with internal reviews, refinement of staffing terminology, and external consultation for the development of staffing models.

²⁵ The VA EHCPM projects Veteran enrollment, health care utilization, and expenditures for 20 years into the future. The Model projects the number of Veterans expected to be enrolled in a geographic area, their total health care needs, and the portion of that care they are expected to receive in VA versus other health care providers. The expenditure projections that support the VA health care budget request are based on the anticipated costs associated with the projected utilization (not patients). <https://www.va.gov/HEALTHPOLICYPLANNING/planning.asp>. Accessed July 26, 2017.

VHA reported completing a review of internal staffing models to identify common best practices and evaluate application of the models among the field. VHA also outlined that clinical staffing terminology will be further defined so that each term has a specific and commonly understood meaning.

VHA completed an external consultation for the development of a clinical staffing model for Medical Support Assistants; the review of this model by external consultants is ongoing. In addition, VHA will also determine if external consultation would be incorporated into the next phase of the SC Services Staffing Model.

Issue IV. Staffing Survey of Facilities

In an effort to better understand staffing processes and identify staffing barriers we conducted a survey of 141 VHA facilities in May 2017. We received a request from Senator Thom Tillis to evaluate staffing requirements and demand for select non-physician professionals. We included questions in the survey related to those professionals (optometrists, pharmacists, and medical technicians).

The survey was designed to gather information and not measure compliance with VHA guidance on staffing.

Identifying Staffing Needs

Our question to identify staffing needs included a request for the data used to support that process. All but one facility responded they used a locally developed process that was not solely a formal staffing model. While many facilities utilized nationally recognized staffing models, they also used additional information to supplement the recommendations of the staffing model. For example:

Service lines utilize staffing methodologies outlined in various directives and handbooks such as:²⁶... when reviewing resources needs. These methodologies are reviewed against service demand/access needs, productivity data, performance measures, alignment with facility/VISN and VACO [VA Central Office] strategic plan, and local budgetary considerations to determine what human capital resources are needed to support facility operations.

The majority of facilities reported using operational data like workload and access measures that were collected at the service level and rolled up to a facility level to assist with making staffing decisions. Almost a quarter of the facilities reported using organizational charts which alternatively indicated a process that begins at a higher level and rolls down to the service level. This suggested that facilities overall are initiating their staffing analysis at various levels of management.

²⁶ ED Directive, VHA Eye Care Handbook, Surgical Complexity directive, MHR RTP Staffing Guidelines, PACT Staffing Model, National VA Pharmacy Benefits Group staffing model, etc.

Prioritizing Hiring for Identified Staffing Needs

We asked facilities about how they prioritize positions once staffing needs are identified. An overwhelming majority specified they continued to use a locally developed process as opposed to a formal staffing model. Many facilities indicated utilizing their resource management committees, Executive Leadership Teams, and Service Chiefs to establish priority for recruitment efforts within their facilities. Further, the majority of facilities reported using metrics such as demand, workload, and patient access in order to support prioritization decisions.

Specifically, one facility reported that staffing requests and needs were prioritized based on the following: national and local priorities; risks associated with not filling a position; benefits of filling a position; whether the positions were required by Congress, VACO, or the VISN; and the budget to fulfill requests. Before a position could be approved, it had to be presented and sanctioned through the resource management committee to the Director. Clinical positions typically had priority over administrative positions, and in both cases, the facility must have the budget to support approval. Another facility stated that its process of prioritization for recruitment and hiring was identified by leadership with the emphasis on direct patient care followed by non-direct patient care positions. One facility indicated that patient care and positions that had critical impact to the organizational mission were given a high priority.

Approximately one-third of facilities indicated using service-specific approaches to triage the positions to prioritize. One facility reported the lack of a facility-wide mechanism for the prioritization of authorized recruitments. Instead, individual service line chiefs were authorized to prioritize their individual recruitment requests, and the servicing Recruitment and Placement Specialist processed them in the order they were received.

Additionally, less than one-third of facilities acknowledged that budget and funding were factored into their prioritization process. Many of these facilities reviewed these issues anywhere from weekly to annually. One such facility described examining the budget annually to determine if an increase in FTE was affordable. Then, as requests came through the finance board, they were justified and prioritized. Often, unplanned requests came up, or special funding was obtained and those requests were considered as needed. The facility prioritized positions that could be transitioned from contract to FTE as that was usually a cost savings. Access and cost in the community was considered.

Barriers to Staffing

In an effort to understand the challenges faced by facilities in managing their staffing needs, we asked for information about barriers encountered with staffing. Almost all facilities stated they had barriers to staffing, the nature of which was varied. Just over one-half of those facilities reported that salary, financial incentives, or

position classification²⁷ posed barriers. One facility reported encountering recruitment challenges generally related to “extreme competition” for quality healthcare professionals. The facility further stated that it made use of multiple recruitment endeavors such as special salary rates, incentives (for recruitment, relocation, and retention), and an education debt reduction program. Even with these options, the facility continued to experience recruitment challenges for certain professions. The facility also reported that recently imposed ceilings on 3R incentives²⁸ had negatively impacted its ability to overcome the challenges.

Survey-identified barriers included position descriptions and associated pay determinations that were too low to be competitive. As such, facilities were challenged with matching salaries to those paid in the private sector. In addition to pay-related recruitment challenges, we noted instances where candidates had come on board, received training, and then transferred to another government agency in order to earn a higher salary. This series of events resulted in a “revolving door” at these facilities causing them to become a training ground for other agencies.

Many facilities noted that OPM Classification Appeal²⁹ downgrade decisions and/or outdated OPM classifications affected their ability to offer competitive salaries and advancement opportunities within the organization. This resulted in facilities being less competitive to attract new staff and retain highly skilled staff.

Shortages of Human Resource Management staffing and difficulty in recruitment and retention of staff were each reported as staffing barriers in one-quarter of the facilities. Many of the facilities cited a shortage of candidates or competition for candidates from other non-VA sources as barriers to unmet staffing needs. The impact of shortages of human resources personnel is also discussed in Issue I of this report.

Approximately one out of three facilities reported the following staffing barriers in equal measure: budget, funding, geographical features, and a cumbersome application or hiring process. Of those facilities that reported budget and funding issues, nearly half reported salary issues as barriers to staffing. With respect to the hiring process, facilities listed issues ranging from applicants facing challenges navigating the USAJOBS website to complex onboarding practices. One example included lag time between tentative and final offers due to pre-employment requirements, such as

²⁷ Classification standards for positions in the General Schedule were established by the Classification Act of 1949, which was codified in 5 U.S.C. 51. The statute outlines that the Office of Personnel Management will define various classes of position in terms of duties, responsibilities, and qualification requirements; establish official class titles; and set forth the grades in which the classes of positions have been placed.

²⁸ Recruitment, relocation, and retention incentives (3Rs) are compensation flexibilities available to help Federal agencies recruit and retain a world-class workforce. The 3Rs are administered under 5 U.S.C. 5753 and 5754 and 5 CFR part 575, subparts A, B, and C.

²⁹ The OPM Classification Appeals process can be used by current employees of the United States Federal Government in order to appeal current position classifications. The appeal may result in one of the following five outcomes: no change, new pay system, new series, upgrade, or downgrade. Each appeal and the resulting decision is unique and involves extensive fact finding and analysis. Regulations for classification appeals for General Schedule employees can be found in 5 CFR part 511, subpart G.

physicals, credentialing, background investigation, and information technology access issues. An additional barrier facilities mentioned included the time lost between an employee leaving the facility and the recruitment request being submitted/approved due to policy restrictions.

Decision to Utilize Care in the Community

VHA has several mechanisms to expand the ability to provide care including the Choice Program³⁰ (Choice), utilization of non-VA care, and securing of contract staff. Survey results confirmed that most facilities were utilizing VHA guidelines as their primary means for making this determination. In the survey, we specifically asked what processes “outside of normal policy consideration” were engaged at the facility level to insure adequate patient care. We found that three-quarters of facilities made this decision based on resource consideration or demand/access in combination with national guidelines. A number of additional factors were mentioned, but no unifying themes were identified.

Review of Staffing Demands for Optometrists, Pharmacists, and Medical Technicians

We found that optometry services generally did not utilize nationally recognized staffing models while pharmacists and medical technicians did. Regardless, all three occupations used indicators such as demand and patient access when assessing staffing needs. Another distinction was that an overwhelming majority of facilities indicated no significant gap in the ability to deliver optometry services. Many of these facilities reported they were able to meet optometry demand through staffing alternatives via Choice, non-VA care, and contract. Notably, these options were not available for pharmacists and medical technicians.

Unique Challenges Faced by Each Occupational Series

While their titles are often interchanged, medical technicians and technologists are authorized to perform different duties of varying complexity. The training requirements for Medical Technicians are generally less stringent, and they perform less complex tasks than Medical Technologists. Many facilities reported no longer using medical technicians due to the challenges of hiring with the current position description and compensation.

Federal regulations along with numerous national policies and directives govern the practice of pharmacy. Pharmacy was unique among the occupations that we reviewed by having multiple national staffing models and tools. Pharmacists can also

³⁰ The Veterans Choice Program was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of third-party administrators.

subspecialize and may not be deployed interchangeably. In contrast to optometrists, no ready substitutes are available for the pharmacist occupational series.

As noted above, the majority of facilities described little difficulty in meeting the demand for optometry services. For example, one facility reported its staffing was current, measured by timeliness of service and wait times. In addition, many facilities stated they were adequately staffed and did not have staffing issues or challenges within this occupational series. One facility in particular shared that at this point, they did not see a need to hire additional optometrists.

Each of these factors affects the facility's process for determining staffing needs as well as the practicality of filling identified positions.

Conclusions

This is the fourth determination of staffing shortages in VHA. We determined that the top five critical need occupations for FY 2017 are Medical Officer, Nurse, Psychologist, Physician Assistant, and Medical Technologist.

In looking at the gains, losses, and changes in onboard staffing for critical need occupations, we found that in the past year, VHA did increase the absolute numbers of staff (that is, net onboard) in four of the top five critical need occupations moving VHA closer to its goal of improving staffing levels.¹ However, the overall gains were reduced by high loss rates and did not significantly impact availability of staff in critical needs occupations.

Throughout the years in completing these reports, we have noted the relatively long onboarding process and challenges in finding suitable candidates. Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and FTE allocation at the individual facility level. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures to address the above concerns.

OIG reported on the need for staffing models for critical need occupations in the first report of this series over 2 years ago. At the time of the writing of this report, VHA still does not have operational staffing models that comprehensively cover critical need occupations. VHA has made progress in developing a SC provider staffing model; however, this model is not operational and is unlikely to be operational within a year. In the absence of facility-specific staffing targets or an operational staffing model, determining whether facilities are making meaningful progress in filling critical staffing shortages is challenging. Without staffing models, VA leadership is unable to ensure that staffing is consistent and sufficient.

VHA reported that it incorporates EHCPM data into staffing model development, and the SC staffing model incorporates demand projection data. We noted VHA's efforts with internal reviews of its staffing models and refinement of staffing terminology as well as efforts with external consultation for the development of staffing models.

VHA chartered a work group to review data on regrettable losses and consider ways that these numbers could be reduced. The work group compiled a report on regrettable losses and submitted it to VHA leadership. The report focused on the need for additional studies to determine causative and other factors related to regrettable losses. The work group reported issuing a follow-up report in September 2017.

We made four recommendations.

Recommendations

1. We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations.
2. We recommended that the Acting Under Secretary for Health review the Veterans Health Administration report on regrettable losses and implement effective measures to reduce such losses.
3. We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model.
4. We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.

OIG National Staffing Project FY 2017 Survey Questions

(1) How does your facility identify staffing needs? Please identify processes and data, not departments or committees (i.e. HR or resource committee).

(2) Excluding Staffing Methodology for VHA Nursing Personnel, Primary Care Management Module (PCMM), and Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers, do you use other staffing models and/or tools to identify staffing needs (include community/NonVA tools if applicable)?

Yes No

(A) If yes, please describe:

(3) After staffing needs are identified, what is the process of prioritization for recruitments and hiring?

(4) Are there barriers or other reasons that result in unmet staffing needs?

Yes No

(A) If yes, please describe them in order of importance.

(5) Currently the VA has mechanisms to expand the ability to provide care including the Choice Program, utilization of fee basis care, and securing of contract staff. Outside of policy considerations prescribing when these mechanisms must be used, how does your facility make a decision to use one of them?

(6) Does your facility have the following occupations (check all that apply)?

Optometrists (GS-0662)

Pharmacists (GS-0660)

Medical Technicians (GS-0645)

None of the above

Based on Question 6, answer for each occupation(s):

Optometrists (GS-0662)

(A) How do you formally assess the staffing requirements and demand for the optometrists (GS-0662) occupation (please specify the criteria used, i.e. metrics)?

(B) Is the optometrists (GS-0662) occupation staffed adequately to meet veteran demand?

Yes No

(C) How do you measure demand for this occupation to optimize staffing patterns?

Pharmacists (GS-0660)

(A) How do you formally assess the staffing requirements and demand for the pharmacists (GS-0660) occupation (please specify the criteria used, i.e. metrics)?

(B) Is the pharmacists (GS-0660) occupation staffed adequately to meet veteran demand?

Yes No

(C) How do you measure demand for this occupation to optimize staffing patterns?

Medical Technicians (GS-0645)

(A) How do you formally assess the staffing requirements and demand for the medical technicians (GS-0645) occupation (please specify the criteria used, i.e. metrics)?

(B) Is the medical technicians (GS-0645) occupation staffed adequately to meet veteran demand?

Yes No

(C) How do you measure demand for this occupation to optimize staffing patterns?

I certify this information is accurate to the best of my knowledge.

Yes No

Acting Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 14, 2017

From: Acting Under Secretary for Health (10N)

Subj: Healthcare Inspection—OIG Determination of VHA Occupational Staffing Shortages FY 2017

To: Assistant Inspector General for Healthcare Inspections (54)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, *OIG Determination of VHA Occupational Staffing Shortages FY17*. The Veterans Health Administration (VHA) concurs with the recommendations and provides the attached action plan.
2. As the nation's largest integrated health care delivery system, VHA workforce challenges mirror those of the health care industry as a whole. Industry demand for clinical staff in all health care sectors exceeds the supply of appropriately trained health care professionals to meet projected nationwide health care needs. In spite of that, VHA has been extremely successful at increasing the number of clinical providers and support staff needed to continue meeting demand, expanding access, and making VA the Veteran's first choice for health care.

3. VHA has grown by an average of 3.5 percent per year over the last 5 years, resulting in a net increase of nearly 5,000 additional health care providers and support staff. Much of the increase has occurred in the areas of mental health, primary care, and specialty care as a result of several specific hiring initiatives for those areas. VHA typically experiences an annual turnover rate of approximately 9 percent. The constant churn of turnover means that VHA expects to have a 9 percent to 10 percent vacancy rate at any given time. This compares quite favorably to the typical turnover in private sector of 20–30 percent.
4. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRService@va.gov.

(original signed by:)

Poonam Alaigh, M.D.
Acting Under Secretary for Health

Comments to OIG's Report

The following Acting Under Secretary for Health comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations.

Concur

Target date for completion: September 2018

Acting Under Secretary for Health response: To further mature clinical staffing models for the critical occupations cited in the OIG report, the Specialty Care Delivery Network Model Work Group Co-Chairs (Workforce Management and Consulting and the National Surgery Office) will leverage on-going work in the following arenas:

- 1) The Specialty Care Delivery Network Model Work Group has completed a comprehensive review of clinical staffing correlations across all 25 Specialty Care disciplines, at all VA Medical Centers, both inpatient and ambulatory. The analysis represented a "first of its kind" linkage between the determinants of Veterans enrollee population, current care-delivery capacity, productivity and cost. The review demonstrated a strong correlation between each of these factors, indicating a basis for a specialty care staffing model that establishes not only minimal staffing requirements at the clinical level, but also enables data-driven decision-making for outsourcing care.

In February 2017, this analysis was presented to the VHA National Leadership Council (NLC), who recommended additional internal review. In August 2017, the analysis was subsequently re-presented to the NLC, after feedback from VHA's Workforce and HealthCare Delivery Committees. In May 2017, the analysis was also presented to the OIG. Both the OIG and VHA leadership endorse the work to date, and VHA leadership has directed the team to continue its work.

The next phase of that work will be the development of a specialty care complexity model, building upon the correlations and variables identified in the research to date. Contiguous with the complexity model will be the development of specific tools for staffing requirements and facility leadership "make/buy" decision-making. VHA is targeting completion of this work in fiscal year (FY)18.

- 2) As noted in the previous edition of this report (September 30, 2016) VHA initiated a comprehensive review of all defined VHA clinical staffing models. This exercise has two goals: 1) to identify common best practices (and noteworthy

distinctions) between the various staffing model techniques and 2) to assess field application and evolution of the models towards the next level of excellence.

The review included more than a dozen models, ranging from the broad and continuing (such as the Primary Care Patient Aligned Care Teams) to the more narrowly-focused (such as Geriatrics & Extended Care).

Work is now underway to incorporate these models into VHA Workforce Planning (WFP) practices. VHA's WFP program is undergoing a substantial redesign and upgrade, with a goal of a more data-driven planning strategy derived from consistent application of common modeling techniques and standards, facility by facility. This does not mean that every practice area will model staffing requirements in the same fashion—as an example, the tools for establishing requirements for Patient-Aligned Care Teams (PACT) will be very distinct from establishing requirements for nurse professionals provide in-patient care delivery. The goal instead is to ensure that regardless of the method employed, facilities have the tools to define and plan for staffing requirements, tailored for local conditions, and with a data-driven rationale for any needed deviations.

- 3) Review and engagement on issues as identified in the OIG Staffing Survey of Facilities (Section IV of this report). The OIG survey captured field reporting of a number of staffing inhibitors, including issues related to classification, pay-setting, recruiting, on-boarding, prioritization and funding.

These concerns are also known to VA and VHA leadership, and multiple activities are in play to address. As an example, VA Modernization is centralizing classification to enable a more consistent application of position descriptions. Related activities include new tools for automating elements of the on-boarding process, deployment of upgrades to USA Staffing, and the establishment of a VA Manpower Office to define, staff and track positions at all levels of management. VHA will continue to work these issues throughout FY18.

Recommendation 2. We recommended that the Acting Under Secretary for Health review the Veterans Health Administration report on regrettable losses and implement effective measures to reduce such losses.

Concur

Target date for completion: September 2017

Acting Under Secretary for Health response: As noted in the previous edition of this report, VHA recognizes reduction of regrettable losses is a classic “force multiplier,” paying a variety of dividends in maintaining clinical capacity and quality. A strategic review of trends, barriers, practices and solutions influencing regrettable losses has been undertaken.

Note: VHA prefers and recommends the term “voluntary quits” or “VQ” in place of “regrettable losses.” VQ is a more precise term.

The objective of our analysis was to determine if voluntary quit patterns could be identified by characteristics such as practice areas, gender, years of service, geography and other categories. To meet this requirement, VHA leadership chartered a project team of human resource experts, with subsequent review by clinical professionals. The analysis does demonstrate correlation on VQ that may be mitigated by a variety of clinical, financial and human resource strategies.

In May 2017, VHA presented the Regrettable Losses report to the OIG. The meeting included a discussion of the findings and a detailed review of the methodology. OIG stated they were satisfied with the technical approach and conclusions drawn, and requested that VHA prepare a close-out report summarizing actions taken to formally close this recommendation. VHA will provide OIG with documentation of the activities identified below.

- A review of turnover intentions, exhaustion and burnout indicators from the All Employee Survey for each of the 6 shortage occupations reviewed.

- A review of Exit Survey implementation practices at individual healthcare systems.

- A deep dive into physician loss rates by specialty and a review of incentive utilization.

- Creation of a Human Resources workgroup to explore recruitment and retention issues unique to the occupation.

- A review of the use of temporary appointments.

Recommendation 3. We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model

Concur

Target date for completion: September 2018

Acting Under Secretary for Health response: As noted in the previous edition of this report, VHA agrees that demand prediction is an essential component of staffing models. While accurately assessing productivity and staffing at a given point in time is valuable, to gain the full effect of a competent model requires prediction of future states driven by the care likely to be required by Veterans at different points in time. Such capability enables focused recruiting, capacity planning and budget projections.

The VA Enrollee Health Care Projection Model (EHCPM), which was developed in 1998, is a sophisticated health care demand projection model and uses actuarial methods and approaches to project Veteran demand for VA health care. These approaches are consistent with the actuarial methods employed by the nation's insurers and public providers, such as Medicare and Medicaid. The EHCPM projects enrollment, utilization, and expenditures for the enrolled Veteran population for more than 90 categories of health care services 20 years into the future.

A key component in of the EHCPM is “reliance.” A unique aspect of the enrolled Veteran population is that enrollees have many options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, and private insurance. Approximately 80 percent of enrollees have some type of public or private health care coverage in addition to VA. As a result, enrollees rely on VA for approximately a third of their health care needs. Changes in enrollee reliance occur as a result of many factors such as enrollee movement into service-connected priorities, changing economic conditions, VA’s efforts to provide Veterans access to the services they need, VA’s efforts to enhance its practice of health care, the opening of new or expanded facilities, and the availability of services and/or the cost sharing associated with services in the private sector.

The VHA Office of Enrollment and Forecasting and the Specialty Care Delivery Network Model Work Group Co-Chairs (Workforce Management and Consulting and National Surgery Office) are incorporating EHCPM data into our staffing model development, including the Specialty Care Delivery Network Model cited in Recommendation 1 above. VHA will continue to expand our capability to predict Veteran demand for care, and to further enhance the ability of our staffing models to leverage demand prediction.

Recommendation 4. We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration’s resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary.

Concur

Target date for completion: June 2018

Acting Under Secretary for Health response: In developing the VACAA 201 Independent Assessments submitted by VA to Congress on September 1, 2015, Workforce Management and Consulting and the National Surgery Office partnered with a variety of external experts. Such third-party evaluation and analysis proved invaluable in the successful completion of the legislative requirement. VHA previously collaborated with commercial firms and with peer organizations on clinical staff model strategies and techniques.

In sum, VHA Workforce Management and Consulting and the National Surgery Office endorses consultation with professionals from government, education and commercial activities for the development and evolution of clinical staffing models, including the Office of the Inspector General. VHA leadership will continue the evaluation of all ongoing activity and determine where, when and with whom such consultation will be most valuable.

Based upon these experiences, VHA Workforce Management and Consulting and the National Surgery Office plan to consult with external experts prior to the implementation of the Specialty Care Delivery Network Model Work Group deliberations in FY18.

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