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*Partnered Evidence-based Policy Resource Center*
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**POLICY BRIEF**

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# FY24 PEPReC Population-based Workforce Guidelines

**PhiYen Nguyen**, MPP, VA Boston Healthcare System
*Policy Analyst, PEPReC*
**Elsa Pearson Sites,** MPH, VA Boston Healthcare System
*Policy Director, PEPReC*
**Rebecca Thorsness**, PhD, VA Boston Healthcare System
*Investigator, PEPReC*
**Kyle Barr**, MS, VA Boston Healthcare System
*Sr. Data Strategist, PEPReC*
**Steven D. Pizer**, PhD, VA Boston Healthcare System
*Chief Economist, PEPReC*

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
*Health Services Research & Development Service*

***Bottom Line Up Front***

In response to the PACT Act, the Partnered Evidence-based Policy Resource Center is developing population-based workforce guidelines to help Department of Veterans Affairs Medical Center (VAMC) leaders assess staffing needs and project changes required to meet predetermined access targets. These VAMC-specific, specialty-specific guidelines provide a dynamic view of Veteran health care needs and VAMC-level challenges and are responsive to insights from national and local leaders that highlight key access barriers. The guidelines are under continual refinement and are updated annually.

## Introduction

In 2022, Congress passed the PACT Act, which increases access to care for Veterans affected by military toxic exposures such as burn pits.[1] The law also mandates that the Department of Veterans Affairs (VA) assess staffing levels at VA Medical Centers (VAMCs) and develop a data-driven approach to estimate present and future staffing needs. The Office of Human Resources and Administration / Operations, Security, and Preparedness asked the Partnered Evidence-based Policy Resource Center (PEPReC) to support these efforts, leveraging our expertise in health care supply and demand modeling.

PEPReC's goal is to create population-based workforce guidelines that help leaders assess current staffing and identify the necessary adjustments to meet predetermined access targets, such as new patient wait times. The guidelines account for local Veteran demand for VA care, including shifts related to PACT Act changes, making them adaptable to VAMC-specific needs.

*Benefits of PEPReC's Population-based Workforce Guidelines*

| Benefit | | Explanation |
|---|---|---|
|  | **Sensitive to population-based variations in demand for care** | Responsive to current Veteran population shifts and variations in clinic time (i.e., capacity), clinic work rate (i.e., productivity), and VA purchased community care. Supplements the Veterans Equitable Resource Allocation model and the Enrollee Health Care Projection Model, both based on *historical* utilization. |
|  | **Responsive to real-time clinic activity with enhanced data transparency** | Accurately captures the time clinicians are available in clinic for direct patient care. Supplements Office of Productivity, Efficiency, and Staffing's productivity metrics, based on *reported* clinician availability. |

## Key Proposed Usage of Workforce Guidelines

These workforce guidelines provide national and local VA leaders with an evidence-based tool to better understand the factors that impact the provision of care in outpatient setting. PEPReC's models provide insight into the relationship between different management levers and access to care so that managers can more efficiently and effectively improve the Veteran experience. Key decision-making areas include:

- **Optimizing existing resources**: Using current staff to serve the Veteran population more efficiently (e.g., adjusting scheduling practices and productivity, reassigning staff).
- **Adding additional resources**: Targeting specific areas to add additional staff to increase the care available to Veterans (e.g., hiring, expanding virtual care).

## Fiscal Year 2024 (FY24) Methodology

PEPReC's statistical modeling calculates recommended adjustments in clinic time (i.e., capacity) and clinic work rate (i.e., productivity) for VAMCs to meet predetermined access standards, new patient wait time targets set by the MISSION Act: 20 days for primary care and 28 days for specialty care.[2] See Figure 1 for our modeling framework. In FY24, PEPReC's modeling focused on developing outpatient workforce guidelines for primary care and eight specialties, including cardiology, gastroenterology, oncology, orthopedics, otorhinolaryngology, pulmonology, rheumatology, and urology. The FY24 model used data from August 2022 to July 2024, incorporating VAMC-specific factors such as current Veteran demographics.

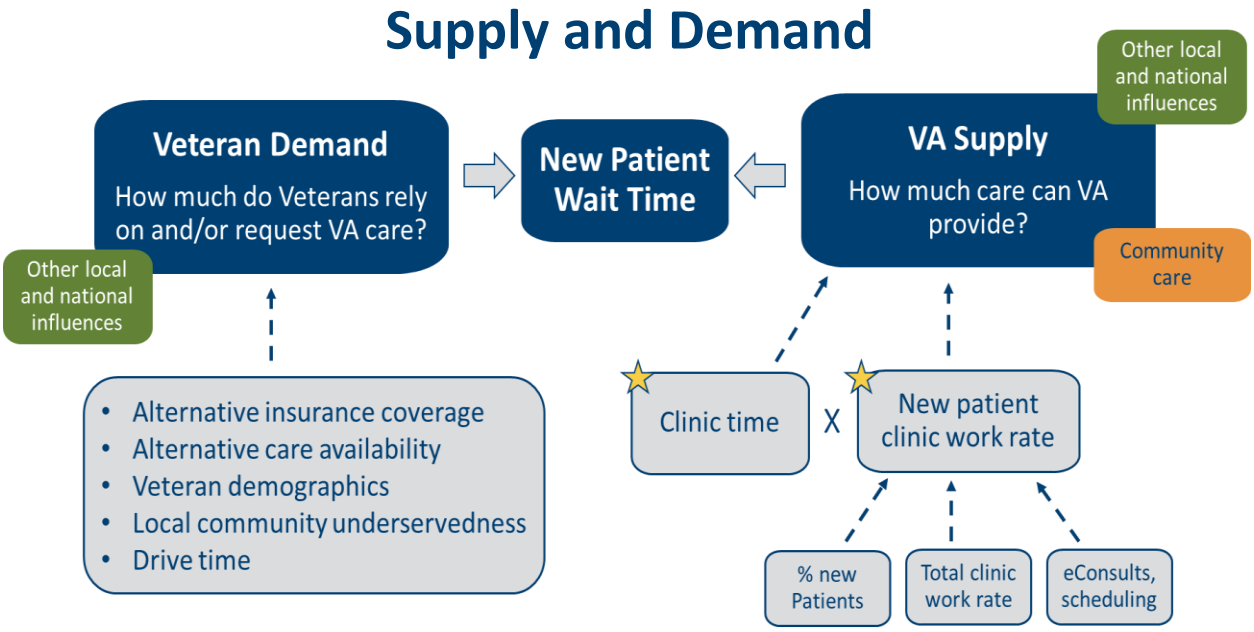


**Figure 1**: Supply and Demand Modeling Framework

PEPReC presented our preliminary guidelines to national and local leadership, collecting feedback and engaging in discussions that would help refine our modeling approach. Additionally, two other evaluation centers conducted qualitative evaluations with the field to assess the impact of PACT Act implementation and, specifically, the new Toxic Exposure Screening (TES), on primary and specialty care, respectively.

**Clinic Time**

The total time clinicians are available in the outpatient clinic for direct patient care, measured directly from administrative data.

## FY24 Workforce Guidelines

The following table summarizes the projected clinic time Full-Time Equivalent (FTE) increases and changes to work rates needed to meet the MISSION Act new patient wait time targets in FY24, by specialty.

**New Patient Clinic Work Rate**

The total number of new patient encounters per eight hours of clinic time.

*National Overview by Specialty*

| Specialty | Number of VAMCs Needing Additional Clinic Time FTE | Number of VAMCs Needing Adjusted Work Rate | Projected National Increase in FTE (%) | Projected National Increase in FTE |
|---|---|---|---|---|
| Primary Care | 67 VAMCs | 74 VAMCs | 45.6% | 1811.0 FTE |
| Cardiology | 49 | 68 | 7.2% | 29.5 |
| Gastroenterology | 65 | 74 | 41.6% | 94.2 |
| Oncology | 9 | 68 | 2.3% | 6.2 |
| Orthopedics | 30 | 80 | 5.7% | 16.1 |
| Otorhinolaryngology | 30 | 58 | 13.1% | 18.0 |
| Pulmonology | 63 | 74 | 24.3% | 47.4 |
| Rheumatology | 39 | 58 | 26.0% | 22.8 |
| Urology | 57 | 76 | 16.5% | 40.6 |

*Summary of FY24 Qualitative Findings*

During discussions with national and local leadership, six key themes emerged, highlighting areas for improvement in future iterations of the workforce guidelines.

1. **Results Validation**: Our workforce guidelines were well received. Most national and local leaders agreed with PEPReC's approach and findings, confirming that our guidelines accurately reflected current staffing needs and emphasizing the need for tailored solutions.
2. **Staffing Gaps**: Recruitment and retention remained major challenges, especially in rural areas where it is difficult to attract specialists. Private sector competition and clinician burnout further exacerbated staffing shortages, impacting care delivery across VAMCs.
3. **Physical Space Limitations**: About 75% of interviewed VAMCs reported that limited clinic and procedural space restricted their ability to expand services, even when hiring was possible. This ultimately led to longer wait times and reliance on community care.
4. **Advance Practice Providers (APPs) and Physician Trainees**: APPs, such as physician assistants and nurse practitioners, and physician trainees were deemed essential to offset staffing shortages, though their usage varied widely between VAMCs. VAMCs with very high clinic work rates highlighted the importance of delineating attending physician and physician trainee workloads in our modeling.
5. **Concerns about MISSION Act Access Standards**: Leaders expressed that the MISSION Act's 28-day wait time for specialty care is too long for some specialties like oncology and too short for some stable patients who may prefer to book appointments further out. They called for more nuanced, specialty-specific access standards.
6. **Community Care Utilization**: Most leaders noted that the private sector often has longer wait times and more variable care quality than VA. They stressed the need to reduce reliance on VA purchased community care and bring more Veterans back in house.

## FY24 Updates and FY25 Future Steps

PEPReC's population-based workforce guidelines are under continual refinement. Based on feedback from national and local leaders, we adjusted how we set clinic work rate targets in our final FY24 workforce guidelines to emphasize productivity before the addition of new staffing.

In FY25, aligning well with stakeholder feedback, PEPReC intends to enhance the guidelines by incorporating VA purchased community care utilization and TES positivity rates (to better assess demand related to military toxic exposures). Additional efforts will focus on refining workforce benchmarks, incorporating specialty-specific considerations, and improving how we consider APPs and physician trainee workload.

## Conclusion

PEPReC's population-based workforce guidelines provide clinic managers and leaders with valuable transparency into clinic performance, highlighting the tradeoffs between access, staffing, and productivity. These guidelines are most effective use in informing workforce requirements (i.e., FTE) necessary to care for Veterans and guide resource allocation decisions. While the recommendations offer potential solutions to meet MISSION Act standards, the guidelines are a dynamic tool, enabling managers to make data-driven decisions that improve access to care. PEPReC will continue to incorporate stakeholder feedback to update these guidelines and better address the needs of Veterans.

## References


1. U.S. Department of Veterans Affairs. The PACT Act and your VA benefits. www.va.gov/PACT
2. U.S. Department of Veterans Affairs. VA announces access standards for health care. VA News. 2019 https://news.va.gov/press-room/va-announces-access-standards-for-health-care/


# ABOUT PEPReC POLICY BRIEFS

This evidence-based policy brief is written by Partnered Evidence-based Policy Resource Center (PEPReC) staff to inform policymakers and Veterans Health Administration (VHA) managers about the evidence regarding important developments in the broader health system and economy. PEPReC is a Quality Enhancement Research Initiative-funded resource center that collaborates with operational partners to design and execute randomized evaluations of VHA initiatives, develops and refines performance metrics, and writes evidence-based policy briefs. *The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.*


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