OIG Reports on Staffing Shortages for All VA Medical Centers

WASHINGTON – The VA Office of Inspector General (OIG) issued today its report OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages. The report is the fifth annual report on Veterans Health Administration (VHA) staffing shortages nationwide. For the first time, it reveals the self-reported gaps in both clinical and nonclinical occupations for 140 of the 141 VA medical centers.

Previous OIG reports examined VHA national staffing shortages for clinical staff only. This report allows users to examine the particular needs of an individual facility as opposed to only national data. In keeping with statutory changes, this report also includes nonclinical occupations (such as human resources and custodial personnel) that also ultimately affect the ability of VHA facilities to provide quality and timely patient care in a safe environment.

Although there was wide variability in occupational shortages reported by medical centers, directors most commonly cited the need for medical officers and nurses, which is consistent with the OIG’s four previous VHA staffing reports. Within nonclinical occupations, the OIG found that human resources management and police occupations were among the most often cited as shortages. The report also identified challenges to meeting staffing goals, including a lack of qualified applicants, noncompetitive salaries, and high staff turnover.

The report repeated its call for VHA to develop a new staffing model that identifies and prioritizes staffing needs at the national level while supporting flexibility at the facility level to ensure taxpayer dollars are invested in delivering the highest quality of care to veterans. Without the ability to analyze accurate data, VHA risks spending significant dollars without any measurable improvement in the quality of health care.

“This report should prompt meaningful discussions at both the local and national level about how to implement, support, and oversee staffing in VA medical centers that will result in the highest possible quality of veteran care,” said Inspector General Michael J. Missal. “VHA needs to develop the recommended staffing models that will provide leaders with the data needed to inform recruiting and hiring decisions within medical centers that are responsive to local needs.”
The broad range of distinct staffing needs identified by individual medical center directors reflects how each facility’s staffing must consider such factors as their patients’ specific needs and the local pool of qualified care providers. Depending on those local needs, solutions may involve using more third-party care providers in the community, bringing particular types of care into VA facilities, or expanding telehealth capabilities.

Local and national leaders have difficult financial management and staffing decisions to make, and such decisions should not be made without the kind of accurate local-level staffing data and models that are currently lacking. Consequently, the OIG will continue to monitor VA’s action plans and progress on implementing recommendations addressing critical staffing shortages.

A companion podcast about the report will be available at www.va.gov/oig/podcasts.

The VA OIG conducts oversight of VA programs and operations, providing independent and objective reporting to VA and Congress in order to prevent and detect fraud, waste, and abuse, as well as enhance the VA’s integrity, efficiency, and effectiveness. To report potential fraud, waste, mismanagement, or other abuse, contact the VA OIG Hotline at www.va.gov/oig/hotline.

###