DEPARTMENT OF VETERANS AFFAIRS

Congressionally Mandated Report
Assessing the Staffing Needs of Each Medical Facility within the Department of Veterans Affairs

March 2023

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Summary
Section 301(d) of P.L. 113-146, the Veterans Access, Choice and Accountability Act of 2014, also known as the Choice Act (established with the Veterans Choice Program) requires the Department of Veterans Affairs (VA) to prepare a biennial report "assessing the staffing of each medical facility of the Department." The objective of this report is to provide an update on the Veterans Health Administration's (VHA) provision of timely access to high-quality care.

The first edition of this report was submitted to Congress on March 9, 2015; the second edition was submitted on April 30, 2017; the third edition was submitted December 31, 2018; the fourth edition of the report was submitted December 30, 2020. This is the fifth edition of the report as required by the Choice Act.

VHA is the largest integrated health care system in the United States, providing care at 1,250 health care facilities, including 172 VA Medical Centers and 1,069 outpatient sites of care. In fiscal year (FY) 2022, more than 9 million Veterans were enrolled in the VA health care system. VHA employs 379,830 employees (361,310 full-time and 18,520 part-time). Out of 361,310 full time VHA employees, 96,931 or 26.8% are Veterans.

VHA's workforce challenges mirror those of the health care industry. There is a national shortage of health care professionals, especially physicians and nurses. The American Association of Colleges of Nursing, Association of American Medical Colleges and other national health care organizations have written about this workforce shortage at length. VHA remains fully engaged in a fiercely competitive clinical recruitment market. VHA has been successful in increasing the number of clinical providers including hard-to-recruit-and-retain physicians, such as psychiatrists.

VHA staffing plans account for normal rates of workforce turnover, retirement and growth and the expectation that there will always be vacant positions. VHA carefully monitors several measures of Veteran access to care, health care outcomes and patient satisfaction to ensure the Veteran is being served. The best indicators of adequate staffing levels are Veteran access to care and health care outcomes, and VHA continues to make substantial progress on these measures. As identified by external research and studies, in general, Veterans are receiving the same or better care at VA Medical Centers as patients at non-VA hospitals. VA continues to focus on measuring and monitoring performance of each Medical Center.

This report is divided into 12 sections, grouping the elements of the legislation into common topics. Key findings are as follows:

<u>Sections 1, 2 and 3</u>
"Appropriate staffing levels for health care professionals to meet the goals of the Secretary for timely access to care for Veterans."
"*Appropriate staffing levels for support personnel, including clerks."*
"Appropriate sizes for clinical panels."

“Appropriate numbers of full-time staff, or full-time equivalents, dedicated to direct care of patients.”

Section 505 of P.L. 115-182, the John S. McCain III, Daniel K. Akaka and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VA Personnel Transparency, requires VA to make information regarding vacancies, accessions and separation actions, new hires and personnel encumbering positions publicly available for each medical facility. Vacancies reflect a hiring demand signal but do not indicate significant shortages in most instances. As of September 30, 2022, VHA had approximately 76,877 vacancies, which is consistent with 1) annual turnover of approximately 9-10%, 2) growth of approximately 2-3% annually and 3) the churn associated with internal movement of staff due to promotions and location or career changes. VHA turnover rates compare favorably with the health care industry, including for those occupations identified as mission critical. The best indicators of adequate staffing levels are not turnover or vacancies, but Veteran access to care and health care outcomes.

The 2019 Enrollee Health Care Projection Model (EHCPM) projected the Veteran population eligible to enroll for VA health care to decline from 2019-31; but the enrollee population was expected to remain relatively constant with only a slight decline. In 2022, however, the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, P.L. 117-168, was enacted into law, which aims to expand eligibility for Veteran enrollment. The full extent of the expansion of enrollees and enrollee reliance on VHA care as a result of the PACT Act has not yet been fully projected.

Enrollee population trends do not always correlate directly with the trends in demand for VA health care. This is because there are several factors driving projected workload including changing enrollee demographics (e.g., age, gender, morbidity, etc.) and health care trends. Even if the enrollee population were to remain relatively constant, these factors will drive a net increase in workload, particularly for ambulatory services. This does vary by service and geography. Based on the 2019 EHCPM (without PACT Act projections), the following changes in demand for health care were projected in VA facilities between 2019 and 2031:

- Outpatient primary and specialty care combined were projected to grow 50% nationally and outpatient mental health was projected to grow 67% nationally. This increased demand for outpatient services is expected across all Veterans Integrated Services Networks (VISN), with some experiencing slightly more growth and some less.
- Inpatient acute medicine and surgery demand was projected to decrease 13% nationally, with variation across the VISNs from a 23% decline to a 3% increase.
- Inpatient acute mental health demand was projected to decrease 6% nationally, ranging from a 14% increase to a 19% decline across VISNs.

- Home and community based long term services and supports were projected to increase 25% nationally, varying between a 2% decline and a 48% increase across the VISNs.
- Community living center workload was anticipated to decrease 8% nationally, varying between a 22% decline and a 4% increase across VISNs.

All combined, VHA's staffing need is expected to grow approximately 3% or more annually.

Section 4
"Appropriate physical plant space to meet the capacity needs of the Department in that area."

To ensure sufficient capacity for care, VHA will require an additional 63 million square feet of clinical space by 2030. After currently planned construction and leases are considered, VHA's expected inventory of 181 million square feet in 2024 will be 26% short of the Department's requirements.

Section 5
"A plan for addressing any issues identified in the [system-wide assessment of all medical facilities of the Department], including a timeline for addressing such issues."

The preceding analysis revealed two key concerns that must be addressed to ensure continued improvement of Veterans access to care, the need for predictive staffing models and requirement for additional capital assets. VHA has a projected gap of 63 million square feet of clinical capital asset requirements over the next 8 years. VHA cannot ensure timely access for Veterans if there is insufficient clinical space within which to provide care. Given the long lead-times required to acquire capital assets, solutions will need to be resourced well in advance. Such resourcing will also require assessing the current mix of facilities and the potential realignment of underused space to those facilities with greater requirements.

Sections 6 and 8
"A list of the current wait times and workload levels for the following clinics in each medical facility: Mental Health, Primary Care, Gastroenterology and Women's Health."
"The current staffing models of the Department for the following clinics, including recommendations for changes to such models: Mental Health, Primary Care, Gastroenterology and Women's Health."

The report provides the wait time, workload (as a function of patient encounters) and clinical staffing models for the four clinics cited above.

There is considerable variability in how VHA organizes and projects workforce requirements for the four practice areas above. Primary Care represents the broadest range of care, and is organized upon a team-based concept, using the Patient Aligned

Care Team model. Mental Health and Women's Health (WH) require a blend of staffing planning that incorporates elements of both team-based and productivity modeling. Gastroenterology (GI), as a subset of Physician Specialty Care, is evolving towards a productivity-centric approach, albeit with caveats noted in this report.

Improvements to VHA clinical staffing will include: 1) determining the appropriate applicability of productivity standards to the clinics, including Relative Value Units; 2) aligning and standardizing modeling practices in the field; 3) evolving the types of data collected and tools to collect them; and 4) ensuring the results of clinical staffing modeling are incorporated into VHA's budget, workforce and succession planning.

Section 7

"A description of the results of the most current determination of the Inspector General… and a plan to use direct appointment authority… to fill staffing shortages, including recommendations for improving the speed at which the credentialing and privileging process can be conducted."

In August 2017, section 201 of the VA Choice and Quality Employment Act of 2017, P.L. 115-46, required the VA Office of Inspector General (OIG) to identify at minimum five nonclinical and five clinical shortage occupations at each health care system, changing the previous requirement to identify five shortage occupations at the VHA system level established by section 301(d) of the Choice Act. The VA OIG published VHA health care system reported shortages in the "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022.[1]"

In response to the 2017 legislation, VHA leveraged its annual workforce planning cycle to independently identify shortage occupations. In FY 2022, the VHA workforce planning cycle identified 10 clinical and 9 nonclinical occupations that were identified by at least 20% or more of VHA health care systems or 50% or more VISNs or national offices. The clinical shortage occupations identified in 2022 were registered nurse (RN), physician, psychologist, practical nurse, nursing assistant, medical technologist, social worker, diagnostic radiologic technologist, pharmacy technician and medical technician. The nonclinical shortage occupations identified were custodial worker, medical support assistant (MSA), police, general engineering, food service worker, medical supply aide and technician, contracting, human resources (HR) management and HR assistant.

Sections 9, 10, 11 and 12

"The number of positions in medical facilities throughout the Department that are not filled by a permanent employee."
"The length of time [such positions] remained vacant or filled by a temporary or acting employee."
"A description of any barriers to filling [such positions]."
"A plan for filling any positions that are vacant or filled by a temporary or acting employee for more than 180 days."

[1] https://dvagov.sharepoint.com/sites/WMCPortal/WFP/Documents/Reports/VAOIG-22-00722-187.pdf.

“A plan for handling emergency circumstances, such as administrative leave or sudden medical leave for senior officials.”
“The number of health care providers of the Department who have been removed from their positions, have retired, or have left their positions for another reason, disaggregated by provider type, during the 2-year period preceding the submittal of the report.”
“Of the health care providers who have been removed from their positions, the following: the number of such health care providers who were reassigned to other positions in the Department; the number of such health care providers who left the Department; and the number of such health care providers who left the Department and were subsequently rehired by the Department.”

The overall percentage of VHA employees occupying a permanent clinical or support position while in temporary status is minimal: 3.1%. As of October 2022, VHA has 82 field leaders in an acting capacity, out of 738 field leadership positions. This section describes a number of steps VHA is taking to improve the timeliness of filling vacancies including: 1) additional recruiting activities; 2) increased compensation options; 3) field HR training; 4) retention, including leveraging the Choice Act-expanded Education Debt Reduction Program (EDRP) and implementation of the Specialty Education Loan Repayment Program (SELRP); and 5) improvements to HR information systems. Furthermore, VHA is implementing the PACT Act, of which Title IX increases VHA’s flexibility and competitiveness in recruitment, retention and compensation.

VHA Directive 320 requires all VHA medical facilities to have a comprehensive emergency plan in place, to include continuity of operations and commensurate leadership communication chain. A copy of Directive 320 is included in this report as an appendix. Overall, VHA experienced 41,395 health care provider losses in FY 2021 and FY 2022, with 13,256 retirements, 2,056 removals and 26,083 other departures. Of the removals, all were officially separated from service with the VHA, and none were reassigned. Fifty of the removed employees were subsequently rehired. These rehires were primarily clinicians whose licenses had expired, were dropped from rolls, rehired when their licenses were renewed and resumed delivering care for Veterans.

Path Forward
Effective management and forecasting of clinical and non-clinical staffing for VHA healthcare systems is a critical element of meeting the Department’s goal to ensure timely health care for Veterans. The MISSION Act and the PACT Act continue to fundamentally transform elements of VA’s health care system, fulfilling VHA’s commitment to help Veterans live a healthy and fulfilling life. The transformed VHA system will do the following:

1. Ensure easy and reliable access to care when they need it.
2. Provide exceptional care to Veterans anytime, anywhere.
3. Serve as a trusted, caring partner helping Veterans and their families be healthy and well.

Introduction

Section 301(d) of P.L. 113-146, the Veterans Access, Choice and Accountability Act of 2014, also known as the Choice Act, and established with the Veterans Choice Program, requires VA to prepare a report "assessing the staffing of each medical facility of the Department." The law further directs the Department to submit this report within 180 days of the enactment of the Choice Act, and again upon December 31 of each even-numbered year until 2024. This document represents the fifth edition of this report.

Overview

The theme of this report is consistent with the corresponding objectives of the Choice Act legislation: *ensuring timely access to care for the Nation's Veterans.* Ensuring identification of both current and future requirements for care delivery is, and will remain, essential for Veterans to receive the medical care to which they are entitled. Establishing, filling and projecting staffing requirements for VA's health care system is a complex task. VHA is the largest integrated health care system in the United States, providing care at 1,250 health care facilities, including 172 VA Medical Centers and 1,069 outpatient sites of care. VHA provides a full range of primary and specialty care health services for patients ranging in age from our youngest recently discharged service members to our most senior Veterans. There is substantial geographic and chronological variation among the Veteran population, most notably in rural areas. Veterans also present unique health conditions as a result of their experiences in combat and require a commensurate array of professionals to address their requirements. In addition, women Veterans are the fastest growing Veteran population and require a spectrum of care delivery specific to their needs.

While there are many approaches to projecting staffing of medical professionals and support staff across large health care systems, there is no one-size-fits-all solution. Even within common practice areas, there are substantial distinctions driving different approaches to identifying clinical staffing needs. There is no single set of staffing management tools from the private sector or elsewhere in the Federal Government for all areas of care. Some practices, such as Women's Health, require integration across multiple disciplines for effective delivery of care and do not conform to a staffing model in the same way that a specialty practice can adapt.

The preceding factors represent a challenge, but by no means an insurmountable barrier towards achieving the goals of timely access to care for Veterans. In FY 2018, VHA formally stood-up the VHA Manpower Management Office, recently renamed to Workforce Strategy and Standardization (WSS), in conjunction with the VA's establishment of a Department-wide Manpower initiative. VHA has an aggressive schedule for establishing manpower capabilities, which includes establishing staffing models for all functional areas; benchmarking staffing, quality and access at similar health care systems; developing predictive recruitment models; and identifying facilities in danger of critically low staffing levels. VHA has many long-standing clinical staffing models (e.g., primary care, mental health, nursing, pharmacy) and is continuing to develop and validate others, especially for non-clinical functional areas.

As directed by the legislation, much of this report depicts the current state of staffing at VHA's medical facilities, as well as the advancements VA continues to make in timely delivery of care. Furthermore, this report describes the resources and tools VA uses to effect the changes, including congressional authorities made available through more recent legislation, such as MISSION Act and the PACT Act. To that end, this report will also discuss the path forward, proactively evolving care delivery on behalf of the Nation's Veterans.

Section 1: Assessment of Staffing Levels

Veterans Access, Choice and Accountability Act Section 301

"The results of a system-wide assessment of all medical facilities of the Department to ensure the following:

- *Appropriate staffing levels for health care professionals to meet the goals of the Secretary for timely access to care for veterans.*
- *Appropriate staffing levels for support personnel, including clerks."*

Section 1: Assessment of Staffing Levels

Section 505 of the MISSION Act, VA Personnel Transparency, requires VA to make information regarding vacancies, accessions and separation actions, new hires and personnel encumbering positions publicly available for each medical facility. Vacancies reflect a hiring demand signal, but do not indicate significant shortages in most instances. As of September 30, 2022, VHA had approximately 76,877 vacancies, which is consistent with annual turnover of approximately 9-10%, growth of approximately 2-3% annually and the churn associated with internal movement of staff due to promotions and location or career changes. VHA turnover rates compare favorably with the health care industry, including for those occupations identified as mission critical. The best indicators of adequate staffing levels are not turnover or vacancies, but Veteran access to care and health care outcomes.

VHA is the largest administration within VA, accounting for 379,830 of VA's 425,455 onboard employees. Each year, VHA hires more employees than it loses to replace turnover and sustain the growth in demand for services. Staffing plans consider normal rates of workforce turnover, retirement and growth, and the expectation that there will always be vacant positions.

There is a consistent turnover of employees in large organizations such as VHA due to normal retirements and job changes. Vacancies represent current unencumbered positions due to turnover and new positions that are planned to meet an anticipated growth in services. VHA has approximately 90,859 vacancies, which is consistent with the historical annual 9-10% turnover rate and a 2-3% growth rate. These data are illustrated in Table 1.1 below and Figure 1.1. on page 10. VHA turnover rates compare favorably with the healthcare industry, including for those occupations identified as mission critical.

Table 1.1 VHA Onboard, Hires, Losses and Total Loss Rate FY 2017-22

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Onboard Employee	327,329	338,524	349,631	363,474	371,401	379,830
Onboard Employee Growth Rate	2.0%	3.4%	3.3%	4.0%	2.2%	2.3%
Hires	36,837	42,866	43,177	44,176	43,486	47,492
Total VHA Losses (excludes 900 and 901)	29,888	31,753	32,997	31,962	37,022	37,570
Total Loss Rate	9.2%	9.5%	9.6%	9.0%	10.0%	10.1%

VA notes that onboard data totals reflected in this table vary slightly from data published in the quarterly MISSION Act Section 505 reports due to different exclusion criteria and points in time that data are pulled.

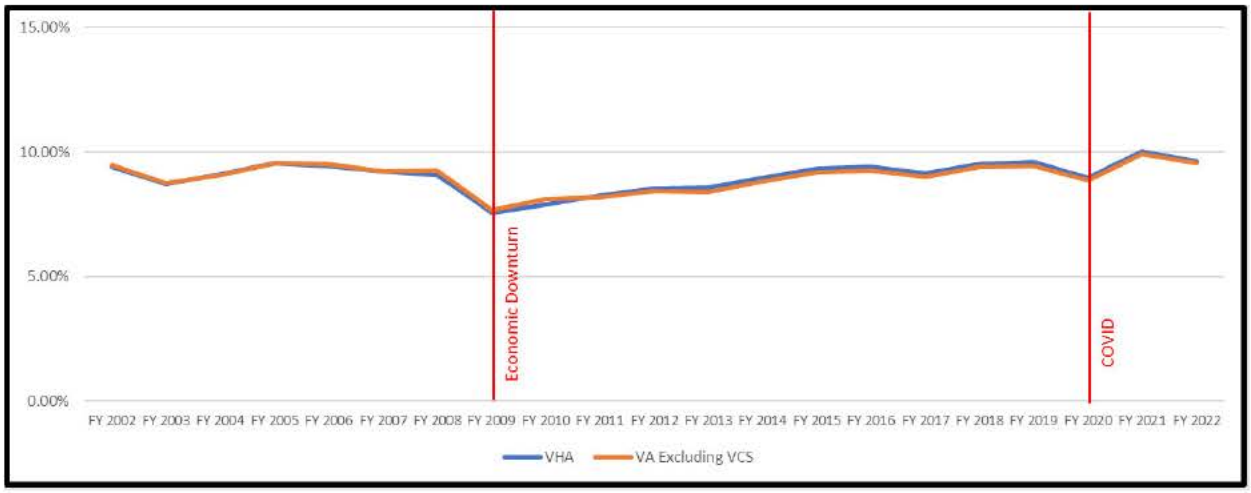

Figure 1.1 VA and VHA Total Loss Rate for FY 2002-22 (excluding Veterans Canteen Service)

Vacancy tracking, while of use, is not the best indicator of adequate clinical staffing levels. More effective measures include Veteran access to care and health care outcomes. VHA carefully monitors several measures of Veteran access to care, health care outcomes and patient satisfaction to ensure the Veteran is being served. External evaluations of the VHA health care system have found that VHA consistently performs better than or equal to the private sector. A study published June 26, 2020, in the Journal of Surgical Research concluded that the surgical care provided by VA was better or equivalent to non-VA hospitals. The study found that the rates of complications were lower at VA hospitals and patient satisfaction scores were comparable.[2]

Since its inception in 2018, the VHA WSS has made steady progress towards an aggressive schedule for establishing manpower capabilities within VHA. With limited capacity WSS has collaborated with internal VA partners to establish staffing models for VHA, which includes benchmarking staffing, quality and access at similar health care systems; developing predictive recruitment models; and identifying facilities in danger of critically low staffing levels. VHA has many long-standing clinical staffing models (e.g., primary care, mental health, nursing, pharmacy) and is continuing to develop and validate others, especially for non-clinical functional areas.

The FY 2022 VHA Workforce Planning Cycle assists VHA in identifying potential shortage occupations and facilities at risk using a standardized, data-driven approach. The clinical shortage occupations identified were the following:

- 0610 Registered Nurse;
- 0602 Medical Officer (Physician);
- 0180 Psychology;
- 0620 Practical Nurse;

[2] Study shows VA surgical care better than or equal to non-VA hospitals

- 0621 Nursing Assistant;
- 0644 Medical Technologist;
- 0185 Social Work;
- 0647 Diagnostic Radiologic Technologist;
- 0661 Pharmacy Technician; and
- 0645 Medical Technician.

The nonclinical shortage occupations identified by VHA healthcare systems were the following:

- 3566 Environmental Services Technician (Custodial Worker);
- 0679 Medical Support Assistant;
- 0083 Police;
- 7408 Food Service Worker;
- 0801 General Engineering;
- 0622 Medical Supply Aide and Technician;
- 1102 Contracting;*
- 0201 Human Resources Management;* and
- 0203 Human Resources Assistant.*

**Consolidated Occupations*

More information on this analysis is available in Section 7: Review of Inspector General Report.

Implications of Projected Growth in Veteran Demand

In 2021, out of a population of 19.2 million Veterans, 13.8 million were eligible to enroll in VA health care, and 8.7 million were enrolled. The 2022 EHCPM indicates that the total population of Veterans, as well as those eligible to enroll are expected to decline from 2023-31; however, the enrollee population itself is expected to remain relatively constant with only a slight decline. This varies across the country, with some VISNs projecting up to an 11% increase in enrollment and some expecting enrollment declines of up to 25%.

Enrollee population trends do not always correlate directly with the trends in demand for VA health care. This is because several factors are driving projected workload, including changing enrollee demographics such as age, gender and morbidity and health care trends. Even with the enrollee population remaining relatively constant, VHA expects these factors to drive a net increase in workload in VA facilities, particularly for ambulatory services. This will vary by service and geography. Between 2023 and 2031, the following changes in demand for health care are projected in the following VA facilities:

- Outpatient primary and specialty care combined are projected to grow 50% nationally, and outpatient mental health care is projected to grow 67% nationally. This increased demand for outpatient services is across all VISNs, with some experiencing slightly more growth and some less.

- Inpatient acute medicine and surgery demand is projected to decrease by 13% nationally. This varies across VISNs from a 23% decline to a 3% increase.
- Inpatient acute mental health demand is projected to decrease by 6% nationally. This ranges from a 19% decrease to a 14% increase across VISNs.
- Home and community based long-term care services and supports are projected to increase by 25% nationally. The change varies between a 2% decrease to a 48% increase across VISNs.
- Community living center workload is anticipated to decline by 8% nationally. At the VISN-level, the change varies between a 22% decrease and a 4% increase.

The Coronavirus Disease 2019 (COVID-19) pandemic had a significant impact on health care demand and delivery in FYs 2020-2022 and is expected to impact the amount of care provided for the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in FY 2020 and FY 2021 as individuals chose to defer certain care. It was anticipated that there would be a resulting surge in care in FY 2022 and FY 2023 to fulfill previously deferred services, however, deferred service impacts have been slower to return than expected. Additionally, the stay-at-home orders and social distancing mandates have had an impact on the U.S. economy, which is expected to increase reliance on VA for health care.

The impact of P.L. 117-168 is not included in the projections used in this report.

Figure 1.2 on the next page illustrates the projected decline in Veterans, but relatively stable projection in enrolled Veterans and enrolled Veteran patients (i.e., enrolled Veterans using VA health care services). It does not include the projected increase in enrollees that will result from the recently enacted PACT Act. Aside from the PACT Act, the most significant enrollment dynamic impacting the projected future demand for VHA health care is the increasing number of enrollees being adjudicated by the Veterans Benefits Administration for service-connected disabilities, which increases the number of enrollees in Priorities 1, 2 and 3. The number of enrollees in Priorities 1-3 is expected to grow 20% from 2021 to 2031. These enrollees are also expected to increase their reliance on VHA, resulting in an increase in utilization of VHA health care.

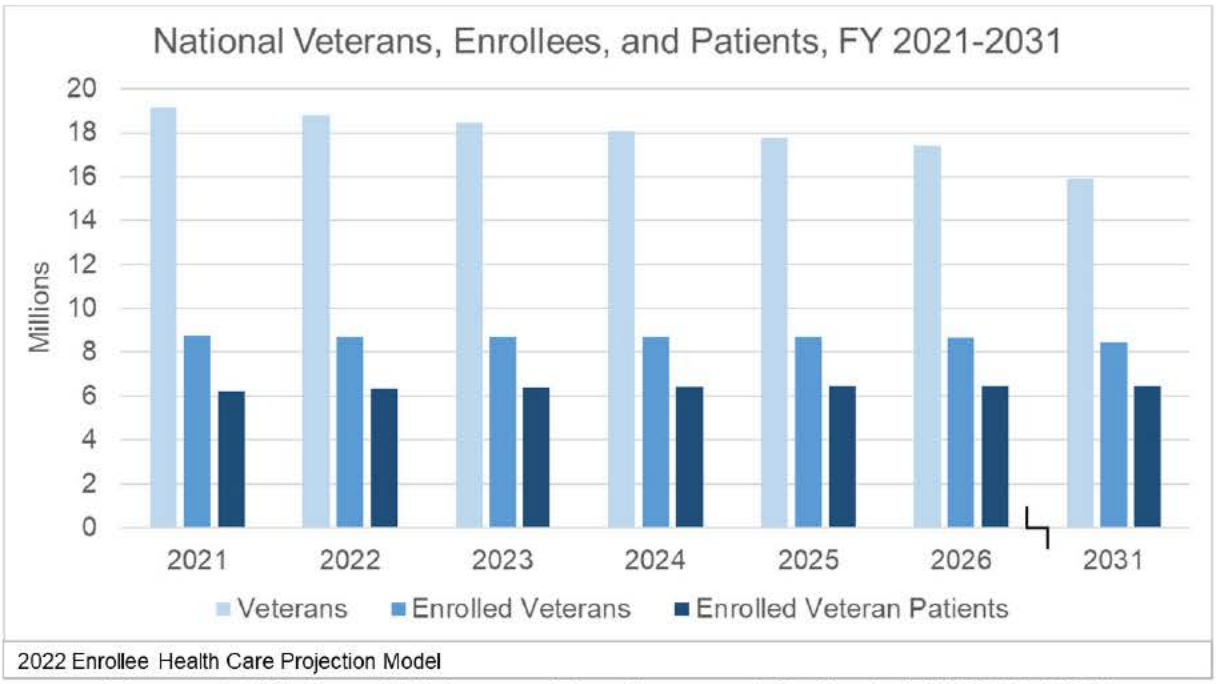

Figure 1.2 National Veterans, Enrollees and Patients FY 2021-2031

Figure 1.3 shows the significant projected growth in service-connected status for Post-9/11, Gulf War and Vietnam era enrollee populations over the next 20 years. For example, the percent of 50-year-old enrollees who are Priority 1-3 will shift from 68% to 81% over the next 10 years.

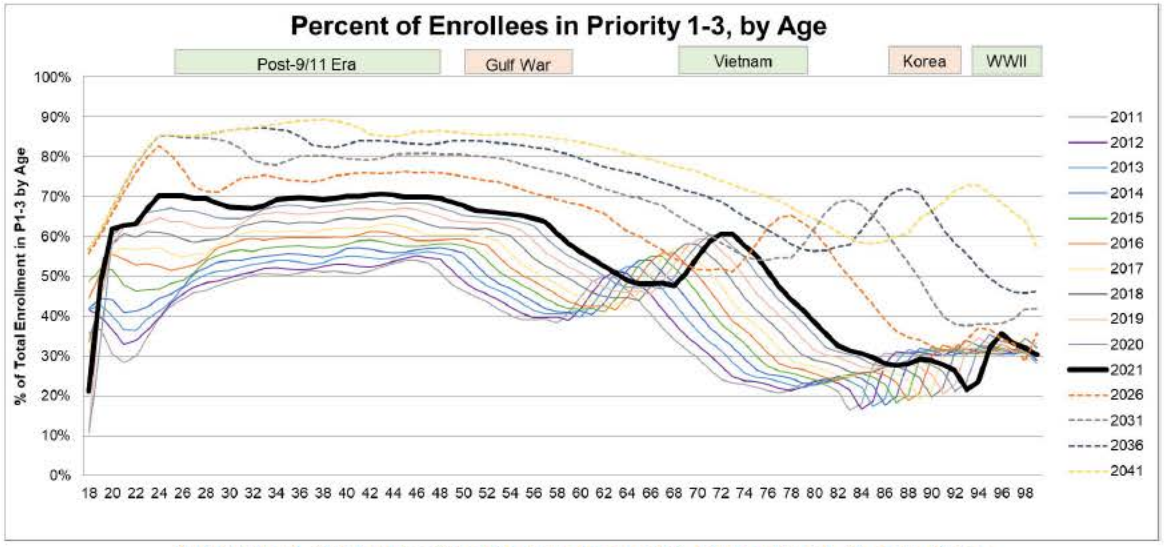

Figure 1.3 Percent of Enrollees in Priority 1-3, by Age

Estimated Staffing Levels for VHA Health Care Systems

The VHA workforce has consistently grown by approximately 2% annually over the last 5 years. Clinical and non-clinical staffing projections thru 2025 are provided in Tables 1.2 and 1.3. Forecasting staffing levels by occupation at specific VHA health care

systems is challenging due to a number of factors such as variability in available workforce, changing care practices and Veteran's preference for care based on availability of other healthcare options. Currently, enrolled Veterans choose to receive approximately 36% of their total healthcare from VA. VHA has many long-standing clinical staffing models (e.g., primary care, mental health, nursing, pharmacy) and is continuing to develop and validate others, especially for non-clinical functional areas. Future work on staffing models will incorporate demand projections and further enhance the ability of VHA staffing models to forecast demand predictions by occupation.

Table 1.2 Estimated Staffing Levels

VISN	0602 Medical Officer (Physician)		0610 Nurse		0679 Medical Support Assistance	
	FY 2022	FY 2025 Projection	FY 2022	FY 2025 Projection	FY 2022	FY 2025 Projection
VISN 01	1284	1,302	3604	4,168	1441	1,906
VISN 02	1503	2,072	3768	11,361	1220	1,239
VISN 04	1151	1,241	3510	4,210	1430	2,194
VISN 05	938	986	2822	3,244	965	1,238
VISN 06	1768	1,859	4858	5,794	2059	2,107
VISN 07	1681	1,765	4460	4,713	2185	2,718
VISN 08	2720	2,852	7,501	8,675	3280	4,214
VISN 09	1219	1,268	3,458	3,750	1273	1,495
VISN 10	1968	2,152	6159	6,876	2753	3,612
VISN 12	1626	1,726	4,658	5,447	1589	1,982
VISN 15	919	944	3219	3,416	1284	1,450
VISN 16	1612	1,640	4998	5,211	2027	2,483
VISN 17	1365	1,447	4858	6,856	2123	2,637
VISN 19	1341	1,451	3491	3,954	1528	1,779
VISN 20	1111	1,266	3659	5,488	1922	2,466
VISN 21	1864	2,109	4861	6,026	1841	2,617
VISN 22	2402	2,551	6,271	6,703	2541	3,217
VISN 23	1160	1,238	4039	4,486	1456	1,710
VHACO	309	355	746	804	43	262
VHA	**27,941**	**29,266**	**80,940**	**89,514**	**32,960**	**39,687**

Projections based upon VISN-specific staffing trends.

Table 1.3 Estimated Clinical and Nonclinical Occupation Levels

VISN	Clinical Occupations		Nonclinical Occupations	
	FY 2022	FY 2025 Projection	FY 2022	FY 2025 Projection
VISN 01	10,513	11,449	6,055	6,210
VISN 02	11,744	17,997	7,064	6,634
VISN 04	10413	12,185	6,257	6,737
VISN 05	7,935	8,815	4,577	4,598
VISN 06	14,025	15,459	6,727	6,753
VISN 07	14099	15,097	8,283	8,696
VISN 08	21,744	24,249	10,945	11,175
VISN 09	9,609	10,100	5,304	5,332
VISN 10	17783	19,310	10,218	11,009
VISN 12	13,297	14,634	7,127	7,582
VISN 15	8511	8,998	5,185	5,333

VISN	Clinical Occupations		Nonclinical Occupations	
	FY 2022	FY 2025 Projection	FY 2022	FY 2025 Projection
VISN 16	14,263	14,777	7,826	8,045
VISN 17	13740	17,600	7,716	8,318
VISN 19	10327	11,690	5,967	6,161
VISN 20	10276	13,086	5,913	6,132
VISN 21	14,406	17,003	7,569	8,391
VISN 22	18,421	20,101	9,256	9,365
VISN 23	10,905	11,609	5,620	5,524
VHACO	5,407	6,540	14,801	14,712
VHA	**237,418**	**258,025**	**142,410**	**154,620**

Projections based upon average VHA staffing trends.
Facility-specific projections available in Appendix E.

VHA continues to develop the capability to incorporate EHCPM data into Specialty Care staffing models. VHA will continue to refine the capability to predict Veteran demand for care, and to further enhance the ability of our staffing models to forecast demand prediction. This will be increasingly important with the historic passage of PACT Act, one of the largest health care and benefits expansions in VA history.

As the world concludes the third year of COVID-19 pandemic, community care systems continue to be stressed by labor shortages. VHA will continue to integrate community care capacity data into clinical staffing analyses. In support of the MISSION Act, PACT Act and related initiatives, this effort includes market-by-market research across the country to inform clinical and business case decisions for delivering Veteran care via VA facilities and/or with our community partners.

Together, these efforts will enable VHA to make increasingly precise projections, facility-by-facility, as to clinical staffing requirements and ultimately, the best possible health care outcome for the Veteran.

Section 2: Assessment of Clinical Panel Sizes

Veterans Access, Choice and Accountability Act Section 301

"The results of a system-wide assessment of all medical facilities of the Department to ensure the following: Appropriate sizes for clinical panels."

Section 2: Assessment of Clinical Panel Sizes

Clinical panels are quantified in two ways: 1) Panel Size (defined as the number of patients assigned to the provider team and 2) Panel Capacity (the maximum number of patients that the provider team can support). VHA employs clinical panels in the area of Primary Care, using Patient Aligned Care Teams. The Patient Aligned Care Teams model is discussed at length in Section 8. While other clinical practice areas, including Mental Health and WH, leverage Patient Aligned Care Teams for elements of their respective care delivery, clinical panels per se are associated with Primary Care.

As noted above, panel capacity is the maximum number of patients that can be cared for by a Primary Care team, and panel size is the number of patients actually assigned to the panel at any one time. Once panels reach or exceed their capacity, access and clinical care may be compromised. To ensure optimal efficiency in accommodating new patients, panel size should be kept smaller than the panel capacity. Primary Care tracks panel size as a more appropriate monitor for supply/demand needs and relationship to access. Panel size includes facility overrides, which accounts for new providers and specialized panels. The data presented represent a snapshot in time, and recent changes in staffing may not be reflected. In some cases, patients remain temporarily assigned to teams even though provider positions are vacant; provider level care is provided by covering staff, while other team members provide additional support where possible according to their capabilities and licensure. Regional and seasonal variations in new patient demand and Primary Care Provider shortage/availability must also be considered in analysis of capacity trends. FY 2022 was especially challenging to maintain continuity with an assigned team and meet access needs. During this time, Primary Care Providers or support staff were redirected to other parts of the hospital and, VHA responded with virtual resources to cover staff vacancies through various virtual modalities. This influenced modeled capacities and panel sizes.

Panel sizes vary according to local conditions, tracking and reporting. Primary Care is continuing to evolve processes and policies for optimal care delivery under the Patient Aligned Care Teams model. This includes assessment of field conditions, measurements of success and additional tools for oversight and reporting.

See Appendix F for appropriate panel sizes and capacity by facilities, as of November 2022. This is not a cumulative or running average total.

Section 3: Assessment of Numbers of Staff Dedicated to Direct Care of Patients

Veterans Access, Choice and Accountability Act Section 301

"The results of a system-wide assessment of all medical facilities of the Department to ensure the following: Appropriate numbers of full-time staff, or full-time equivalents, dedicated to direct care of patients."

Section 3: Assessment of Numbers or Staff Dedicated to Direct Care of Patients
VHA identified occupations as either clinical and non-clinical to best align with the private sector and account for the unique aspects of VHA's operations and workforce (Appendix C). Generally, clinical occupations include personnel who provide direct patient care or services incident to patient care, and whose efforts have a therapeutic intent (e.g., physical, mental, social, spiritual). Non-clinical occupations include administrative and maintenance personnel who do not provide direct patient care.

Currently, clinical staff that provide direct care to patients make up 62.5% of VHA's workforce. Per Section 1, the best indicators of adequate staffing levels include Veteran access to care and health care outcomes. VHA Workforce Strategy and Standardization Office (formerly Manpower Management Office) has made steady progress towards an aggressive schedule for establishing manpower capabilities within the VHA. With limited capacity WSS has collaborated with internal VA partners to begin establishing staffing models for VHA, which includes benchmarking staffing, quality and access at similar health care systems; developing predictive recruitment models; and identifying facilities in danger of critically low staffing levels. VHA has many long-standing clinical staffing models (e.g., primary care, mental health, nursing, pharmacy) and is continuing to develop and validate others, especially for non-clinical functional areas.

Table 3.1 Staffing Levels for Clinical and Nonclinical Occupations by VISN

VISN	Clinical Occupations	Nonclinical Occupations	Percent Clinical
VISN 01	10,513	6,055	63.5%
VISN 02	11,744	7,064	62.4%
VISN 04	10,413	6,257	62.5%
VISN 05	7,935	4,577	63.4%
VISN 06	14,025	6,727	67.6%
VISN 07	14,099	8,283	63.0%
VISN 08	21,744	10,945	66.5%
VISN 09	9,609	5,304	64.4%
VISN 10	17,783	10,218	63.5%
VISN 12	13,297	7,127	65.1%
VISN 15	8,511	5,185	62.1%
VISN 16	14,263	7,826	64.6%
VISN 17	13,740	7,717	64.0%
VISN 19	10,327	5,967	63.4%
VISN 20	10,276	5,913	63.5%
VISN 21	14,406	7,569	65.6%
VISN 22	18,421	9,256	66.6%

VISN	Clinical Occupations	Nonclinical Occupations	Percent Clinical
VISN 23	10,905	5,620	66.0%
VHA TOTAL	**237,418**	**142,411**	**62.5%**

Section 4: Assessment of Physical Plant Space

Veterans Access, Choice and Accountability Act Section 301

"The results of a system-wide assessment of all medical facilities of the Department to ensure the following: Appropriate physical plant space to meet the capacity needs of the Department in that area."

Section 4: Assessment of Physical Plant Space

To ensure sufficient capacity for care, VHA will require an additional 63 million square feet of clinical space by 2030. After currently planned construction and leases are considered, VHA's expected inventory of 181 million square feet in 2024 will be 26% short of the Department's requirements. VA leverages the Strategic Capital Investment Planning (SCIP) process for assessing, projecting and initiating capital asset investments. The long lead times to lease or construct new space for care delivery require a forward-leaning process to ensure capacity for timely access to care for the Veteran. For this analysis, VA began with the SCIP data formulated in support for the FY 2024 President's Budget. This SCIP space analysis incorporated the latest capital planning data, including existing facility support, approved projects and leases and the space requirements based on in-house FY 2030 workload projections. The result is a system-wide space requirement based on anticipated in-house utilization. It should be noted that the FY 2022 workload and FY 2030 projections includes only "in-house" utilization.

***Note**: It should be noted that a positive value in the Space Gap columns indicates a deficit. All values are represented in square feet.*

Table 4.1 SCIP Summary

VISN	Total Adjusted Inventory	Total Planned New	Total Projected Inventory	Total Projected 2030 Need	Space Gap	Space Gap as % of Need
1	8,143,480	266,986	8,410,466	11,014,578	2,604,112	24%
2	12,856,491	752,174	13,608,665	14,999,127	1,390,462	9%
4	7,273,219	630,264	7,903,483	10,490,133	2,586,650	25%
5	6,307,613	857,468	7,165,081	9,487,313	2,322,232	24%
6	8,204,629	1,802,308	10,006,937	14,467,365	4,460,428	31%
7	9,318,832	1,669,201	10,988,033	16,565,577	5,577,545	34%
8	11,863,020	1,787,699	13,650,719	21,995,314	8,344,595	38%
9	6,520,655	1,506,991	8,027,646	10,675,792	2,648,146	25%
10	12,959,053	1,317,696	14,276,749	19,253,534	4,976,785	26%
12	9,674,359	384,398	10,058,757	12,635,433	2,576,676	20%
15	6,957,101	1,288,136	8,245,237	9,161,908	916,671	10%
16	11,435,266	505,227	11,940,493	14,641,074	2,700,581	18%
17	9,283,097	1,345,719	10,628,816	15,352,134	4,723,318	31%
19	6,044,168	786,802	6,830,970	9,874,434	3,043,464	31%
20	6,982,271	490,381	7,472,652	9,933,474	2,460,822	25%
21	7,686,545	1,986,427	9,672,972	12,902,578	3,229,606	25%
22	11,717,290	1,431,200	13,148,490	19,829,586	6,681,096	34%
23	8,628,039	640,828	9,268,867	11,388,180	2,119,313	19%
VHA	**161,855,128**	**19,449,904**	**181,305,032**	**244,667,535**	**63,362,503**	**26%**

Table 4.2 below includes data calculated as of November 2022. Table 4.2 also shows VHA would be facing an over 63 million square feet (26%) space gap in clinical capital access requirements by FY 2030 that can be further mitigated by future budget requests. This space gap assumes that all planned projects currently funded above current physical capacity are completed as projected.

Table 4.2 SCIP FY 2024 Summary Definitions

Category	Definition
Total Adjusted Inventory	Current Space Per Capital Asset Inventory (CAI) Database - Disposals/Lease Terminations (as of FY 2024 President's Budget)
Total Planned New	New Space to be Added Via in Process Projects and Leases (as of FY 2024 President's Budget)
Total Projected Inventory	Total Adjusted Inventory + Total Planned New
Total Projected 2026 Need	Space Needed Based on the FY 2030 Projected Workload Projections
Space Gap	Total Projected FY 2030 Need – Total Projected Inventory
Space Gap as % of Need	Space Gap ÷ Total Projected FY 2030 Need

It is important to note that due to the long lead time required to develop and implement new physical capacity, current space shortages will continue to affect Veteran Access. Even if the projected 26% gap is bridged by FY 2030, existing space shortages will require mitigation in the interim before future budgets can address the 26% gap in the future. Realignment of resources via repurposing of underused facilities would be an additional key measure in contending with space shortages.

Appendix G shows the facility-by-facility breakout. The data show that some facilities are contending with physical capacity space gaps higher than the 26% cited above, while others face smaller space gaps or even surpluses.

In accordance with VA capital management procedures, VHA continuously evaluates physical plant requirements for validation and resourcing. The data presented above is dynamic and will be regularly updated; and subsequently incorporated into VHA planning.

Section 5: Plan to Address Identified Issues

Veterans Access, Choice and Accountability Act Section 301

"A plan for addressing any issues identified in the [system-wide assessment of all medical facilities of the Department], including a timeline for addressing such issues."

Section 5: Plan to Address Identified Issues

The preceding analysis revealed two key concerns that must be addressed to ensure continued improvement of Veterans access to care, the need for predictive staffing models and requirement for additional capital assets. VHA has a projected gap of 63 million square feet of clinical capital asset requirements over the next 8 years. VHA cannot assure timely access for Veterans if there is insufficient clinical space within which to provide care. Given the long lead-times required to acquire capital assets, solutions will need to be resourced well in advance. Such resourcing will also require assessing the current mix of facilities and the potential realignment of underused space to those facilities with greater requirements.

Following this theme, the quantity and characteristics of the Veteran population will change over time, both nationally and locally. While full resourcing as noted above will enable the goal of timely access to care as currently required, the medical needs of our Veteran population will inevitably change over time. It is essential for VHA to evaluate such change and determine resource requirements well in advance.

To meet this challenge, VHA implemented an enterprise-level VHA Manpower Management Office in 2018, renamed to WSS in FY 2022. WSS is responsible for examining organizational design and position structures, determining appropriate full time equivalent (FTE) baselines based on agency specific data, and reviewing vacant positions to ensure the workforce supports and aligns with mission critical functions. This allows VHA real-time ability to monitor vacancies, identify trends and report clinical and non-clinical strength, in precise detail. When coupled with an integrated suite of staffing models, and an expanded capacity for Workforce Planning, VA and VHA can project staffing requirements to an unprecedented degree. Additional augmentation with workload utilization projections provided by the VA EHCPM provides superior resourcing data.

The second key concern arises from capital assets, as shown in Section 4. VHA has a projected gap of over 63 million square feet of clinical capital asset requirements over the next 8 years. As with the potential shortfall of workforce resources described above, VHA cannot assure timely access for Veterans if there is insufficient clinical space within which to provide care. Given the long lead-times required to acquire capital assets, solutions will need to be resourced well in advance. As further noted in Section 4 and in accordance with VA capital management procedures, VHA continuously evaluates physical plant requirements for validation and resourcing. The data presented are dynamic and will be regularly updated; and subsequently incorporated into VHA planning. Gap analysis and mitigation options will be updated in conjunction with quarterly and annual capital asset planning cycles until the projected gap is resolved. Interim mitigation of space shortages will also include the use of purchased care, and leverage delivery of care via telehealth as clinically appropriate. Further interim mitigation will include extension of clinic hours where practicable, allowing more Veterans to be seen within a given facility, consistent with the availability of the patient.

Section 6: Wait Times and Workload Levels

Veterans Access, Choice and Accountability Act Section 301

"A list of the current wait times and workload levels for the following clinics in each medical facility: Mental Health, Primary Care, Gastroenterology and Women's Health."

Section 6: Wait Times and Workload Levels

Wait Times

The 2014 Choice Act legislation requires a list of wait time data for the four clinical practice areas of Mental Health, Primary Care, GI and WH. Wait time data for Mental Health pertain to mental health services while Primary Care data pertain to patient care such as routine check-ups.

Wait time data for each of these clinical practice areas are distinguished between the types of services, so each is presented in this section as a single table. The data provided in this report are a VISN and facility view and support work to assess appropriate staffing levels in the services listed in the tables in this section. The other two clinical practice areas include multiple data sets due to the way in which wait time data is captured for those types of health care services. For example, the wait time data for GI include two data sets, GI Clinic and Hepatology Clinic but do not include wait time data for endoscopy. For further explanation regarding challenges of obtaining endoscopy wait time metrics, refer to Section 8 of this report. Also, health care for women Veterans can range from routine check-ups for a Veteran who is a female to health care that is specifically for women such as Gynecology (GYN). In order to provide a comprehensive picture of WH, four sets of data are used to constitute this clinical practice area for this section of the report.

VHA has a detailed feedback loop for wait time information for both facilities and of clinical practice areas. Wait time information is continuously gathered, reviewed and leveraged to improve field operations. Clinical wait times are published on a regular basis.

Facility by Facility wait time information for these clinical practice areas is available in Appendix H.

Two additional points should be noted about these data sets. First, although the information from which these lists were derived is collected on a regular basis, this information is not publicized in this format according to these four clinical practice areas. For the purposes of this report, specific excerpts of data were obtained for these clinical practice areas. Second, in accordance with VA wait time publishing trends, this data set only includes “Wait Times Calculated Using Preferred Date;” VA discontinued publishing “Wait Times Calculated Using Create Date for New Patients and Preferred Date for Established Patients” as of December 5, 2014.

Workload Levels

VHA maintains detailed clinical workload tracking as a function of patient encounter tracking. As with wait time, clinical workload tracking is continuously gathered, reviewed and leveraged to improve field operations.

The data sets on the next page align with the data sets for wait times. It should be noted that “Gastroenterology” in the first table represents the sum of workload data for three different data sets: GI Clinic, Hepatology Clinic and Endoscopy. While endoscopy data

were unavailable for wait times, they were available for patient encounters. It should be further noted that the second table series represents three different clinical areas that serve women Veterans, all constituting WH for this section of the report, also aligning with the data presented for wait times.

Table 6.1 shows the data for the four clinical practice areas of Primary Care, Mental Health, GI and VHA-wide WH through FY 2022:

Table 6.1 Workload Data for Primary Care, Mental Health and GI– FY 2022

VISN	Primary Care Encounters	Mental Health Encounters	GI Encounters
1	744,298	785,713	17,427
2	755,408	883,394	25,401
4	884,320	733,213	17,000
5	633,246	611,915	13,847
6	1,255,116	950,988	39,366
7	1,460,136	1,210,455	29,250
8	2,131,390	1,450,009	51,898
9	992,864	653,497	21,526
10	1,504,041	1,241,389	34,443
12	877,078	799,146	12,957
15	770,348	526,019	16,240
16	1,299,406	1,031,875	17,267
17	1,364,166	1,051,818	15,898
19	1,011,427	742,212	10,705
20	878,940	675,694	12,294
21	1,015,626	949,647	18,148
22	1,659,125	1,442,518	37,847
23	978,503	624,945	11,393
Total	**20,215,438**	**16,364,447**	**410,332**

Table 6.2 Workload Data for Women's Health – FY 2022

	Comprehensive Women's Primary Care Clinic Encounters	Primary Care/Medicine - Women Encounters	Gynecology Encounters
Total	**382,050**	**1,068,315**	**114,305**

VISN and Facility workload information for these clinics is available in Appendix I.

Section 7: Review of Inspector General Report

Veterans Access, Choice and Accountability Act Section 301

"A description of the results of the most current determination of the Inspector General… and a plan to use direct appointment authority… and to fill staffing shortages.

Section 7: Review of Inspector General Report

Results of the VA Office of the Inspector General (OIG) Report

In August 2017, the VA Choice and Quality Employment Act of 2017, P.L. 115-46, required the VA OIG to identify at minimum five nonclinical and five clinical shortage occupations at each health care system, changing the previous requirement to identify five shortage occupations at the VHA-system level established by Section 301(d) of the 2014 Choice Act.

In response to the 2017 legislation, VHA's Workforce Management and Consulting office leveraged its annual workforce planning cycle to independently identify shortage occupations and physician and registered nurse specialties. The workforce planning cycle is designed to provide a structured, data-driven approach that includes standardized data points and assessment questions to determine specific root causes and assist in validating healthcare system responses.

In FY 2022, the VHA workforce planning cycle identified ten clinical and nine nonclinical occupations that were identified by at least 20% or more of VHA health care systems or 50% or more VISNs or national offices. The clinical shortage occupations identified were nurse, physician, psychologist, practical nurse, nursing assistant, medical technologist, social worker, diagnostic radiologic technologist, pharmacy technician and medical technician. The nonclinical shortage occupations identified were custodial worker, medical assistant (MA), police, general engineering, food service worker, medical supply aide and technician, contracting, HR management and HR assistant.

The VA OIG completed an independent study required by Congress and published VHA healthcare system self-reported shortages in "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022." A comparison of the VHA and VA OIG findings can be found in Table 7.1 on the next page.

Table 7.1 FY 2022 VHA Shortage Occupations Compared to VA OIG Shortage Occupations

Occupational Series or Assignment Codes[a]	Occupation	Number of Facilities that Identified the Occupation as a Severe Shortage with OIG	VHA Results- # of Healthcare Systems Choosing	VHA Ranking
0602/31*	Psychiatry	83	99	1
3566	Custodial Worker	65	61	5
0083	Police	62	81	4
0602/P1*	Primary Care	51	61	6
0620	Practical Nurse	49	55	8 (tie)
0801	General Engineering	48	51	12
0180	Psychology	47	47	15 (tie)
0644	Medical Technologist	45	57	7
0602/25*	GI	41	37	21(tie)
7408	Food Service Worker	37	48	13 (tie)
0679	Medical Support Assistance	36	53	11
0610/88†	Registered Nurse Staff Nurse-Inpatient	36	54	10
0602/K6*	Hospitalist	34	30	27
0647	Diagnostic Radiologic Technologist	33	43	18 (tie)
0610/N4†	Nurse Practitioner – Mental Health/Substance Use Disorder	31	37	21 (tie)
0610/Q6†	RN/Staff-Inpatient Community Living Center	31	55	8 (tie)
0201	Human Resources Management	30	33	23

* Physician Assignment Code + Nursing Assignment Code

A list of VHA shortage occupations and specialties that **did not make the OIG list of 20%** or more is in Table 7.2 below.

Table 7.2 FY 2022 VHA Shortage Occupations and Specialties That Did Not Make the OIG List

Occupational Series or Assignment Codes[a]	Occupation	OIG Number of Facilities that Identified the Occupation as a Severe Shortage	VHA Results- # of Healthcare Systems Choosing	VHA Ranking
0610/CM†	RN Staff Crit Care	24	48	13
0610/CQ†	RN Staff in Mental Health	26	47	15 (tie)
0675	Medical Records Technician	27	46	17
0610/CR†	RN Staff Emergency Center CR	18	43	18 (tie)
0610/Q1†	RN Staff Outpatient	21	41	20
0185	Social Worker	16	31	24 (tie)
0610/75†	NP Primary Care	24	31	24 (tie)
0622	Medical Supply Aide and Technician	27	30	26
0649	Medical Instrument Technician	27	29	28 (tie)
0610/CW†	RN Staff PERI OP	20	29	28 (tie)
0602/12*	Urology	26	28	30 (tie)
0602/16*	Emergency Medicine	25	28	30 (tie)

Most occupations included in VHA's shortage occupation list were identified by the VA OIG's FY 2022 report as being chosen by 20% or more of the VHA health care systems in the "Determination of VHA's Occupational Staffing Shortages." There were 2 occupations identified as shortage occupations through the VHA workforce planning cycle—0661 Pharmacy Technician and 0622 Medical Supply Technician (Sterile Processing)—that were selected by fewer than 20% of facilities for the OIG list. Likewise, 0649 Medical Instrument Technician and 0858 Biomedical Engineer were 2 occupations identified by 20% or more facilities for the OIG list, but not for the VHA list.

Utilization of Direct Hiring Authority

After careful comparison between the VA OIG and VHA analysis, VHA will seek approval to waive the requirement to apply T5 Veterans' preference for the following 12 hybrid title 38 occupations identified as critical shortage occupations by 20% or more of the health care systems by the VA OIG and/or VHA workforce planning: (1) diagnostic radiologic technologist; (2) medical instrument technician;

(3) medical supply aide and technician; (4) pharmacy technician; (5) medical support assistant; (6) general engineer; (7) practical nurse; (8) psychologist; (9) social worker; (10) medical technologist; (11) nursing assistant; and (12) biomedical engineer.

Credentialing and Privileging

The specialties cited by the OIG typically require a Credentialing and Privileging (C&P) as part of the hiring of each medical professional. Those who are in occupations categorized as Licensed Independent Practitioner (LIP) and who provide direct patient care are also privileged in accordance with Joint Commission Medical Staff standards and VHA policy. VHA has focused efforts on C&P Programs throughout VHA including centralization and standardization of reporting structure under the facility Chiefs of Staff, standardization of position descriptions and grades of C&P Specialists, publication of clearer guidance and procedure through updated policies and supporting Standards of Practice and publication of benchmark baseline staffing levels needed for credentialing support at the facility level.

Section 8: Staffing Models

Veterans Access, Choice and Accountability Act Section 301

"The current staffing models of the Department for the following clinics, including recommendations for changes to such models: Mental Health, Primary Care, Gastroenterology and Women's Health."

Section 8: Staffing Models

Improvements to VHA clinical staffing will include: 1) determining the appropriate applicability of productivity standards to the clinics, including Relative Value Units; 2) aligning and standardizing modeling practices in the field; 3) evolving the types of data collected and tools to collect them; and 4) ensuring the results of clinical staffing modeling are incorporated into VHA's budget, workforce and succession planning.

The term "staffing model" is used to represent different concepts ranging from prospective workforce management to day-to-day operations and scheduling. For large integrated health care organizations, where staffing needs are a complex interrelationship of many variables, a staffing model is a set of reports, charts, graphs and measures that are used identify and describe work activity, labor hours, employee utilization and overall cost. The general purpose of a staffing model is to provide information on staffing: the process of acquiring, deploying and retaining a workforce of enough quantity and quality to create positive impacts on the organization's effectiveness.

For health care organizations, a staffing model requires understanding the relationship between the health care providers, the patient population, workload volume and variation, the complexity of the workload, facility mission (including research and education), local facility dynamics and specific practice management measures. Because health care staffing requires understanding the relationships between each of these disparate pieces of information, staffing models are rarely as straightforward as they are in other disciplines like manufacturing.

VHA's staffing models are a set of interrelated reports designed to use data relating to workforce supply, workload volume and workload demand to provide a comprehensive picture of the existing workforce, existing workload, internal benchmarks, external benchmarks and related measures that help the individual health care systems understand how facility specific measures relate to staffing requirements.

Overview of VHA's Staffing Model for Specialty Care Group Practice

Within health care approaches exist to model staffing requirements; however, there is no consensus on a definitive methodology or technique. Recent literature suggests that an integrated approach that combines elements of supply and demand with that of benchmarking. One accepted industry approach for addressing staffing needs is to compare staffing against workload using benchmarks internal to the organization. VA accomplishes this comparison using its extensive data systems. VHA maintains a comprehensive database of the provider workforce with near real-time reporting (by pay period) of staffing levels, clinical workload and productivity by specialty and practice setting.

VHA's staffing model for specialty care group practice is summarized in VHA Directive 1065,Productivity and Staffing Guidance for Specialty Provider Group Practice. The Office of Productivity, Efficiency and Staffing (OPES) defines appropriate staffing

through the lens of an appropriately productive workforce. The following text summarizes VHA's approach to staffing models through the analytic tools developed based on existing data from VHA's electronic health record.

Provider Productivity

Within the health care context, there is a generally accepted approach to calculating productivity of physician practices that is used in the private sector both in operations and in academic literature: specialty practice workload measured in work relative value units (wRVU) divided for physician FTE totals. VHA mirrors this approach through its productivity measurement and guidance (workload in wRVUs divided by clinical FTE).

Workload

VHA uses an industry accepted metric of a wRVU to measure provider productivity (clinical work per provider). Provider clinical workload, measured in wRVUs, adjusts for the differences in time, intensity and complexity of medical services. RVUs are assigned to VHA workload by extracting Current Procedural Terminology (CPT) coding from the electronic health record. Capture of workload incorporates all inpatient and outpatient reported workload with CPT coding that passes workload capture data checks. Workload is assigned to the provider who completed the workload as noted on the encounter. Specialty/discipline classification of the workload is derived from the specialty/discipline group practice provider active person class code/taxonomy assignment of the workload-completing provider.

Workforce

The number of hours of clinical worked time (defined as Provider FTE(C)) is calculated based on the provider's actual hours worked are reported on a pay period basis in the VHA payroll system. Only worked hours are included in the productivity calculation; hours associated with annual leave, sick leave or leave without pay are excluded from the worked hour count. Only the clinical portion of the hours worked are considered. Hours associated with administration, research and education are excluded.

Non-VA Personnel and Accounting Integrated Data System (PAID) providers (including in-house fee providers, contract staff and without compensation (WOC) providers) are not covered in the process of productivity measurement because while workload information is available (in wRVUs completed), there is no source of data for clinical hours worked.

VHA imputes the FTE total of work received through in-house fee, contract staff and WOC workload by comparing the total work completed by the contract staff divided by the VHA national average productivity for VA PAID staff for the specialty of the providers. The imputed workforce estimates are included in the Provider Clinical FTE estimates in the OPES tools relating to counts of the provider workforce.

Productivity Standards

VHA productivity benchmarks rely on internal performance data. Specialty group practices are compared based on VHA internal peer groupings to ensure that similar practices are compared against each other. Thresholds both low and high for Specialty/Discipline Group Practice Productivity. This is generally referred to as the acceptable range of productivity for the specialty. Minimum productivity thresholds are established at the median group practice provider productivity minus 1.25 standard deviations for the specialty's peer group.

Productivity standards are re-evaluated as needed by the Assistant Deputy Under Secretary for Health for Clinical Operations and the Assistant Deputy Under Secretary for Health for Patient Care Services. Re-evaluation must take place because as health care evolves over time, RVU values change and relative workloads shift. Productivity standards consist of the acceptable group practice range of productivity, the peer grouping and the minimum productivity threshold for the specialty. The productivity data used to establish the productivity standards are the same data developed by OPES as a part of their ongoing productivity reporting.

Specialty Group Practice Productivity Standard Outlier Reports

The Specialty Provider Productivity Standards Performance and Outlier Review report provides information on historic productivity in comparison to established productivity standards for the standards established for the selected fiscal year. Additionally, the outlier review report provides fiscal year to date (FYTD) productivity levels with a projection of whether the specialty group practice is on track to meet existing productivity standards or fail to meet existing minimum productivity thresholds. The outlier report also provides the full set of specialty group practice productivity standards and the list of specialty group practices in need of remediation plans or productivity review.

Specialty Staffing Profiles

Existing specialty workforce and support staff are described by the amount of clinical time dedicated to the specialties at the facility. Specialty staffing profiles are based on the data from the provider productivity calculations in combination with staffing data relating to different types of staff required for running a specialty clinic (e.g., residents, advanced practice providers, administrative support staff and clinical support staff). Using these data on staffing in conjunction with specialty workload data, specialty practices can get a picture of how specialty specific staffing at a site compares with VHA, VISN and peer VA medical facility staffing for a given specialty.

The Specialty Provider Workforce Report delivers system level staffing norms by geographic location VISN and practice setting or Medical Center Group (MCG). Staffing levels per population (core facility unique patients and specialty specific patients treated) are included in this report as well as provider productivity levels. VA medical facility managers should contextualize these data to their potentially unique

characteristics such as patient reliance and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

Comparison of Productivity of Existing Staff to Demand

OPES publishes a Specialty Provider Group Practice Productivity Access Report and Quadrants (SPARQ) tool that compares specialty group practice productivity to access. The SPARQ tool combines practice-level productivity and access metrics into an Importance-Performance Analysis framework. This identifies the following four potential staffing states:

- Specialties with above-average productivity with above-average access (optimized);
- Specialties with above-average productivity and below-average access (possibly under-resourced – i.e., the practice is productive, but even with a productive staff, the current demand cannot be handled without an above average wait time);
- Specialties with below-average productivity and above-average access (possibly over-resourced – i.e., demand for the service is satisfied such that wait times are low, but the staff have below-average productivity indicating an area that may require fewer resources to fill the demand); and
- Specialties with below-average productivity and below-average access potentially inefficient – i.e., the wait times may be able to be addressed by increasing the throughput/productivity of the existing staff).

Comparison of Specialty Practice Groups to Peer Groups

The SPARQ tool also aggregates practice management data designed to provide VA medical facility specialty service chiefs and clinical leadership with views of various measures known to have a relationship with specialty group practice productivity, including the following:

1. Facility level specialty utilization;
2. Workforce supply;
3. Workforce per population;
4. Procedure suite-based workforce (for applicable specialties);
5. Office-based clinic support staff;
6. Advanced practice provider workforce;
7. Provider productivity;
8. Teaching mission;
9. Practice management measures;
10. Specialty workload measures;
11. Employee turnover; and
12. Physician compensation.

Specialty Provider Productivity Benchmarking Reports

VHA reports both internal and external benchmarks for understanding the relative productivity of its workforce at the group practice specialty level.

Internal Benchmarks
The Physician Productivity Standards Reports provide a management tool for the systematic, longitudinal measurement and reporting of clinical productivity, efficiency and staffing in VHA. The productivity benchmarking tools show the average, range and variation in productivity across specialties at the national, VISN, complexity group and administrative parent level. This information can be used to identify areas of need or improvement within relevant comparison groups.

External Benchmarks
The benchmarking report specifically provides the descriptive statistics of productivity performance at the VA medical facility level with comparisons to existing productivity standards, current year moving statistics and private-sector benchmarks in the form of the Medical Group Management Association (MGMA) Academic and Private Practice Mean and Median specialty group practice productivity measures.

The benchmarking report additionally provides productivity data at the subspecialty level, VA medical facility rankings for specialty productivity, trends in specialty productivity over time summarized at the national, MCG group and VA medical facility level and comparisons between VHA's productivity performance and MGMA's benchmarks over time.

Provider Productivity Leadership Dashboard
The Provider Productivity Leadership Dashboard provides detailed information about the staffing levels, clinical workload and provider productivity for each VA medical facility, at the specialty level. This analytic tool assists VHA managers and leadership in effectively managing their specialty provider practices towards the goal of ready access to quality specialty services. VHA tracks specialty care practice and provider level productivity performance for over 30 areas of specialization as well as advanced practice providers.

The leadership dashboard provides a Chief of Staff dashboard with views of specialty provider productivity at the aggregate specialty level, views of associate provider productivity, views of rehabilitation provider specialty productivity and social work provider productivity at the facility level.

Detailed workload reports provide trend information on year-over-year specialty workload growth in key practice management metrics like total workload (RVU sum), unique encounters per unique Veteran, RVU sum per unique Veteran and RVU sum per encounter. The dashboard also provides time-level detail to identify when during the day workload is happening for the given specialty.

Detailed workforce reports provide trend information on key practice management metrics like year-over-year changes in physician workforce labor mapping distribution, FTE growth over time and FTE counts by aggregate specialty.

Prescriptive Staffing Models

Sometimes the term "staffing model" is used in conjunction with a prescriptive approach to staffing (e.g., to produce 1,000 vehicles per year at an automotive plant, requires 200 assembly line workers, 15 quality control staff, etc.) VHA's approach to date is not prescriptive. This is intentional, and prescriptive staffing requires the following three conditions that are not present in VHA's health care system:

1. A link between funding or revenue and the staff;
2. A simple process that can be readily described as a function of staff to time commitments; and
3. Quality measurement that can be readily linked to staffing output.

While the first requirement could be met (and is at times met via specific purpose funding) within the context of VHA, the latter two requirements are unlikely to ever be met in a health care context.

Health Care is Not a Simple System

As noted previously, health care is not a simple system. Appropriate staffing depends on many inputs and those many inputs have interrelationships that are not readily describable. Examples of the list of inputs into appropriate staffing levels are the following:

- Volume of patients (current and projected);
- Complexity of care provided (current and projected);
- Patient risk (current and projected);
- Patient reliance (on the existing VA system, on non-VA care paid by Medicare, on non-VA care provided by private insurance and on non-VA care paid by VA in addition to future states);
- Non-clinical mission-required time (e.g., education, research and fourth mission time);
- Clinical time required per patient or procedure;
- Available space for providing health care;
- Changes in the health care marketplace;
- Changes in populations covered (e.g., changing regulations); and
- Specific facility level variation (e.g., geographic variation, potential available staffing pools, etc.).

The above list is not exhaustive. While VHA is on the path to providing standardized definitions and measurements of the current state of these variables, accurate projection of these variables into the future is unlikely to be more than directionally accurate. As a result, VHA recommends allowing facility directors to be able to use the data at their disposal to make educated staffing decisions based on the information about their local facility.

Health Care Lacks Quality Measures That Link to Staffing Profiles

VHA is dedicated to providing a workforce of sufficient quantity and quality to create positive impacts on the organization's effectiveness. However, there is little consensus,

either within VHA or outside the VHA on how “quality” should be defined and measured. For any given quality indicator, there is a high level of uncertainty about the effect of specific interventions. There is additional uncertainty about whether the quality measure actually measures the quality sought by the care. There are virtually no studies in the clinical literature that link outcome-oriented measures of quality to the intensity of physician staffing.

VHA is dedicated to the continual measurement of quality and to the provision of high-quality care. As quality measurement methods advance, there may eventually be an available link between quality and the intensity of physician staffing, but to date, that link eludes both VHA and non-VHA health care organizations alike.

Mental Health Clinical Staffing

Clinical Program Overview

Between FY 2006 and 2022, the number of Veterans who received mental health care from VHA grew by 83%. This rate has grown three times faster than the rate of increase in the number of VHA users. Outpatient mental health encounters increased from 10.7 million in 2006 to a high of 21.8 million in 2019 then decreased during the COVID-19 pandemic to 19.6 million in 2022. Though the volume of mental health care declined during the COVID-19 pandemic, VA projects a 50% growth in inpatient and outpatient mental health care from 2020 to 2030, which represents an increase to 31 million mental health clinical encounters. It is evident that the proportion of Veterans served by VHA who receive mental health services has increased substantially. In 2006, 20% of all VHA users received mental health services. In 2022, that number grew to 29%.

VHA mental health care is comprised of an unparalleled integrated system of comprehensive services designed to meet the individual mental health needs of Veterans and their families. VHA provides a continuum of forward-looking outpatient, residential and inpatient mental health services across the country. VHA has many entry points for care through 171 Medical Centers, 15 stand-alone residential care facilities and 1,113 community-based outpatient clinics. There are also 300 Vet Centers that provide readjustment counseling. The Veterans Crisis Line and telehealth to home and community settings are also available for mental health services. VHA staff are also found on college and university campuses. There are additional outreach efforts that creatively seek to connect to Veterans.

VA has integrated mental health services with Primary Care in the Patient Aligned Care Team model through Primary Care Mental Health Integration (PCMHI). Providing mental health care within the primary care clinic minimizes barriers that can discourage Veterans from seeking mental health care. This program has contributed to the increases in the number of Veterans whose mental disorders are recognized and treated. Open access is a key principle in implementation of PCMHI and full implementation of PCMHI at all required locations is one strategy to fulfill this commitment to same-day access.

The hiring of outpatient mental health clinical staff has approximately paralleled the growth in patient numbers. This may reflect capacity constraints on patient receipt of mental health care due to availability of staff. Consistent with the increased reliance on outpatient care, the inpatient/residential care mental health staff FTE has seen only a slight rise since 2009.

Mental Health Care Providers
Several disciplines have expertise in the core components of effective mental health treatment (e.g., diagnostic assessment, psychotropic prescribing, psychotherapy, case management and psychosocial support) and work in inter-professional teams to provide care to Veterans with mental health conditions whose needs are consistent with their professional training. Inter-professional mental health programs commonly include providers from the following disciplines:

- Psychiatrists;
- Psychologists;
- Social workers;
- RNs;
- Licensed Practical Nurses;
- Clinical Nurse Specialist, Nurse Practitioners (NP);
- Physician Assistants;
- Licensed Professional Mental Health Counselors;
- Marriage and Family Therapists;
- Other counselors, such as addiction therapists, occupational therapists and recreational therapists;
- Pharmacists and clinical pharmacists; and
- Peer support specialists.

Operational Overview
As part of our ongoing comprehensive review of mental health operations, VHA has considered several factors to determine how to optimize staffing levels distributed across the system, including the following:

- Veteran population in the service area;
- The mental health needs of Veterans in that population; and
- Range and complexity of mental health services provided in the service area.

Because there are no industry standards defining accurate mental health staffing ratios, VHA is setting the standard as have done for other dimensions of mental health care. VHA has developed a prototype for the overall staffing of outpatient mental health services.

Outpatient mental health is organized into three broad levels of care: PCMHI, General Mental Health (GMH) and Specialty Mental Health (SMH). PCMHI works with Veterans in primary care to address mental health concerns that typically require low intensity treatment and to provide on-going treatment to patients with chronic mental health conditions. GMH provides inter- professional recovery-oriented care for Veterans in

need of mental health care, including assessment, medication management, pharmacotherapy, case management/care coordination, psycho-education and common psychotherapies for mental health conditions (e.g., evidence-based therapies including cognitive behavioral therapy for depression). Specialty mental health provides time-limited or diagnosis specific specialty care for Veterans including, but not limited to, intensive Substance Use Disorder (SUD) and Posttraumatic Stress Disorder (PTSD) treatment, mental health intensive case management, psychosocial rehab and recovery programs and medication-assisted treatment.

VHA's delivery of mental health care is Veteran-centered. Mental health services that are clinically needed by Veterans must be made available and may be provided by appropriate facility staff, tele-mental health providers, by referral to other VHA facilities, or by sharing agreements, contracts or referral to community care providers to the extent the Veteran is eligible.

VHA has developed multiple staffing models that it uses in combination to identify staffing needs, including a 'minimum' model (described VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Provider*s*) and growth-based and population coverage-based staffing models. P.L. 116-171 § 501(a) of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) requires the Secretary of Veterans Affairs to submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate a plan to address staffing of mental health providers of VA, including filling any open positions.

Overall Outpatient Mental Health Staffing Ratio Recommendations

The prototype 'minimum' staffing model for outpatient mental health provides a recommended minimum ratio of mental health providers to Veterans with mental health conditions based on performance data that assesses access and quality of services. In this model, mental health providers are staff who generate clinical workload within mental health clinics. The recommended minimum staffing ratio provides guidance regarding minimal staffing needed to meet access and quality standards at a typical facility. Facilities with many sites of care (e.g., that provide services to a geographically large rural areas), that serve Veterans with more severe mental health conditions (e.g., regional specialty hubs), or have greater than average demand for services are likely to require higher staffing ratios to maintain adequate access to high quality outpatient mental health services.

Analyses examining relationships between outpatient staffing levels and mental health treatment access and quality found that the ratio of outpatient staff to Veterans was significantly related to measures of population access, timeliness, continuity of care and mental health provider and Veteran satisfaction. Based upon extensive internal reviews, VHA launched the Mental Health Hiring Initiative in April 2012 to increase provider staff at facilities with access concerns. The goal for new hiring at that time was to bring all facilities up to a minimum ratio of facility staff to Veterans of 7.72 FTE per 1,000 outpatient mental health Veterans being treated, with plans to continue monitoring and

conduct further analyses to better determine an optimal staffing ratio. Given ongoing rapid growth in the number of Veterans with mental health conditions, on-going hiring is required to reach that goal, and additional hiring initiatives have been utilized to address hiring goals. Recent analyses and published research continue to support associations between this overall outpatient mental health staff to Veteran ratio and better access to, quality of and satisfaction with mental health services.

Provider productivity is an indicator used to identify sites that have staffing ratios above the minimum recommended ratio that may require additional mental health staffing to meet demand. When average provider productivity is above productivity standards and performance on access and quality metrics is below average, it indicates that more staff are needed to meet demand for care. If average provider productivity is above standards and performance on access and quality metrics is above average, we encourage facilities to consider hiring additional staff to prevent provider burnout or declines in access or quality.

Finally, it should be noted that the staffing ratios for the component programs described below are not additive as the model uses different denominators for the purpose of calculating the recommended ratios. Generally increasing the number of staff continues to improve access to, quality of, and satisfaction with mental health services, but a mathematical “cut” was used at the point where staffing ratio was heuristically determined as reasonable for delivery of standard services in a typical location.

Components of the Overall Outpatient Mental Health Program
Included in the overall outpatient mental health staffing ratio of 7.72 mental health providers for every 1,000 mental health Veterans are staff from the PCMHI, GMH and SMH programs. These programs can be staffed by multiple disciplines. Additional guidance has been developed to help facilities determine the appropriate staffing for each of the broadly defined levels of outpatient mental health services described below. Of note, when a staffing ratio is applied to a specific facility, it must be considered within the context of other ways a treatment facility is meeting the needs of Veterans through tele-health, community care providers or other fee-for-service agreements intended to meet the mental health needs of Veterans.

<u>PCMHI Staffing Recommendations</u>
Full implementation of the PCMHI component of overall outpatient mental health services is expected to require 0.67 mental health FTE per Patient Aligned Care Team serving 1,200 patients. PCMHI implementation is expected to have benefits both for immediate access to mental health services for Veterans who might be reluctant to make use of mental health services in a specialty setting (e.g., due to stigma) and for reducing long-term mental health costs and demand by addressing lower severity mental and behavioral health concerns before they become more severe, chronic or lead to serious negative consequences (e.g., disability, loss of employment, legal problems, etc.). Full implementation of PCMHI is considered an essential strategy for addressing mental health access concerns.

General Mental Health Team Staffing Recommendations (including Specialty Mental Health)

Patients with more severe or persistent mental health conditions may be referred to the general mental health services. VHA has developed a model of inter-professional team-based delivery of general mental health services, including collaborative management of Veterans assigned to the team. These team-based general mental health service models have been implemented at many facilities.

Psychiatrists

Psychiatrists are essential members of outpatient mental health programs but are both more expensive and often harder to recruit than other disciplines. To ensure that outpatient programs are adequately staffed with psychiatrists, VHA recommends that of the 7.72 FTE mental health providers specified in the overall outpatient mental health staffing recommendation, psychiatrists represent 1.35 FTE.

Specialty MH Staffing

Per VA policy, specialty MH staffing guidelines and staffing minimums have been developed for the following:

a) SUD outpatient specialty programs; VHA Programs for Veterans with Substance Use Disorders: VHA Handbook 1160.04;
b) PTSD clinical teams (PCT); Programs for Veterans with PTSD: VHA Handbook 1160.03;
c) Residential Rehabilitation Treatment Programs; Mental Health Residential Rehabilitation Treatment Program: VHA Directive 1162.02;
d) Compensated Work Therapy; Therapeutic and Supported Employment Services Program: VHA Handbook 1163.02;
e) Intensive Community Mental Health Recovery Services (formerly known as Mental Health Intensive Case Management (MHICM)): VHA Directive 1163.06;
f) Community Living Centers (formerly known as nursing homes); Uniform Mental Health Services in VA Medical Center and Clinics: VHA Handbook 1160.01);
g) Evidence-based Psychotherapy Coordinators; Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions: VHA Handbook 1160.05;
h) Military Sexual Trauma Coordinators; Uniform Mental Health Services in VA Medical Centers and Clinics: VHA Handbook 1160.01;
i) Suicide Prevention Coordinators; Uniform Mental Health Services in VA Medical Centers and Clinics: VHA Handbook 1160.01; and,
j) Mental Health Provider Productivity Management; VHA Directive 1161.

Conclusion

VHA is committed to ensuring timely access to care for Veterans in need of mental health care. As noted above, delivery of care relies heavily upon the ability to project, recruit and assign qualified mental health professionals. VHA has made significant strides in expanding staff and services. VHA is improving its world class system of integrated mental health care and services following the path outlined above through:

(1) recommended staffing minimums; (2) productivity monitoring to optimize efficiency, access and quality of services; and (3) PCMHI and team-based general mental health care delivery.

GI Clinical Staffing

Clinical Program Overview

GI is a medical subspecialty dealing with disorders of the digestive system, including the esophagus, stomach, small intestine, large intestine (colon), liver and pancreas. The field includes the medical diagnosis and treatment of a wide variety of conditions, such as abdominal pain, reflux (heartburn), gastrointestinal bleeding, inflammatory bowel disease, hepatitis, cirrhosis, pancreatitis and nutritional disorders. Gastroenterologists are also involved in the screening, diagnosis and treatment of a variety of gastrointestinal cancers, such as colorectal, esophageal, pancreatic, gastric and liver cancer. Gastroenterologists perform a variety of diagnostic and therapeutic procedures, including gastrointestinal endoscopy (e.g. upper endoscopy), colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), endoscopic ultrasound (EUS), liver biopsy and feeding tube placement).

The provision of comprehensive and timely GI services across VHA has been challenging due to difficulty in fully staffing VHA facilities with Gastroenterologists, support staff and capital infrastructure. Therefore, there has been considerable utilization of community care providers. Over the past several years, VHA has been increasing efforts to optimize the productivity and efficiencies of available specialists and their clinical services.

Clinical Structure

GI care is delivered in a variety of settings, including Outpatient GI Clinic, Outpatient Hepatology Clinic, Gastrointestinal Endoscopy Clinic and Inpatient settings. Increasingly, VA facilities are employing the use of telephone, telemedicine, e-consults and other non-face-to-face modalities.

> Outpatient GI Clinic: Similar to other practices, a single outpatient GI clinics block is typically structured as a 4 to 5-hour time period. Clinic blocks can occur in the morning or afternoon, and providers may have one to two clinic blocks per day. During a typical clinic block, a GI provider sees outpatients with a variety of problems, such as abdominal pain, bleeding, heartburn, dyspepsia or inflammatory bowel disease. In some facilities, NPs, RN case managers and/or physician assistants (PA) may work with the gastroenterologists to provide GI care. In academic-affiliated VA facilities, medical students, residents and/or GI fellows may provide GI care under the supervision of an attending gastroenterologist.
>
> Outpatient Hepatology Clinic: Dedicated Hepatology clinics are generally found only in larger VA facilities, while smaller facilities integrate liver care into a general GI clinic. As with general GI clinics, hepatology clinics

are typically structured as 4 to 5-hour time period where a hepatologist or general GI provider sees outpatients with such problems as hepatitis C, hepatitis B, cirrhosis and non-alcoholic steatohepatitis. Many VA facilities include NPs or PAs in the care of patients with hepatitis C. Medical students, residents and GI fellows may also be involved in these clinics. Similar to GI clinics, most hepatology clinics have only one room per provider.

Gastrointestinal Endoscopy Clinic: “GI Endoscopy Clinic” in this document refers to provision of GI Endoscopy services to Veterans, which may occur within a variety of locations under different models, such as the following:

(1) GI Endoscopy-Specific Procedure Unit: Dedicated, purpose-built space for GI Endoscopy care delivery, including its own admission area, procedure rooms and recovery rooms. Endoscope reprocessing may also be co-located in this area (for the high-level disinfection of the endoscopes) or may be in a separate location.

(2) Shared Procedure Unit: The space is shared with other specialties performing invasive procedures, such as pulmonary (for bronchoscopy) and urology (for cystoscopy).

(3) Adapted Operating Room (OR) Space: Use of one or more OR rooms for GI endoscopy procedures to be performed.

In each of these models, the procedure itself may be performed by a gastroenterologist, a surgeon, or Advanced Practiced Registered Nurse (APRN)/PA/Generalist physician with appropriate training. In academic centers, GI fellows or residents may perform procedures under the supervision of an attending physician.

GI endoscopy services represent the most labor and time-intensive components of GI specialty care. Most of the care provided in the endoscopy clinic is on behalf of outpatients, but some inpatient care (typically for an emergent or urgent indication) is also provided in this clinic. Fluoroscopy equipment and anesthesia services may be required for the performance of some procedures, especially “advanced procedures” such as ERCP. In some facilities, these procedures may be performed in the radiology suite or in the OR. Coordination between different departments (radiology, anesthesia, surgery and GI) and long patient recovery times add to complexity and required time of scheduling. Moreover, these procedures also require additional support staff for the safe and effective completion of the procedure. Admission, recovery, waiting rooms and endoscope reprocessing facilities may not be co-located near the procedure rooms.

Support staff for the endoscopy clinic includes RNs, Licensed Practical Nurses (LPN), Medical Instrument Technicians and clerical support. These

support staff may or may not, be dedicated to the GI section depending upon the organizational structure of the medical facility. Importantly, the support staff required will vary significantly depending upon the scope and complexity of services provided (e.g., admit/recovery/reprocessing, standard vs. advanced procedures). All the above factors have significant impact on the productivity of an individual VHA facility.

Inpatient Care: Gastroenterologists typically provide inpatient consultative care for such common conditions as gastrointestinal bleeding, end-stage liver disease, abdominal pain and severe diarrhea. They may perform a variety of GI procedures on these patients, including endoscopy, paracentesis and liver biopsy. Some gastroenterologists also work as a medicine ward attending professional. Some facilities may use NPs or PAs to help with inpatient care. The volume of inpatient work can impact overall physician productivity and workload tracking, as care of inpatients is typically complex.

Provider Overview

Gastroenterologist: Generally, gastroenterologists are physicians who have completed a three-year internal medicine residency as well as an additional 3 years of GI fellowship training. Some gastroenterologists receive additional training to further sub-specialize in advanced endoscopic procedures (such as ERCP and EUS) or inflammatory bowel disease (including Crohn's disease and ulcerative colitis).

Hepatologist: Some gastroenterologists have focused training in hepatology (the study of the liver) and have expertise in the management of such diseases as hepatitis C, hepatitis B, end-stage liver disease (i.e., cirrhosis), liver cancer and abnormal liver function tests. Certification as a Liver Transplant Hepatologist is available through the American Board of Internal Medicine and is a requirement for those primarily responsible for the care of patients undergoing liver transplantation. Other gastroenterologists' function as hepatologists without attaining this certification.

GI is recognized as a nursing clinical specialty. The specialty is supported with a national association that sets standards for practice and provides specialty certification. These standards may be found in documents contained in the Society for GI Nurses and Associates website at: http://www.sgna.org/. As with many areas of medicine, it takes many years for nurses to attain the knowledge and experience to be expert in the area of GI nursing. This experience is especially valuable in the Endoscopy Clinic where the presence of experienced GI nurses has been associated with improved colon polyp detection and reduced incidence of procedural complications.

NPs are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers as per the American Association of Nurse Practitioners. The Position Statement may be found at: http://www.aanp.org/images/documents/publications/scopeofpractice.pdf.

GI Clinical Staffing
As a Specialty Care practice area, VHA's GI Clinic operates in accordance with the models and tools developed for Specialty Physician and Staffing.

An outline of the overall Specialty Physician and Staffing program follows:

Overview
The idealized Staffing Model outcome is defined as a team that meets relative value unit (RVU) productivity goals in the context of performance quality and timely access to care. Physician staffing can be considered adequate when the provider productivity falls within an acceptable range, with ready patient access to the delivery of high-quality care/outcomes. Using productivity, quality outcomes and access measures, clinical leadership can evaluate team function to determine whether any imbalances are related to inadequate provider productivity, systems to support high productivity (e.g., support staff and capital infrastructure) and/or the supply of providers for the Veteran population served.

Background
Since 2008, VHA has maintained a comprehensive database (Physician Productivity Cube) of the physician workforce that provides information about the staffing levels for each Medical Center and calculates the productivity of our physician workforce utilizing a standard health care measure of RVUs per physician clinical FTE. RVUs consider the time and the intensity of the medical services delivered and has been utilized by Medicare since the early 1990's.

These data are developed and maintained by OPES established in FY 2007 to develop effective management tools, systems and studies to inform leadership on how best to optimize clinical productivity and support policy on the creation of efficiency and staffing standards that promote the goals of clinical excellence, access and the provision of safe, efficient, effective and compassionate care.

The Deputy Under Secretary for Health for Operations and Management issued a memorandum on July 26, 2013, that detailed the initial implementation of Specialty Physician Productivity Standards and Business Guidelines. On May 4, 2015, VHA Directive 1065, Productivity and Staffing Guidance for Specialty Provider Group Practice, was published. This directive establishes policy that each VA Medical Facility monitor and assess specialty care provider group practice productivity and staffing on an annual basis, at a minimum, using standardized methods. Productivity targets are published and updated every 2 years.

Staffing and Productivity Measurement

VHA has a physician workforce of more than 20,000 FTE representing over 30 sub-specialties. The largest proportion of VHA's physician workforce is composed of Internal Medicine (largely primary care) and Mental Health, representing nearly half of the physician workforce.

Direct Clinical FTE = worked FTE removing leave, research, education and administration and is derived from actual labor mapping of the physician workforce from VHA PAID data. Within VHA, the capture of inpatient professional services is inconsistently captured for GI due to limitations in the electronic medical record software (i.e., its design was optimized for clinical care rather than the auditing of physician productivity). To address this gap, the time spent (labor) in inpatient care is removed from the productivity calculation, as applicable.

Implementing Productivity Standards

In FY 2013, informed by actual productivity performance, VHA implemented productivity standards or targets. The goal was to determine reasonable productivity levels, given VHA's unique patient population, and to identify and assist low performing GI practices to become more productive. This resulted in improved VHA productivity as detailed below:

Table 8.1 provides the detailed productivity standards for GI in FY 2020. VHA is holding these standards until we get a representative post-COVID-19 performance year.

Table 8.1 Gastroenterology Productivity Standards

Annual Review Quadrant Report & Practice Management Report *

Productivity Standards Target: Median

Specialty	Integrated Clinical Community (ICC)	1a-High Complexity	1b-High Complexity	1c-High Complexity	2 -Medium Complexity	3 -Low Complexity
Gastroenterology	Specialty Care	7,276	7,276	7,276	5,968	4,621

Annual Review Quadrant Report & Practice Management Report

Productivity Standards: RVU Productivity between 25th-75th Percentile

Specialty	Integrated Clinical Community (ICC)	1a-High Complexity	1b-High Complexity	1c-High Complexity	2 -Medium Complexity	3 -Low Complexity
Gastroenterology	Specialty Care	6,250 - 8,518	6,250 - 8,518	6,250 - 8,518	4,527 - 6,603	3,689 - 5,698

Requires Program Review

Local Actions Required: RVU Productivity > 75th Percentile

Specialty	Integrated Clinical Community (ICC)	1a-High Complexity	1b-High Complexity	1c-High Complexity	2 -Medium Complexity	3 -Low Complexity
Gastroenterology	Specialty Care	> 8,518	> 8,518	> 8,518	> 6,603	> 5,698

Requires Program Review

Local Actions Required: RVU Productivity > Median - 1.25 Standard Deviation and < 25th Percentile

Specialty	Integrated Clinical Community (ICC)	1a-High Complexity	1b-High Complexity	1c-High Complexity	2 -Medium Complexity	3 -Low Complexity
Gastroenterology	Specialty Care	5,376 - 6,250	5,376 - 6,250	5,376 - 6,250	4,269 - 4,527	3,297 - 3,689

Requires Program Review and Mandatory Report to VISN

Mandatory Response: RVU Productivity < Median - 1.25 Standard Deviation

Specialty	Integrated Clinical Community (ICC)	1a-High Complexity	1b-High Complexity	1c-High Complexity	2 -Medium Complexity	3 -Low Complexity
Gastroenterology	Specialty Care	< 5,376	< 5,376	< 5,376	< 4,269	< 3,297

SPARQ

Productivity data coupled with access measures provides a framework for determining specialty physician staffing. A web-based tool was developed that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions for specialty care physicians. This integrated approach, coupled with measures of the practice environment and the amount of specialty non-VA community care, was developed to assist VA Medical Center leaders make informed decisions on the appropriate numbers of specialty physicians needed to meet patient care needs.

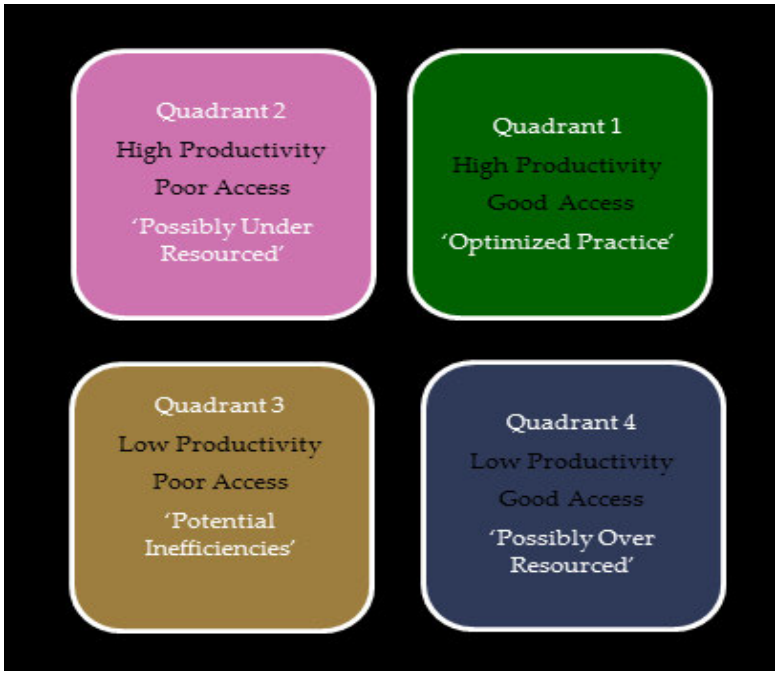

Figure 8.1 Specialty Productivity – Access Report Quadrant tool (SPARQ)

A critical component of the implementation of the productivity standards was the development and deployment of the SPARQ tool. The goal of the SPARQ tool is to provide information for local managers and an algorithm for the effective management of VHA's specialty physician practices. The tool is designed to drive performance improvement in Veteran access to specialty care. The SPARQ tool uses an importance-performance framework and plots each VHA specialty practice into one of four quadrants based on their productivity and access performance. Practices with high productivity and above average access to care for Veterans are identified as optimized. Practices that have high productivity and below average access are identified as potentially needing resources. Practices with low productivity and below average access are identified as inefficient. Practices with low productivity and above average access are identified as practices that have potentially been over-resourced. SPARQ provides information to inform business strategies including measures of specialty-specific fee care expenditures (care purchased in the community) and VA Reliance or Market Share. The tool also includes measures of value that include compensation per RVU to

assist in ‘make or buy’ decisions. The tool expands to evaluate adding in the physician extender workforce (NPs, PAs and clinical nurse specialists), support staff and workload (RVUs). The tool also includes measures of projected workload from the Enrollee Health Projection Model so that workforce planning in out years is included**.**

Evaluating Capacity

VHA can evaluate capacity using the framework and data put in place to measure physician productivity and staffing. Capacity is represented by: (1) the numbers of clinical providers (physicians and physician extenders, such as APRNs/PAs) and (2) the specialty-specific productivity expectations (acceptable/achievable levels of productivity) for each of those health care providers. VHA can increase the number of providers, increase productivity, or increase both to attain additional capacity. Achieving desired levels of productivity for health care providers requires: (1) an efficient clinical environment (adequate numbers of exam rooms per provider and efficient clinic space, scheduling support, information technology support, OR availability for surgeons, etc.); and (2) an optimal number and mix of clinic support staff per provider to ensure these providers can practice to the full extent of their license/capability.

VHA has simulated productivity expectations (moving low performers to the standard) and calculated the appropriate support staff ratios to assist providers to become more productive, maintain productivity and assist potentially overburdened practices. This data was used in the assessment of VHA’s actions to address the access crisis. Additionally, these data have been leveraged to assess VHA sites with inefficient specialty practices (low productivity, below average access). OPES staff actively engaging with these sites to assist with process improvement.

While VA productivity appears to be lower than the private sector, it is important to recognize that there are other significant differences to be factored into comparisons between a VA medical practice and the private sector. First, the patient population differs between VHA health care users and the private sector and drives correspondingly distinct delivery of care.

Second, laws and procedures governing Federal, VA and VHA HR practices are more complex than in private practice and can comparatively impact flexibility and timeliness in hiring clinical staff, particularly advance practice providers and other staff that can leverage the productivity of the physician.

Third, the number of clinical support staff team members in VHA are not always equal to those of the private sector, leading to providers spending more time performing administrative and non-physician clinical functions. While VHA has tried to improve support staff in the clinics the ability to recruit and retain quality support staff has proved challenging.

Fourth, VHA providers are often challenged by limited and/or outdated clinical space. Finally, VA providers are frequently tasked with unmeasured workload related to the

management of community care providers (especially with the expansion of community care providers through the Veterans Choice Program and the MISSION Act), including receiving/interpreting results, documenting results and care coordination.

It is important to note that the MGMA productivity data primarily reflect a fee-for-service model. Within VHA, providers are not organized on a fee-for-service basis. The RVU-based measure of productivity is oriented toward procedural-based specialties. Procedural services are weighted with more RVUs than cognitive services, even when the time required to deliver the care is similar. Lower RVU production does not necessarily mean lower productivity or even less “work,” as more non-procedural care may be of greater true health care value to the patient and may require equivalent or greater time and cognitive input from the provider. An example might be employing a fecal occult blood test instead of a colonoscopy for colorectal cancer screening, thereby producing fewer RVUs. This can lead some specialty practice areas, such as GI, to have a lower average RVU total than their private practice counterparts. For example, in a fee-for-service private practice model, the GI physicians employ non-physician staff (e.g., PAs) to provide outpatient clinic services in order to maximize their physician time performing high RVU/high revenue procedures. Within VHA, it may be in the Veterans best interest to provide care via an outpatient clinic non-procedural evaluation by a GI physician specialist

In addition, measures of annual compensation for many VHA specialists are considerably lower than that of the benchmarks. When calculating compensation per RVU for VHA—as compared to MGMA—it is observed to be much lower, as the average non-VA GI salaries far exceed the maximum allowable Federal salary.

VHA has a social mission that might not necessarily be considered in the external benchmarks. For example, payers (Medicare and private insurance) may not recognize important aspects of a Veteran's treatment plan, such as telephone encounters or an extended visit involving the family to assist in the Veteran’s care. VHA considers this a critical component of our work. Because the RVU system, based on payment for healthcare services, might not recognize these important social components of health care delivery, VHA benchmarks internally to drive system improvement while maintaining our important social mission.

Next Steps

VHA has completed productivity and staffing standards for all VHA specialty physicians. VHA will re-visit productivity standards, as appropriate, with the expectation to improve value to Veterans and stakeholders. VHA should continue to refine specialty practice management business strategies to maximize efficiency and health care value in the delivery of healthcare services and ensure ready access to medical care for Veterans. In support of the idealized team-based staffing model described above, VHA will incorporate critical analysis and delineation for the numbers and actions to be performed by all members of the clinical team, using Veteran-centered outcomes as criteria for success.

OPES has already developed additional web-based practice management tools to provide local managers with information on: (1) capacity; (2) support staffing; and (3) physician staffing.

(1) **Capacity:** The methodology employed in the web-based tool identifies sites with below average productivity and estimates the additional specialty-specific workload in RVUs that could be provided if productivity is increased to VHA MCG mean levels for a specific specialty. That projected increase in RVUs can be equated with additional potential specialty capacity. Given that physician productivity depends not only on the effort of the individual physician but also the practice setting (clinic support staff and clinic environment/space), this tool also assesses clinic support staff for each specialty.

(2) **Support Staffing:** To estimate numbers and skill sets of clinic team needs, VHA utilized internal benchmarks because VHA ratios may not be directly comparable to private sector benchmarks. Doctor of Medicine (MD) FTE mapping does not distinguish between time allocated to specialty outpatient clinics versus procedure areas. VHA's clinic support staff ratio only measures staff in the specialty outpatient clinic (and does not include procedure areas). The support staff ratio represents the total outpatient support staff FTE mapped to that specialty clinic divided by the total provider FTE mapped to outpatient care. As previously mentioned, specialists who provide more cognitive care (consults, clinic) than procedures will have a lower productivity ratio but may be improving aspects of patient care if unnecessary procedures are avoided.

(3) **Physician Staffing:** To estimate physician staff needs, it was assumed that all practices with a specialty and MCG-specific productivity level below average (75th percentile) would be staffed up to a level that would bring the practice back to the 75th percentile. This approach was applied to all practices with high productivity (Quadrants 1 and 2). The reasons for including all high-productivity sites, regardless of access, are because of: (1) concerns regarding the accuracy of the access measure, therefore inaccuracy in discriminating a true Quadrant 1 from a true Quadrant 2 practice; and (2) any site operating at the very high end of productivity (even with timely access to care) has very little margin or reserve in terms of a sudden change in FTE levels (e.g., retirement, illness) and could easily slip into Quadrant 2. This approach provides a margin for all high productivity sites and sets a productivity standard at the VHA specialty and MCG-specific 75th percentile.

VHA is currently working to develop tools that align VA in-house provided GI care with care purchased in the community to better understand, manage and coordinate care for the Veteran.

As part of these efforts, OPES has created a web-based tool that allows a composite facility-level view (aggregated data across all specialties) that includes the following:

- Predominant quadrant designation (quadrant where most specialties are located);
- Electronic Wait List data (aggregated across all specialties for a facility);
- Percent of specialties with support staff ratios below the mean;
- Fee costs; potential physician capacity data (total physician RVUs for all specialties, projected RVUs that could be produced if all specialties could achieve productivity levels for each specialty that are at the mean or greater, and potential increase in capacity);
- Physician staff data (current total MD FTE, additional MD FTE needed to address high-productivity specialties above the 75th percentile, and the percent increase in physician staffing required);
- Support staff data (total support staff on board, additional support staff needed to bring all specialties up to at least the mean level, and percent increase in support staff necessary); and
- Right sizing VHA's provider workforce to meet the goal of maximizing Veteran's outcomes in a cost-efficient manner is a complex task. Within health care, approaches exist to model staffing requirements; however, there is no consensus on a definitive methodology or technique. Recent literature suggests that an integrated approach that combines elements of supply and demand with that of benchmarking. Within VHA, demand projections are complicated because of variation in VA reliance and more recently the Choice Act legislation. VHA maintains its Provider Workforce Report that includes these integrated elements of supply, demand and benchmarking. The Provider Workforce Report delivers system level staffing norms by geographic location (VISN) and Practice Setting (Medical Center Complexity Group). Staffing levels per population (Core Facility Unique Patients and Specialty Specific patients treated) are included in this report as well as provider productivity levels. Additionally, the composition of the care team (physicians, advanced practice providers and support staff levels) is included. This report can be used to determine comparison staffing levels; however, local facility managers must contextualize these data to their potentially unique characteristics such as patient reliance and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

Table 8.2 on the next page summarizes GI baseline staffing norms.

Table 8.2 FY 2022 Gastroenterology MCG/VHA Comparisons

Comparison Group	Facility Count	Facility Average Physician Clinical FTEE	Facility Average Residents	Produc-tivity (FYTD)	Annual Produc-tivity Target	Physician Clinical FTEE per 10K Specialty Uniques	Physician Clinical FTEE per 100K Core Facility Uniques	Residents per Clinical Physician	Associate Providers per Physician Clinical FTEE	Admin Support Staff per Physician Clinical FTEE	Clinical Support Staff per Physician Clinical FTEE	Total Support Staff per Physician Clinical FTEE
1a-High Complexity	39	5.03	4.69	7,188	7,276	8.92	5.83	0.91	0.71	0.49	0.61	1.10
1b-High Complexity	21	3.62	3.93	6,768	7,276	9.49	5.80	1.03	0.47	0.37	0.86	1.23
1c-High Complexity	23	1.96	2.67	6,285	7,276	8.58	4.18	0.89	0.70	0.52	0.98	1.50
2 -Medium Complexity	22	1.27	1.70	5,750	5,968	8.81	3.21	0.12	0.51	0.43	0.61	1.04
3 -Low Complexity	17	0.95	-	4,795	4,621	8.96	1.90	0.00	0.27	0.40	1.30	1.70
VHA	122	2.96	4.00	6,762	-	8.94	5.36	0.83	0.62	0.46	0.74	1.20

Gastroenterology Challenges:
Overall productivity for GI is impacted by the difference in RVUs generated by procedures compared to clinic visits. Since endoscopic procedures generate two to three times more RVUs than outpatient clinic visits (often in a similar amount of time), those facilities that provide a higher proportion of consultative care will generate lower overall RVUs than those that focus more on procedures. For example, those that provide a higher proportionate volume of hepatitis C care will likewise have lower RVU measures of productivity. Considerable variability in productivity could also result from differences in physician extender availability. APRNs and PAs working in the GI specialty contribute to the GI Team RVU production.

The SPARQ tool plots productivity (as measured by RVUs per clinical FTE) versus access. The measure of access for GI is based solely upon outpatient GI clinic access. But as noted above, GI care is multi- faceted (i.e., outpatient GI clinic, outpatient hepatology clinic, gastrointestinal endoscopy clinic, inpatient care). There is currently no means to comprehensively measure access across the entire spectrum of GI services, especially in the endoscopy clinic. While considerable attention has been placed upon access to endoscopic services, especially in light of high-profile examples of delays in care (e.g., Columbia, South Carolina), VHA lacks systems to track endoscopy access.

The scheduling of GI endoscopic procedures is a complex process that involves clinical triage of each patient referred for care. Surveillance procedures and elective cases may be placed on the endoscopy schedule weeks or months in the future without implying any limitation in true access. On the other hand, GI sections with extremely limited capacity may reserve slots for urgent or semi-urgent procedures and only release them for elective cases a few days in advance. Therefore, any measure of open clinic slots or percent of patients scheduled within 30 days of the consult will misrepresent the true situation.

To compound matters, the endoscopy clinic scheduling software lacks the flexibility required for monitoring of endoscopy clinic access. The GI Field Advisory Committee established a working group with OPES to identify a valid means to track endoscopy access but unfortunately, no valid process was identified due to limitations in the current scheduling and endoscopic reporting software.

As an aside, the cancellation by patient rate, same-day cancellation rate and no-show rates for endoscopy procedures are relatively high across VHA (17.8%, 2.3% and 11.5%, respectively). These missed opportunities reduce the productivity of the gastroenterology section and decrease access to endoscopy, as many of these patients must be rescheduled at the patient's request. VHA has strategies in place to reduce no-show rates but the patient population has many risk factors for canceling appointments or no-shows (e.g., lack of family/friends to transport them for medical procedures).
GI workload has increased significantly over the last several years. Notably, productivity per physician also increased by increasing the number of gastroenterologists and by improved productivity per specialist.

Emphasis of SPARQ upon RVUs, while important, does not represent the full complexity of endoscopy management, and resulting trade-offs between cognitive (clinic) and procedural care. VHA will carefully evaluate the appropriate applicability of productivity to the gastroenterology practice. The objective is to ensure effective use of resources, while preserving flexibility for those elements of GI care delivery that need to address factors beyond productivity.

Recommendations for Change
The strategy for evolving productivity and staffing standards across all specialty physician practice areas is outlined above. Specific to GI, the National Gastroenterology and Hepatology Program and the Gastroenterology Field Advisory Committee have advocated for investment in endoscopic reporting software that will improve documentation of clinical care and assist VHA endoscopic productivity, access and quality measurement. It is recommended that an enterprise GI endoscopy software solution be implemented at all facilities performing these procedures.

Additional work is ongoing to improve capture of outpatient and inpatient workload, refine labor mapping of physician and support staff time. Given the complexities and variability in the structure of endoscopy unit staffing across VHA, detailed data collection will be required for formal analysis of optimal staffing models. Underperforming facilities may need managerial interventions to improve productivity of the existing staff or the addition of providers, support staff and/or space and capital infrastructure to optimize efficiency and productivity. Consideration should be given to strategic, evidence-based, limited “overstaffing” in order to offer capacity for growth in demand and avoid crises when staff attrition occurs. Furthermore, the addition of care coordinators, case managers and patient navigators can significantly improve both the quality of care and prevent patient no-shows, thereby improving both access and productivity.

The goal is the delivery of high-quality and timely GI care. VHA is committed to evolving our measures, tools and capacity for all elements of GI services to ensure Veterans receive effective and efficient care. In pursuance of these objectives, the National Gastroenterology and Hepatology Program and the Office of Veterans Access to Care have been working together for the past several years. Working groups have been established to address a variety of areas for process improvement, such as reduction in overuse of gastrointestinal endoscopy, streamlining consult management and expansion of the role of GI nurses. These efforts resulted in a toolkit that was disseminated nationwide, with future revisions planned as we refine interventions to address these important issues. Moreover, we are continually developing guidance and policy, as needed, to support these goals.

Primary Care Clinical Staffing

The National Academy of Medicine definition of primary care provides the foundation of VHA primary care. “*Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal*

health care needs, developing a sustained partnership with patients and practicing in the context of family and community."

Primary Care represents the largest single component of health care delivery for Veterans.

In early 2009, the VA Universal Services Task Force Report, "Veterans Health Care: Leading the Way to Excellence," recommended the formal adoption of a team-based model of care featuring the three major principles: patient-centered care, coordination of care and access to care. To apply these principles more completely within Primary Care, VHA adopted and customized the patient-centered medical home model of care, and branded VHA's patient-centered medical home model as the Patient Aligned Care Team. The model was developed and launched in October 2009 as part of the Veterans Health Administration Transformational Initiatives. The patient-centered medical home model of care has been favored by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association. After nearly a decade of implementation experience and accumulation of scientific evidence, the vision of Patient Aligned Care Teams and medical homes more generally, has continued to evolve. Evidence suggests that Primary Care providers without a larger patient support team meet significant challenges in providing high quality preventive and chronic care management in addition to addressing patients' other biopsychosocial needs.

Key Definitions

Patient Aligned Care Team: A care delivery model based on the Patient Centered Medical Home that, when the recommended staff are present and well-trained, produces superior outcomes with respect to quality metrics, access, patient and employee experience. Adherence to the staff model is highly recommended to maximize opportunities in these areas and optimize care coordination.

Patient Centered Management Module (PCMM): PCMM is a VHA web-based application that allows input of VA medical facility specific and Primary Care panel specific data and allows national roll up of this data for tracking, case finding and comparison purposes. PCMM supports set up and definition of the health care team, assignment of staff to positions within the team and assignment of patients to the Patient Aligned Care Team.

Teamlet: A Patient Aligned Care teamlet consists of a PCP, Registered Nurse Care Manager (RNCM), Clinical Associate (CA) and Administrative Associate. The teamlet is the subset of Patient Aligned Care Team staff to which one entire panel of patients is assigned in PCMM. Generally, Patient Aligned Care teamlet members are designated in PCMM to the following positions: Provider, Registered Nurse, LPN/Licensed Vocational Nurse (LVN)/Health Technician (HT) and Clerk. Special population Patient Aligned Care Teams may have additional or other designated Patient Aligned Care teamlet positions in PCMM.

Patient Aligned Care Team Members

Administrative Associate: The Administrative Associate is the teamlet member who provides administrative support for the delivery of Primary Care services and operations management (e.g., medical clerk (MC), HT, MSA).

Associate Provider (AP): AP is a designation in PCMM intended primarily for trainees who require close supervision and oversight from a physician provider.

Clinical Associate: A Clinical Associate is an LPN, LVN or unlicensed assistive personnel (e.g., certified nursing assistant, MA, HT. The Clinical Associate is a teamlet member.

Discipline-Specific Team Member: A discipline-specific team member is a health care professional designated to a Patient Aligned Care Team position in PCMM who provides direct discipline-specific patient care to one or more panels of patients, but not to all primary care patients at the facility. Examples of discipline- specific team members are: Clinical Pharmacy Specialists, Registered Dietitians, Social Workers, Primary Care-Mental Health Integration staff.

Patient: The central member of the Patient Aligned Care Team is the patient. Each eligible Veteran receiving primary care from VHA is assigned to a Patient Aligned Care Team, which includes a single PCP or AP linked with supervising PCP. Veterans are typically assigned to only one Patient Aligned Care Team, unless their care requirements make multiple Patient Aligned Care Team assignments more appropriate.

PCP: PCPs are physicians, APRNs and PAs who provide primary care to an assigned panel of patients and in accordance with licensure, privileges, scope of practice or functional statement. The PCP is a teamlet member. Physician assistants may be designated as PCPs but must function as agents of a supervising physician specified by scope of practice and facility policy, consistent with state licensure requirements, and therefore must function in a collaborative relationship with a physician.

RNCM: The RNCM is a teamlet member who provides comprehensive and coordinated nursing care to an assigned panel of patients. The RNCM collaborates with both VA services and community services, as appropriate, to effectively meet the health promotion or disease prevention, acute, chronic and long-term needs, based on the Veteran’s goals and plan of care with a focus on self-management.

Panel Management and Structure:
A panel is defined as the number of patients under the care of a specific provider. Panel capacities are set for each Patient Aligned Care Team based upon the characteristics of the patient panel, such as proportion of patients from special populations (e.g., women’s health, elderly, end-stage renal disease, etc.) that may require additional time and resource-intensive care management and care coordination to provide high-quality care.

Other factors that impact panel capacities include the number of staff and exam rooms assigned to the teamlet.

PCMM supports set up and definition of the health care team, assignment of staff to positions within the team, and assignment of patients to the team. Patient Aligned Care Team Comprehensive Services include the following:

a. Chronic Care and Care for Patients at High Risk for Complications or Morbidity. For patients with chronic health conditions, Patient Aligned Care Team staff provide evaluation, diagnosis, treatment, care management, care coordination, health education and self-management support. Teamlets utilize registries and other tools to quickly identify individuals requiring additional services and closer follow up. In addition, patients at high risk for complications or morbidity receive a special focus from the Patient Aligned Care Team to ensure integrated and comprehensive care management and coordination over the lifetime of the patient and across the continuum of care settings. Patient Aligned Care Team staff provides care coordination and care management to meet the needs of patients.

b. Acute or Urgent Care. Patient Aligned Care Team staff provides evaluation, diagnosis and treatment of acute or urgent care that can be provided safely at the site of care and is within the clinical privileges, or scope of practice and expertise. Patient Aligned Care Team staff engage appropriate discipline-specific team members for acute or urgent care requiring discipline-specific skills, expertise, or licensure. Patient Aligned Care Team staff arrange for safe transition and transfer of patients to other health care settings (e.g., Emergency Department, hospital admission) when needed.

c. Preventative Health Care. Patient Aligned Care Team staff offer preventive health care tailored to individual patients' needs and preferences and provide preventive care to which the patient has agreed. Patient Aligned Care Team staff use population management tools, such as registries, to identify patients and cohorts who may benefit from preventive health care and develop health care plans for efficient delivery of care to patient cohorts. Patient Aligned Care Team staff use nationally and locally developed data collection methods for evaluation and measurement of preventive health care services. Patient Aligned Care Team staff use and apply VHA Clinical Preventive Services Guidance Statements to offer recommended screening for conditions or risky health behaviors (e.g., cancers, mental health conditions, tobacco use), immunizations, health education (including counseling regarding health effects associated with certain health behaviors, e.g., tobacco use, physical activity, healthy eating) and preventive medications for selected high-risk conditions, as appropriate. When clinically indicated, Patient Aligned Care Team staff engage providers of specialty care and discipline-specific team members for preventive care services (e.g., colonoscopy, special services for women with a spinal cord injury).

d. Mental Health Care. Patient Aligned Care Team staff provide routine mental health care, consistent with team members' clinical privileges, skills, scope of practice or functional statements. Patient Aligned Care Team staff perform nationally required preventive mental health screenings. In addition to screening, clinical evaluation of patients during routine primary care may also lead to recognition of symptoms of mental disorder. Patient Aligned Care Team staff typically provide brief alcohol counseling and treatment for uncomplicated disorders such as anxiety, depressive and adjustment disorders. When caring for patients with mental health disorders, Patient Aligned Care Team staff engage PCMHI providers, behavioral health providers, disease prevention specialists, or other discipline-specific members of the Patient Aligned Care Team when appropriate. PCMHI co-located collaborative care and care management options must be available at VA Medical Centers and community-based outpatient clinics (CBOC) per VHA guidance, maximizing virtual modalities (telephone, telehealth) to meet patient preferences.

e. Health Education, Coaching and Developing Health Care Partnerships. Patient Aligned Care Team staff provide patients with information, education and skill building to support self-management, as well as access to materials, resources and programs appropriate to the patient's needs. Patient Aligned Care Team staff promote therapeutic alliances between the patient, the patient's personal support persons and the patient's health care team by using health education interventions, health coaching, motivational interviewing, self-care strategies and connecting patients to community resources to encourage, guide and support health behavior changes that promote wellness or reduce the risk of illness and adverse health events.

f. Military Health History, Unique Concerns and Health Risks Associated with Deployment. Patient Aligned Care Team staff are knowledgeable on issues related to deployment health risks with basic competencies for the common concerns of post-deployed Veterans including but not limited to unique health risks, exposures, sleep issues, pain, chronic multisystem illness, traumatic brain injuries and mental health issues (including PTSD), the Veteran's problems and concerns and to build therapeutic partnerships with the Veteran. Patient Aligned Care Team staff screen patients for post-deployment related health issues and coordinates referral to the appropriate specialist when further evaluation is indicated. Patient Aligned Care Team staff manage common acute and chronic pain conditions and consult with providers in pain medicine and other related specialty care when appropriate and according to VHA policy on pain management.

g. Advance Care Planning. Patient Aligned Care Team staff notifies and screens patients for Advance Directives. Patient Aligned Care Team staff help or engage appropriate health professionals to assist patients in stating their advance care preferences.

h. Special Population Patient Aligned Care Teams. VHA also operates several Patient Aligned Care Teams for specialty Veteran care needs, as out lined below. The following Patient Aligned Care Teams are typically smaller in size than the primary Patient Aligned Care Teams, focusing on the unique and specific needs of the population requiring care:
   - Geriatrics;
   - Home-Based Primary Care (HBPC);
   - HBPC- Patient Aligned Care Team Programs Operating in Highly Rural Areas;
   - Homelessness;
   - Infectious Diseases;
   - Rehabilitation;
   - Post-Deployment Care;
   - Renal/Dialysis;
   - Serious Mental Illness;
   - Spinal Cord Injury; and
   - Women's Health.

Primary Care Panel Size

VHA primary care practices must establish maximum panel capacities for all PCPs and APs (using the PCMM tool noted above). This panel consists of "active patients" for whom the provider delivers PC. Parameters that are considered in establishing recommended panel sizes are support staff and space considerations (available exam rooms). VHA Facilities are responsible for routinely updating patient assignments, staffing, and space availability for all primary care practice sites including divisions/CBOC. After adjustment for the factors identified, maximum panel capacities for VHA PC providers largely fall in the range of 900 to 1,400.

Special Population Patient Aligned Care Team Panels. Some providers may serve as PCPs for specialized panels of patients with specific, complex diseases. For example, Infectious Disease specialists may serve as PCPs for panels of patients with HIV infection; Spinal Cord specialists may serve as PCPs for panels of SCI patients; and geriatric providers may serve as the PCPs for Geriatric Primary Care clinics. Designated Women's Primary Care panels represent another population with specialized care requirements. As noted above, it is recognized that panel sizes for special population Patient Aligned Care Team panels may need to be smaller than for a typical primary care panel. This is acceptable and the maximum panel capacity for these providers and panels needs to be determined locally, incorporating guidance from national programs where available.

Recommended panel capacities are calculated based on the following parameters:

Support Staff Ratio. Support staff ratio is the number of staff (FTE) present in the clinic area assisting providers with delivery of PC per one FTE provider. Support staff consists

of RNs, LPNs, pharmacists (including Doctor of Pharmacology (PharmDs)), medical assistants, HTs, as well as MCs in the clinic.

Time spent in the following activities must be included in the determination of support staff of FTE providers:

1. Checking patients in and out of PC appointments;
2. Obtaining vital signs;
3. Collecting medical information, and completing health screening tasks;
4. Clinic nursing activities, such as patient education, nursing evaluations, injections and other office procedures; Independent follow-up visits by nurses and registered pharmacists for the management of blood;
5. Space: The number of rooms available for the team in which to provide care influences the capacity of the team. When space is constrained, fewer patients can be accommodated, and with more space greater efficiency can be achieved; and
6. Telephone calls for PC patients.

Excluded from Support Staff Ratio are the following:

- Staff time dedicated to Business Office functions, file room activities, or supporting non-PC clinics are not to be included (or pro-rated for time spent supporting PC); and
- Dietitians, social workers and PC-mental health integration staff are valuable members of the PC team, but for the purposes of obtaining comparable measurement of support staff across all sites, are not included in this count.

Further, time spent in the following activities should not be included:

1. Phlebotomy;
2. Business Office functions, such as enrolling new patients, means testing, registration and billing;
3. Support for specialty or mental health clinics; and
4. Support for dietitians, social workers, or other health care providers not working directly with the PCPs.

Time spent with pharmacists filling prescriptions (e.g., at a satellite clinic or CBOC). Additionally, prorating support staff FTEs is used when the support staff performs more than one function or supports non-PC clinics, as well as PC. Support staff is prorated for the time they spend in PC support versus time spent in other activities.

Space: The number of rooms available for the team in which to provide care influences the capacity of the team. When space is constrained, fewer patients can be accommodated, and with more space greater efficiency can be achieved.

Panel Size Adjustments

VHA and private data indicate that current levels of support staff in VHA are often below the level of private sector practices and are at a level that may reduce the productivity of

individual providers. At least three FTE support staff or providers are recommended for VHA primary care clinics. A mix of approximately one RN, one LPN or MSA and one medical clerk represents a reasonable combination of staff.

Support Staff. Adjustment in panel size from the baseline of 1,200 for levels of support staff can be made as local conditions require.

Space. Clinic rooms include fully equipped exam rooms, as well as interview rooms reserved for clinical staff. Levels of 2.5 rooms per 1 FTE provider have been recommended as a minimum for VHA. Adjustment in panel size for room availability for a baseline panel of 1,200 patients needs to be made as follows:

Table 8.3 Panel Capacity Adjustment

Exam Rooms per PCP FTE	Panel Capacity Adjustment
< 2	-5%
2 – 2.5	No adjustment
>2.5	+5%

Panel capacity is also adjusted for the number of female patients on the panel. Women Veterans generally have more visits and utilize more resources than men, necessitating this adjustment. Virtual care and telework staff may also decrease space requirements. One FTE non-physician provider (NP or PA) is expected to carry a panel 75% the size of a one-FTE MD. However, ratios of support staff and space should be the same for a one-FTE non-physician provider as for a one-FTE MD provider.

Panel size should be prorated to the time the provider spends in Primary Care Direct Patient Care

Recommendations for Future Changes

Since its inception in 2009, the VHA Patient Aligned Care Team method has proven to be an effective evolution of care delivery for Veterans. As with all clinical practice areas, VHA continues to strive for improvement in patient care outcomes and wait times for Primary Care. Efficient use of resources is a critical component to such improvement. In July 2020, roughly half of Patient Aligned Care teamlets were fully staffed nationally, and projections show that hiring providers and nursing staff will become progressively more difficult in the future. To continue to provide excellent service to Veterans, VHA needs to develop alternate staffing models that leverage anticipated resources. Primary goals will be to maintain access, deliver high-quality primary care and support both staff and Veteran experience. A major feature of any future model will include having staff provide virtual care, either on a permanent or rotational basis, which will allow increased access to care without requiring substantial increases in physical space.

Women's Health Clinical Staffing

VHA's commitment to the health of women Veterans requires a practice focused upon the specific needs of women as a population distinct from male Veterans. Women's Health must not only incorporate gender-specific clinical practices such as gynecology,

but also address the reality that common experiences in service can nevertheless produce differing health outcomes between female and male Veterans.

There are currently 2 million living women Veterans. Based on the upward trend of women in all military service branches, the expected number of women Veterans using VA health care will rise rapidly, and the complexity of injuries of returning female troops is also likely to increase.

Designated Women's Health Providers
VA has enhanced provision of care to women Veterans by focusing on the goal of developing Women's Health Primary Care Providers (WH-PCP) at every site where women access VA. VA has at least two WH-PCP at all of VA's health care systems. In addition, 90% of CBOC s have a WH-PCP in place. VA is in the process of training additional providers to ensure that every woman Veteran has an opportunity to receive her primary care from a WH-PCP.

Women's Health Models of Care
Designated WH-PCPs may practice in any of three models of care shown in Figure 8.2.

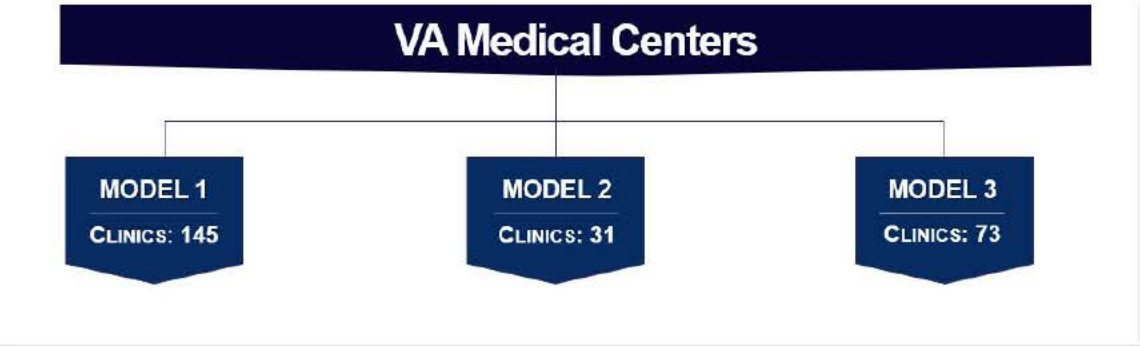

Figure 8.2 VAMC Women's Health Models of Care

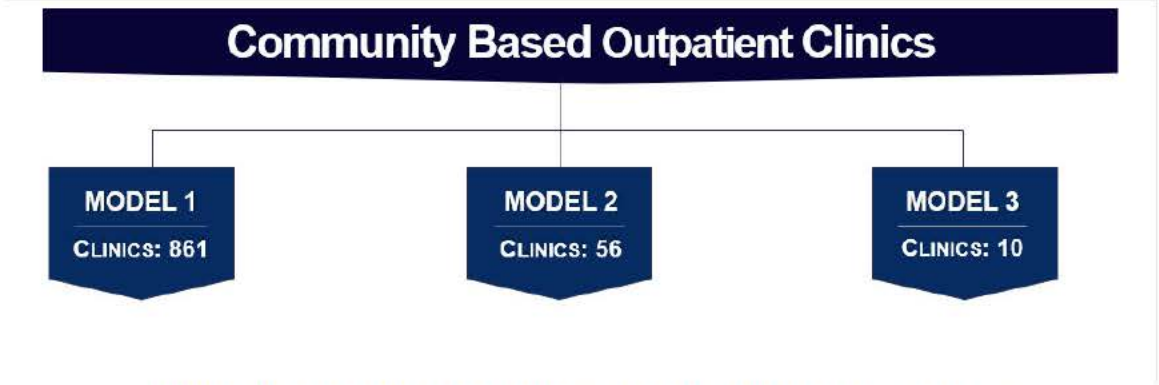

Figure 8.3 VAMC CBOC Women's Health Models of Care

Model 1 is a gender-integrated primary care clinic. Within this model, patients are preferentially assigned to WH-PCPs practicing within a "usual" primary care clinic setting. Model 3 is a women's only clinic arrangement, known as a Comprehensive

Women's Clinic. In this model, WH-PCPs practice in a separate clinic for women, including a separate entrance and separate waiting room. In addition to primary care, Comprehensive Women's Clinics incorporate gynecologic care, mental health care, social work and other services for women Veterans. Model 2 falls between Models 1 and 3 and is known as "Separate but Shared Space." This describes a model of care where WH-PCPs are practicing in a clinic setting that may be a section or area of a gender-neutral primary care clinic that is just for women, or another clinic area that is reserved for women at certain times. This model often works well in smaller sites that choose to have a separate women's clinic, but do not have a large enough population of women to support a fully staffed Comprehensive Women's Clinic.

Table 8.4 below shows how many facilities are practicing under each model.

Table 8.4 VHA Women's Health Models of Care

Total Women's Health Clinic Models of Care (FY 2021)					
Total: Model 1	**1,006**	**Total: Model 2**	**87**	**Total: Model 3**	**83**
VA Medical Centers	145	VA Medical Centers	31	VA Medical Centers	73
CBOCs	861	CBOCs	56	CBOCs	10
Total Models of Care: 1,176					

Women's Health Patient Aligned Care Team and Staffing Requirements

VHA Primary Care uses a team-based model of care, where a panel of patients are assigned to a provider who is part of a Patient Aligned Care Team. Generally, within Patient Aligned Care Teams, a full-time provider has a panel of approximately 1,200 patients; this is known as a Patient Aligned Care teamlet. A general Patient Aligned Care teamlet in VA is required to have 3 full-time support staff including a clerk, an RN and an LPN or Health Technologist. Women's Health Patient Aligned Care Teams are one of the Special Population Patient Aligned Care Teams and have increased staffing requirements due to the need for chaperones for gender specific exams. It is recommended that Women's Health Patient Aligned Care Teams have an additional health technologist position to chaperone gender specific exams, resulting in a recommended 4:1 staffing ratio.

Additionally, Women's Health Patient Aligned Care Teams have high care coordination needs due to mammogram and pap programs that require time intensive scheduling, follow-up and tracking; maternity care coordination and coordination for other types of outsourced women's health care such as fertility care, breast cancer care or gynecologic oncology care.

Because of these needs, an additional Patient Aligned Care Team RN Care Coordination position is recommended to support Women's Health Patient Aligned Care

Teams. One additional RN Women's Health Care Coordinator can support several Women's Health Patient Aligned Care Teams.

Panel Size Reductions
Women Veterans, on average, use more primary care visits than male Veterans, for both reproductive health and other health care needs. Therefore, to provide adequate access for women Veterans it is recommended that WH-PCPs have reduced panel sizes. The WH-PCP's panel is reduced by 20% of the proportion of their panel that is female. Thus, if the WH-PCP's entire panel is female, then the panel size is reduced by 20% of 1,200. If 200 of patients are female, then the overall panel size is reduced by 20% of 200.

Co-Located Mental Health Care
Women Veterans who use VA have a high prevalence of mental health or substance use conditions (45% compared to 31% of male Veterans), and Primary Care Mental Health Integration (mental health co-located with women's primary care) is essential. A co-located Mental Health provider must be available to assist with mental health conditions in clinic at the time of primary care encounters.

In sites that have separate women's clinics, those clinics must have their own Primary Care Mental Health integration staff.

Gynecology
Women Veterans have access to Gynecology care as a basic component of high-quality care. For those facilities that VA does not have a gynecologist on site (28 out of 140), Veterans receive services through care in the community. Basic gynecologic care, such as contraception, cervical cancer screening, menopausal care, etc. is usually provided by WH-PCPs. When women require referral for Specialty Gynecologic Care (including gynecologic surgery) it may be provided on site, or through community care providers.

Emergency Departments also must be prepared to provide emergency gynecologic care for such things as acute vaginal bleeding, pelvic pain and pregnancy complications.

Maternity Care
VA provides maternity care, including prenatal care and delivery and limited newborn care to eligible women Veterans. This care is usually provided off site through community care providers.

Each site is required to have a Maternity Care Coordinator who maintains monthly contact with pregnant women during their pregnancies and is responsible for coordinating VA with community care providers during their pregnancies. This position can be a collateral duty assigned to an RN or social worker.

Care Coordination
Women Veterans who use VA care have a high burden of trauma, mental and physical health conditions and psychosocial needs. In addition, women Veterans using VA care are much more likely than male Veterans to require a referral outside VA for mammograms, breast care, gynecologic care or maternity care. Women's breast and cervical cancer screening programs require time intensive tracking, scheduling and follow-up. These issues contribute to a significant need for care coordination for women Veterans that exceeds that of men Veterans and should be taken into account in staffing considerations.

Mental Health Care Including Reproductive Mental Health Care
The prevalence of mental health conditions in women Veterans is higher than that of men Veterans using VA. Mental health departments in VA must be staffed with providers who are trained and/or experienced in mental health care of women. This includes experience in treating victims of sexual trauma and applying evidenced based therapies to women with multiple medical/mental health and psychosocial co-morbidities. Additionally, knowledge and experience with mental health conditions that occur throughout the reproductive life cycle such pre-menstrual dysphoric disorder, post-partum depression, or mental health conditions during the menopausal transition is essential. Mental health providers must also have knowledge and skills for medication management in women of potentially childbearing age, understanding risks and benefits of using psychotropic medications in this setting.

For women Veterans, all sites must ensure equal access to engaged and knowledgeable mental health care providers and staff.

Sub-Specialty Medical and Surgical Care
Because women Veterans have been and are still a minority population in VA, some specialty providers have seen few women in their practices. This may result in a lack of knowledge (or up-to-date skills) in conditions that are unique to women, more common in women, or have gender specific manifestations. Examples of these types of conditions include fibromyalgia, migraine headaches or cardiovascular disease in women. Each site must ensure that they have specialty providers on site who are trained and proficient in the specialty care of women Veterans. Additionally, specialty care clinics must ensure that they have adequate support staff to provide chaperones for any physical exams or procedures that require exposure of breasts or genital areas. Providers must also be attuned to needs of women Veterans including sensitivity to needs of women with sexual trauma histories, and privacy and security of the health care environment.

Summary of Staffing Requirements
Women's Health Staffing Requirements:

- 1 FTEE Designated Women's Health Primary Care Providers for every 1,000 women Veterans.
- Patient Aligned Care Team support staff for each WH-PCP

    - RN
    - Health Technologist or LPN
    - Chaperone
    - Clerk
    - RN Care coordinator shared between Women's Health Patient Aligned Care teamlets (coordinates breast and cervical cancer screening, maternity care, fertility care and other outsourced care)
- It is suggested that Gynecology is provided on site at all large Medical Centers. For very small sites, or those who do not have surgical programs, Gynecology may be provided in the community, provided that the full range of Gynecology services are available in the community to include access to contraception and abortion services as indicated. If there is a gynecologist on site, then Gynecology support staff is required. Gynecology support staff includes:
    - RN
    - Health Technologist or LPN/chaperone
    - Clerk
    - Surgical Support Staff—ordering supplies, scheduling OR, etc.
- Women's Mental Health Providers
    - Primary Care Mental Health Integration for Women's Health
    - Mental Health Staff Proficient in Women's Mental Health including Reproductive Mental Health.
- Specialty Care
    - Additional specialists for conditions that are unique to women, more common in women, etc. High impact conditions—rheumatology, pain management, cardiology, neurology.
    - Chaperones for specialty clinics

Recommendations for Future Change
VHA is pursuing the following initiatives:

Designated Women's Health Providers Assessment of Workforce Capacity: To collect information about VA's Designated Women's Health Provider workforce, the Women Veteran Program Manager (WVPM) at each of 140 health care systems is asked annually to identify all local Designated Women's Health Providers within their health care systems, including Medical Center and associated CBOCs. In addition to identifying names of providers, additional information is collected to identify the "capacity" of the site to provide primary care to women Veterans. For each WH-PCP, WVPMs are asked to identify how many half-day sessions per week the WH-PCPs provided care to women and to identify the model of care (Gender Integrated Primary Care Clinic or Comprehensive Women's Clinic) in which the WH-PCPs practiced. VHA also assesses provider women's health training and experience by asking about attendance at Continuing Medical Education (including Women's Health Mini-Residency) or prior experience working in a practice that was at least 50% female.

WH-1 Indicator Hotspot Initiative: VHA WHS monitors the national WH-1 indicator score as well as those health care systems (HCS) with the lowest scores (hotspots) throughout each fiscal year. The WH-1 indicator measure is calculated by dividing the number of unique women Veteran patients who are assigned to a WH-PCP by the total number of unique women Veteran patients using the VA health care system. Each HCS identified as a hotspot is contacted by WHS staff and creates and implements an action plan to improve their score.

Women Veteran Access Hotspot Initiative: VHA WHS monitors primary care wait times for new and established women Veterans annually. The goal is to reduce the number of women Veterans waiting more than 30 days for a primary care appointment across all VHA hotspot sites identified at the end of the first quarter 50% by the end of the fourth quarter. VHA WHS contacts the leadership of each hotspot site to review women Veteran patient wait time data and to discuss potential solutions for improving access. Each site creates and implements an action plan over the remainder of the fiscal year to address identified issues negatively impacting wait times for women Veterans. At the end of FY 2018, the percent reduction from baseline of women waiting more than 30 days across all hotspot sites was 24%.

Women's Assessment Tool for Comprehensive Health: The Women's Assessment Tool for Comprehensive Health Initiative is an annual online self-assessment of Women's Health Programs (WHP) in VHA. The assessment identifies the current capabilities of each WHP and identifies local and national opportunities for improvement. Topics of interest include WHP workforce and strategic planning development, women's health care services, outreach, communication, collaboration, patient centered health care delivery, Patient Aligned Care Team implementation and women's health education and training. The assessment also reviews the models of care available for comprehensive primary care delivery in each VA Medical Center and CBOC.

Qualitative Assessment and Feedback: A qualitative analysis of women's health care staffing needs was completed. The areas of greatest concern for women's health were identified and analyzed. The analysis used on-site discussions, interviews and analysis to obtain perspectives regarding gaps and barriers. Sites selected represented the various VA Medical Center facility tiers and WH models of care. Findings from this analysis were that women's health providers reported needing longer appointment times, more staffing and more time spent in care coordination for women Veterans.

Summary of Women's Health

As noted above, there is no single staffing model for Women's Health. Ensuring VHA provides comprehensive care for women Veterans requires integration of evidence-based policy to guide national clinical operational practices. VHA is committed to ensuring all women Veterans receive the integrated, quality care to which they are entitled; and will work aggressively to meet this mandate.

Section 9: Analysis of Succession Planning

Veterans Access, Choice and Accountability Act Section 301

"A detailed analysis of succession planning at medical facilities of the Department, including the following: 1) The number of positions in medical facilities throughout the Department that are not filled by a permanent employee. 2) The length of time [such positions] remained vacant or filled by a temporary or acting employee.3) A plan for filling any positions that are vacant or filled by a temporary or acting employee for more than 180 days. 4) A description of any barriers to filling [such positions].

Section 9: Analysis of Succession Planning

Note: The VHA workforce can be expressed in terms of labor (Full-Time Equivalents) or people (employees). Sections 9, 11 and 12 of this report represent employees.

The overall percentage of VHA employees occupying a permanent clinical or support position while in temporary status is minimal: 3.1%. As of October 2022, VHA has 82 field leaders in an acting capacity, out of 738 field leadership positions. This section describes a number of steps VHA is taking to improve the timeliness of filling vacancies; including 1) additional recruiting activities; 2) increased compensation options; 3) field HR training; 4) retention, including leveraging the Choice Act-expanded EDRP and implementation of the SELRP; and 5) improvements to HR information systems. Furthermore, VHA is implementing P.L. 117-168, the PACT Act of 2022, of which Title IX increases VHA's flexibility and competitiveness in recruitment, retention and compensation.

Temporary Employees

For this analysis, VHA began by identifying all Medical Center staff officially employed in a temporary status, using a September 2022 data set. VHA sorted this group of employees into those whose temporary status is a direct function of their duties versus those who are serving in an operational role. In other words, VHA distinguished between medical professionals serving as students, researchers and Temporary or Term Appointments positions designed for a limited duration from those medical professionals charged with the delivery of care.

Note: Temporary and term appointments are used to fill positions when there is not a continuing need for the job to be filled.

The group "all others" refers to those temporary employees that do not fall in any of the other three categories of students, researchers and temporary/term appointments. The "all other" category of temporary employees may represent temporary placement into permanent positions. The overall results sorted by VISN are depicted in Table 9.1 below:

Table 9.1 Temporary Employees

Temporary Employees					
VISN	All Others	NTE Appt.	Research	Student	Temporary Employees
1	244	595	158	4	1,001
2	296	109	35	2	442
4	147	155	76	9	387
5	117	49	31	1	198
6	272	210	46	1	529
7	308	295	60	13	676
8	1,021	314	69	11	1,415
9	146	96	45	6	293

Temporary Employees					
VISN	All Others	NTE Appt.	Research	Student	Temporary Employees
10	382	297	146	22	847
12	421	195	58	11	685
15	140	76	3	1	220
16	299	309	51	1	660
17	192	107	22	-	321
19	239	266	97	5	607
20	121	395	69	-	585
21	537	310	95	17	959
22	535	263	161	3	962
23	235	172	55		462
Total	**5,652**	**4,213**	**1,277**	**107**	**11,249**

The facility breakout of temporary employees is depicted in Appendix J.

VHA then analyzed the data to determine the extent to which VHA hires temporary employees for staffing positions for which it would be expected that a permanent employee would be hired instead.

The following data represents all temporary VHA employees broken down by hiring authority and employee category.

Table 9.2 Employee Category

	Employee Category				
Hiring Authority	All Others	NTE Appt.	Research	Student	Total by Hiring Authority
Title 38 (T38)	2,382	-	100	-	2,482
Title 38 Hybrid (T38H)	2,317	61	210	-	2,588
Title 5 (T5)	953	4,152	967	107	6,179
Total by Employee Category	**5,652**	**4,213**	**1,277**	**107**	**11,249**

Student, research and not to exceed (i.e., term) appointments make up approximately 50% of temporary appointments in VHA, the majority (93%) of which are Title 5 positions.

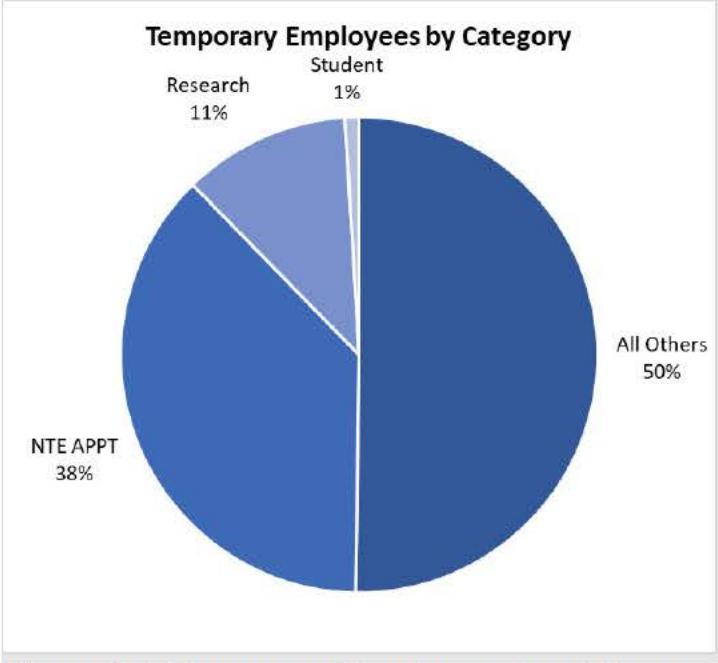

Figure 9.1 Temporary Employees by Category

The “all other” category represents 50.2% of temporary appointments, of which 83% are in T38 or T38H clinical positions, and for the most part represent temporary placements into positions that are intended for conversion to permanent.

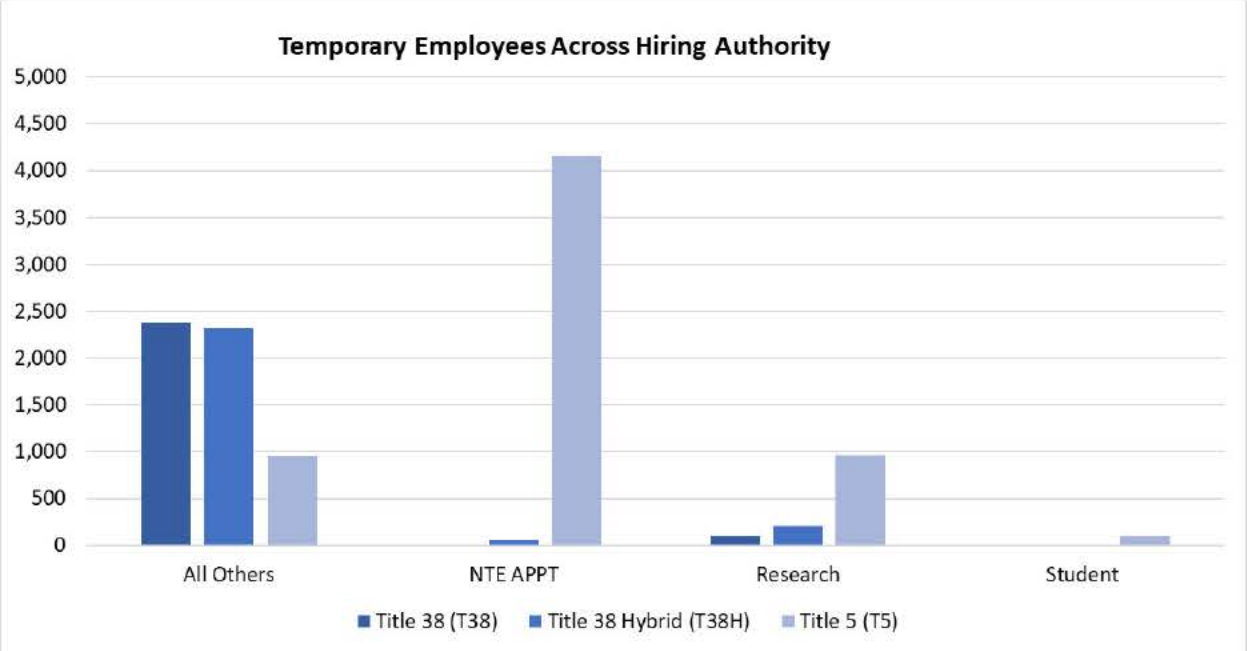

Figure 9.2 Temporary Employees Across Hiring Authority

It is important to keep in mind the size of the temporary workforce relative to health care employees in the VHA.

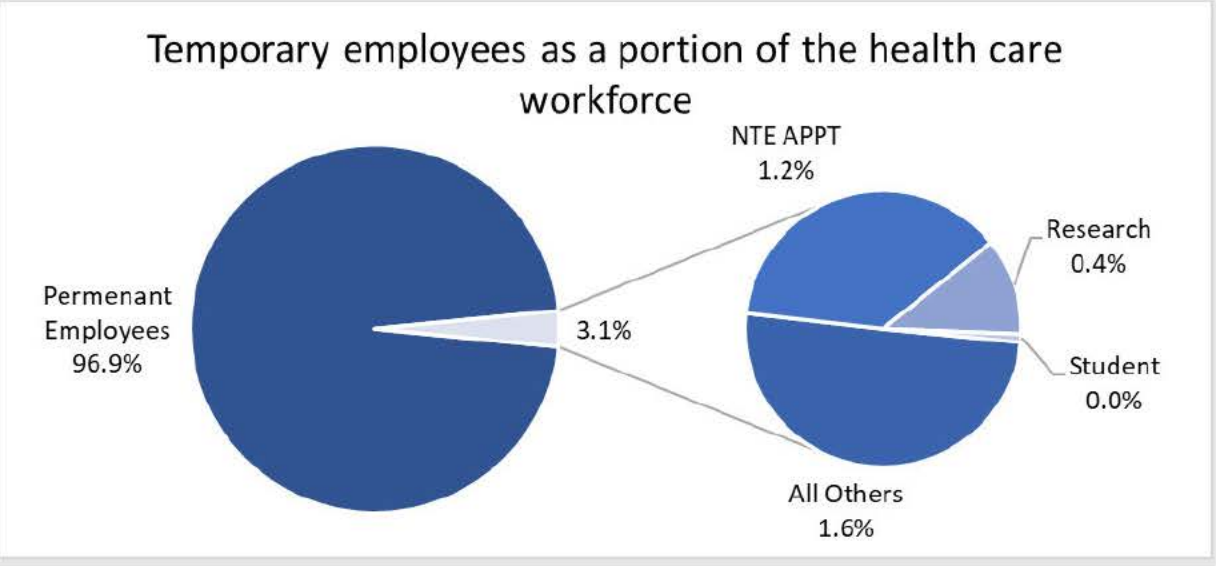

Figure 9.3 Temporary Employees as a Portion of Workforce

Temporary employees, as shown in Figure 9.3 above, constitute just 3.1% of the VHA workforce dedicated to providing health care. Furthermore, only 1.6% of employees in VHA are in temporary positions that are not student, research or not to exceed appointments, indicating that the maximum number of temporary employees occupying permanent positions is 1.6% of the health care workforce.

Acting Employees

To supplement this information on temporary employees and vacancies, we also identified all Medical Center and VISN leaders serving in an acting capacity. As of October 2022, VHA has 82 field leaders in an acting capacity, out of 738 field leadership positions. Leadership positions also include Deputy Directors, Chiefs of Staff and Chief Medical Officers.

Also, as of October 2022, there are 26 Medical Centers without a permanent Medical Center Director (MCD) in place. VHA continues to aggressively pursue recruitment for the 26 vacant MCD positions. Each of the 26 Medical Centers has a qualified, Acting MCD in place. The list of acting leaders is depicted in Appendix K.

Turnover

Turnover can contribute to the need for staff to serve in temporary acting roles. VHA's total turnover rate, however, has been consistent over the last 5 years, from 9.5% to 10.0% annually, except for FY 2020 of which 49% due to COVID-19. In addition, VHA has hired between 42,800 to 47,500 employees annually to fill clinical and administrative vacancies as a result of turnover and to grow the workforce to meet Veteran health care needs by 2% to 4% annually.

Length of Time for Temporary Employees, Acting Employees and Vacancies
The legislation specifies that this report must include the length of time for which each of the positions referenced in this section (i.e., not filled by a permanent employee) were filled, as well as for which each vacancy referenced in this section remained vacant. VHA has implemented a position management system to capture this data.

Barriers to Filling Positions and Reducing Temporary and Acting Employees
As noted previously, the percentage of VHA medical facility positions occupied by temporary staff is very modest: only 3.1% of the workforce. Barriers towards further reduction of temporary staff fall into two broad categories: recruitment to permanently fill vacancies and retention to reduce turnover within permanent positions. Recruitment requires enhancement of medical professionals and staff to join the VHA workforce; retention requires motivating medical staff to remain with the VHA and not depart for other agencies or the private sector.

Overcoming Barriers in Filling Positions and Reducing Temporary and Acting Employees
VHA has a robust plan to overcome the barriers in further reducing temporary or acting employees. VHA is aggressively pursuing the following actions:

<u>Recruiting</u>
VHA's National Recruitment Service (NRS) provides an in-house team of skilled professional recruiters employing private sector recruitment best practices to fill the agency's most critical clinical and executive positions. The NRS focuses its targeted recruitment efforts on mission critical clinical vacancies that directly impact and once filled will improve access to care. These priority specialties include primary care, mental health and critical medical subspecialties. National Recruitment Consultants collaborate directly with clinical, HR and executive leaders in VHA program offices, VISNs and Medical Centers in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs by increasing the size and quality of the talent pool while reducing time-to-hire. The NRS team successfully filled 313 critical vacancies nationwide through its efforts in FY 2022 and referred another 3,231 candidates to be considered, who are at various stages in the hiring process.

NRS specializes in providing reviews and process improvement plans for systemic recruitment issues, as well as field-level training for hiring managers and HR staff. NRS leadership provides site visits to do recruitment assessments for challenged sites and, at the close of their analysis, provide local leadership with strategies to address their site's individual issues. NRS is also coordinating a nationwide effort to hire Physician Provider Recruiters (PPR) at every VHA facility to expand the successful NRS model to the local level. New PPRs receive an NRS mentor to provide initial training and ongoing support as the PPR develops their local recruitment program. PPRs participate in regularly monthly training calls and are members of a national community of practice where they can reach out to get suggestions from their peers on how to fill their local needs.

VHA's NRS, in partnership with the Office of Academic Affiliations, coordinates a large-scale recruitment program targeting health professions trainees in VA facilities, through VA Trainee Recruitment Events (VA-TRE). The quarterly VA-TRE offer a standardized outreach strategy to recruit VHA health professions trainees nationwide for employment upon completion of training, with the ability to connect candidates at one facility with openings across the organization. Residents and fellows receive attractive marketing throughout their programs with information on careers at VHA, as well as the opportunity to schedule a meet-and-greet with their facilities of choice who have vacancies in their profession. In FY 2022, 452 VA-TRE candidates accepted positions through the program (a 187.9% increase over FY 2021), and 48.4% of all VA-TRE program candidates end up successfully recruited to VHA. Every VHA facility has recruited through at least one VA-TRE event, with 74.55% of VHA sites participating in FY 2022. As of October 2022, VA-TRE has resulted in 1,154 VA trainees hired all-time by connecting these local trainees to agency-wide positions.

The demonstrated success of the NRS is also supported by a dynamic and award-winning recruitment and marketing outreach strategy, which allows the team the flexibility to simultaneously address urgent health care provider needs, develop a pipeline of quality candidates to leverage against future vacancies and incorporate additional activities that enhance successful recruitment outcomes and improve access to care for Veterans.

Compensation Planning

Section 3 of P.L. 108-445, the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004 established a new pay system for VHA physicians and dentists, consisting of base pay, market pay and performance pay (38 U.S.C. § 7431(e)(1)(A)). The law further requires that at least once every 2 years, the Secretary shall prescribe for Department-wide applicability the minimum and maximum amounts of annual pay that may be paid to physicians and dentists. VA policy established the creation of a VHA Physician and Dentist Steering Committee. The purpose of the VHA Physician and Dentist Steering Committee is to develop recommendations for the annual pay ranges for each physician and dentist specialty or assignment. Pay ranges are also required to be published in the Federal Register.

Facility-specific Human Resource Assistance

The Consult, Assist, Review, Develop and Sustain (CARDS) team continues to provide HR consultation and guidance to the VHA HR community to promote consistency and a culture of continuous improvement. The HR Consultants emphasize proper application of HR policies in their assessments of various HR programs. The intent is to promote sharing and utilization of HR strong practices in all VHA facilities while developing and retaining a workforce of highly skilled HR professionals. The team conducts consultation reviews of consolidated HR Services and works collaboratively with HR Leadership and HR Quality Assurance teams to address issues and trends identified. The CARDS team assists VISN HR offices with nationally identified problems where needed.

Retention

VHA has emphasized the flexibility and availability of utilizing incentives to be more competitive with the private sector, when it is determined the position is likely to be difficult to fill in the absence of an incentive. A retention incentive may be paid to a current VHA employee if the following is determined:

- The employee is likely to leave the Federal employment in the absence of a retention incentive; or
- Retention is essential because of unusually high or unique qualifications; or
- There is a special need for the employee's services; or
- It is essential to retain the employee in the Department.

Note: A retention incentive may also be authorized for a group or category of employees under these conditions.

The following several additional initiatives exist to enhance the educational preparation of VA employees, including many scholarship programs such as the Employee Incentive Scholarship Program (EISP), the National Nursing Education Initiative (NNEI), the VA National Education for Employees Program (VANEEP), Health Professionals Scholarship Program (HPSP) and the Visual Impairment Orientation and Mobility Professionals Scholarship Program (VIOMPSP):

- EISP authorizes VA to award scholarships to employees pursuing academic degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. EISP awards cover tuition and related expenses such as registration, fees and books. Participants incur a 1- to 3-year service obligation following completion of their program. The maximum amount of a scholarship that may be awarded to an employee enrolled in a full-time curriculum is $42,486.61 for the equivalent of 3 years of full-time coursework.
- NNEI and VANEEP are policy-derived programs that stem from the legislative authority of EISP. NNEI is limited to funding RNs pursuing associate, baccalaureate and advanced nursing degrees. VANEEP provides replacement salary dollars to VA facilities for scholarship participants to accelerate their degree completion by attending school full time.
- HPSP awards scholarships to VA and non-VA employees pursuing degrees or training in healthcare disciplines for which recruitment and retention of qualified personnel are difficult. HPSP authorizes VA to award a monthly stipend, tuition, allowable fees and other reasonable educational expenses. Awards are offered on a competitive basis and are exempt from Federal taxation. In exchange for awards, scholarship program participants agree to complete a service obligation at a VA healthcare facility.
- VIOMPSP awards scholarships to students seeking a degree or certificate in visual impairment or orientation and mobility. Awards are offered on a competitive basis, provide for the payment of tuition and required fees and are exempt from Federal taxation. In exchange for the award, scholarship program participants agree to a 3-year service obligation at a VA health care facility.

An additional recruitment and retention incentive related to paying off student loan debt for employees in critical, hard-to-recruit and retain positions is the EDRP. EDRP is specific to VHA and authorizes VHA to reimburse educational loan debt for hard to recruit and retain health care professionals in Title 38 or Title 38 Hybrid positions in VHA. VHA uses EDRP as a recruitment and retention incentive to assist health care employees in paying down their qualifying education loans. This program targets individuals for hard to fill positions who would likely decline an opportunity to work for VHA, or who would otherwise leave VHA employment without this incentive. As enhanced by the Choice Act, the EDRP incentive is designed to assist individuals in reducing their qualifying loan balances and to aid in retaining employees by reimbursing loan payments over a five-year service period. The Choice Act increased the maximum award amount from $60,000 to $120,000, and the 2018 MISSION Act further strengthened the EDRP recruiting arm when it increased the maximum amount to $200,000. Local facilities have the flexibility to prioritize hard to recruit occupations based on facility needs. EDRP requires no service obligation as employees can only receive reimbursements while they remain employed by VHA in the hard to fill position for which they were awarded EDRP, for up to 5 years, thereby acting as a significant retention incentive.

Demand for EDRP as a recruitment and retention tool is high (and increasing) across the VHA HealthCare system. Full funding of EDRP is essential to ensure this valuable resource can be used to the maximum extent possible to hire and keep critical staff. VHA is also reviewing all other incentive programs for recruitment, relocation and retention allowances to ensure we are making the best possible use of these tools. The reviews are ongoing and will include procedural and policy updates for medical facilities. VHA will also initiate training programs for executive leadership, selecting officials and others involved in the hiring process.

Summary
Timely recruiting and hiring of medical professionals, and retaining qualified personnel once on-board, is essential to ensuring appropriate levels of staffing are maintained for each medical facility. The pursuit of our existing and new initiatives, as noted above, is critical for success, and for ensuring timely access to care. VHA leadership and staff at all levels are committed to using all available tools to improve our staffing management.

Section 10: Plan for Handling Emergency Circumstances

Veterans Access, Choice and Accountability Act Section 301

"A detailed analysis of succession planning at medical facilities of the Department, including the following: A plan for handling emergency circumstances, such as administrative leave or sudden medical leave for senior officials."

Section 10: Plan for Handling Emergency Circumstances
VHA Directive 320 requires all VHA medical facilities to have a comprehensive emergency plan in place, to include continuity of operations and commensurate leadership communication chain. A copy of Directive 320 is included in this report.

Emergency operations planning is essential for all VHA medical facilities, particularly those with an in-patient, 24/7 operational mission. VHA requires all facilities to develop, maintain and exercise an Emergency Operations Plan that includes a Continuity of Operations. VHA Directive 0320 provides policy and responsibilities for VHA's Comprehensive Emergency Management Program (CEMP) ensuring health security of Veterans from the impacts of emergencies and disasters. VHA Directive 0320.01 establishes CEMP implementation procedures. VHA Directive 0320.02 establishes policy and responsibilities for ensuring continuity of essential health care functions and services during emergencies. VHA Directive 0320 can be found in Appendix L, VHA Directive 0320.01 can be found in Appendix M and VHA Directive 0320.02 can be found in Appendix N.

Section 11: Health Care Provider Losses

Veterans Access, Choice and Accountability Act Section 301

"The number of health care providers of the Department who have been removed from their positions, have retired, or have left their positions for another reason, disaggregated by provider type, during the 2-year period preceding the submittal of the report."

Section 11: Health Care Provider Losses

Provider loss data were analyzed in two parts. First, losses were considered broadly based on loss category. Second, losses were analyzed according to clinical practice area, with an in-depth perspective on those clinical practice areas that experienced the greatest number of losses and the highest loss rates. The provider loss data represents FY 2021 and FY 2022. Average onboard data, an average headcount of a clinical practice area for a fiscal year, was used to calculate loss rates for each clinical practice area. It should be noted that for this section of the report, the terms "occupation" and "clinical practice area" are used synonymously.

Part I – Losses by Category

The Data Set and Analysis

VHA identified all medical professionals and support staff who departed service with the Administration between October 1, 2020, and September 30, 2022. The legislation specifically asks for the number of losses over two years to be broken into three categories: removals, retirements and "other" losses as shown in Table 11.1 below.

Table 11.1 Medical Professionals and Support Staff Departing Service

Loss Category	FY 2021	FY 2022	Two-Year Period
Removals	1,179	877	2,056
Retirements	6,580	6,676	13,256
Left for Other Reason	12,767	13,316	26,083
Total Health Care Provider Losses	20,526	20,869	41,395

Given that the category of "Left for Other Reason" constitutes more than half of all losses, this report accounts for a fourth category, "Quits," in order to provide a better context for understanding losses in the VHA. This more-detailed breakdown is shown below:

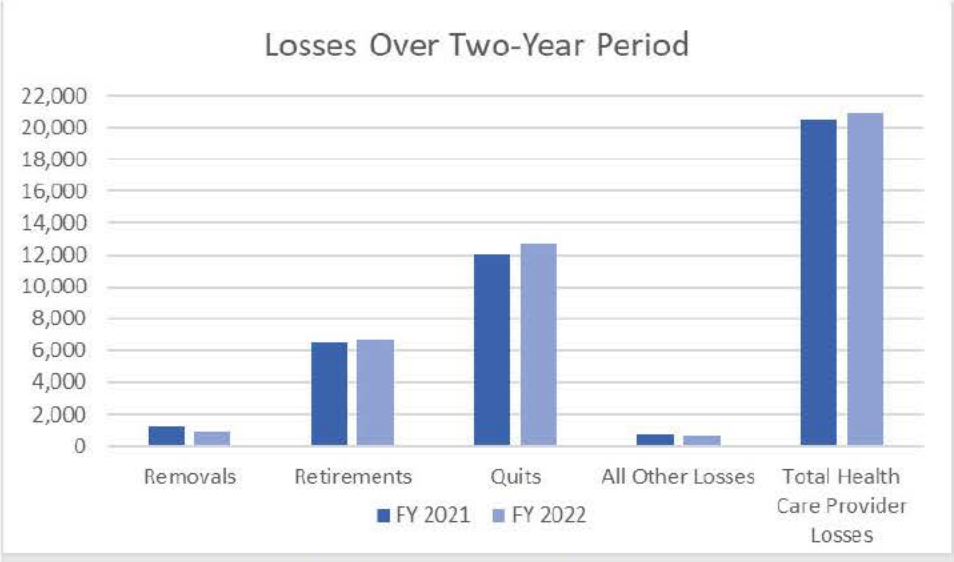

Figure 11.1 Losses Over 2-Year Period

Conclusion
Most losses experienced are voluntary, with just over half of all losses falling in the category of "Quits."

A breakdown of each of these loss categories by clinical practice area is available at Appendix O.

Part II – Losses by Clinical Practice Area
The Data Set and Analysis
The legislation further states that losses should be disaggregated by provider type. This report takes an extract of that data to highlight the occupations that experience the highest losses.

Losses were first analyzed to determine where the highest number of losses were occurring. Table 11.2 below depicts the results:

Table 11.2 Top 10 Losses by Provider Type

Top 10 Losses by Provider Type per Number of Losses	Total Two-Year Losses
0610 Nurse	14,037
0602 Medical Officer	4,379
0620 Practical Nurse	2,876
0621 Nursing Assistant	2,690
0185 Social Work	1,931
0640 Health Aid and Technician	1,557
0601 General Health Science	1,220
0180 Psychology	792
0644 Medical Technologist	790
0660 Pharmacist	697

However, this information does not consider the relative workforce sizes of each occupation. To accurately represent the data set, loss rates were calculated because the data set without them merely highlights the occupations with the largest workforce size. Yet, once rates were calculated, the data set mostly represented those occupations with the smallest head count since each loss experienced in each of those occupations constituted a far greater impact on its respective rate than did those losses for occupations with significantly higher head counts. Thus, for the loss rate analysis, this report excluded the occupations that constituted the smallest 10% of all clinical practice areas with respect to headcount, resulting in removing from the analysis those clinical practice areas with less than 125 employees.

By utilizing loss rates and removing outliers, Table 11.3 below displays FY 2021 occupations with the highest loss rates.

Table 11.3 FY 2021 Occupations with Highest Loss Rates

FY 2021 Occupations with Highest Loss Rates			
Occupation	**Total Losses FY 2021**	**Average Onboard FY 2021**	**Loss Rate FY 2021**
0181 Psychology Aid and Technician	86	473.3	18.2%
0189 Recreation Aid and Assistant	26	159.3	16.3%
0645 Medical Technician	282	1,748.80	16.1%
0640 Health Aid and Technician	1,415	9,010.10	15.7%
0646 Pathology Technician	36	275.1	13.1%
0186 Social Services Aid and Assistant	48	369.8	13%
0621 Nursing Assistant	1,830	14,344.00	12.8%
0620 Practical Nurse	1,728	15,661.80	11%
0644 Medical Technologist	485	4,631.40	10.5%
0102 Social Science Aid and Technician	131	1,290.80	10.2%

As can be seen, the list of clinical practice areas in this list differs greatly from the list that only considered losses without respect to the relative size of each group. This data set, when compared with the average loss rate of all occupations considered in this report, which was 10.0% in FY 2021, yields that 0102 social science aid and technician, the 10th occupation on the list, is at 10.2% which is more than the VHA loss rate while 0181 Psychology Aid and Technician, the 1st occupation on the list, is at 18.2%. Figure 11.3 depicts this perspective:

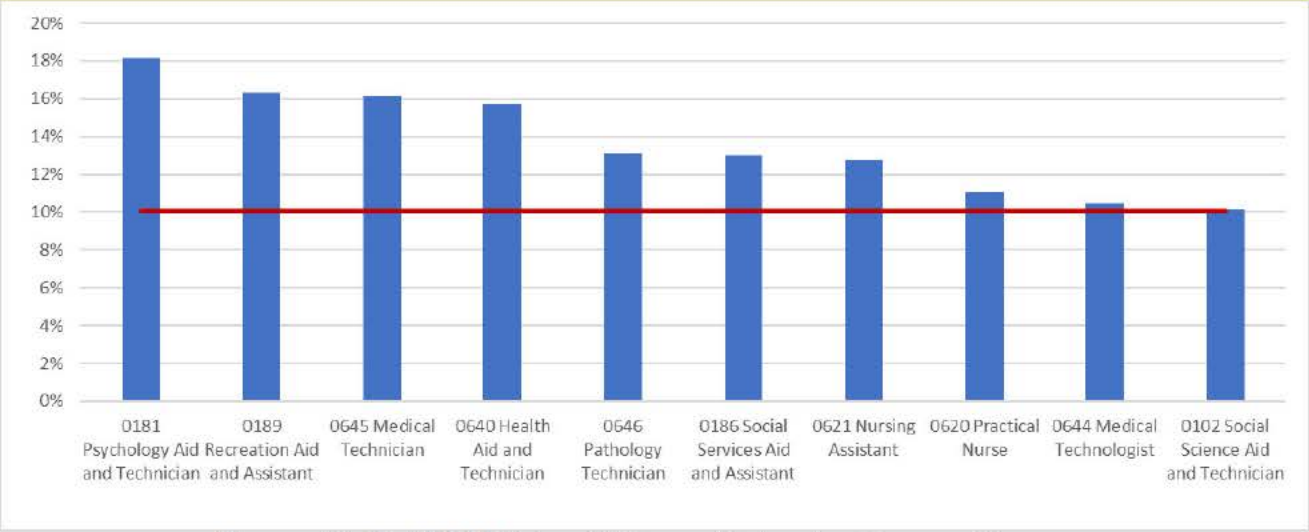

Figure 11.3 FY 2021 Top 10 Loss Rates by Occupation

The same rate analysis was conducted for FY 2022 as shown in Table 11.4 below.

Table 11.4 FY 2022 Occupations with Highest Loss Rates

Occupation	Total Losses FY 2022	Average Onboard FY 2022	Loss Rate FY 2022
0181 Psychology Aid and Technician	92	434.2	21.2%
0645 Medical Technician	263	1,645.30	16%
0189 Recreation Aid and Assistant	24	157.9	15.2%
0646 Pathology Technician	39	275.8	14.1%
0640 Health Aid and Technician	1,234	8,911.50	13.9%
0621 Nursing Assistant	1,717	13,824.80	12.4%
0186 Social Services Aid and Assistant	49	428.9	11.4%
0644 Medical Technologist	512	4,512.30	11.4%
0102 Social Science Aid and Technician	140	1,279.10	11%
0620 Practical Nurse	1,663	15,200.90	10.9%

The FY 2022 Top 10 Loss Rates by Occupation for FY 2022 as shown in Figure 11.4.

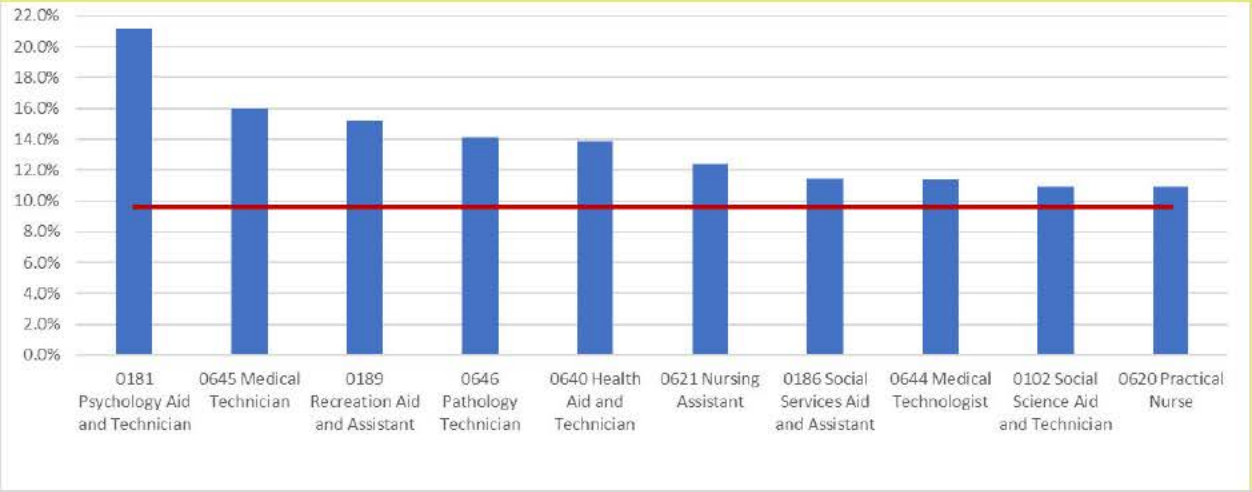

Figure 11.4 FY 2022 Top 10 Loss Rates by Occupation

The VHA loss rate in FY 2022 was 9.6%. As noted for FY 2022, the 10th occupation on the list, 0620 practical nurse, is at 10.9% which is higher than the VHA loss rate while 0181 Psychology Aid and Technician.

Conclusion

Pure losses by head count show that there are certain occupations, such as that of 0610 Nurse, that represent some of the highest losses by head count. However, these high losses are consistent with the headcount of that occupation relative to the headcount of other occupations and their respective losses.

Loss rates provide a different perspective. When both fiscal years are considered, there are seven clinical practice areas that fall within the Top 10 Loss Rates by Occupation in both years.

There are four occupations that experienced both high losses by head count and high loss rates. Each fell within the Top 10 Loss Rates by Occupation for at least 1 year and were within the Top 10 Losses by Provider Type per Number of Losses over the 2-year period considered. They are the following:

- 0620 Practical Nurse;
- 0621 Nursing Assistant;
- 0640 Health Aid and Technician; and
- 0644 Medical Technologist.

A breakdown by clinical practice area of loss rates is available at Appendix P.

Section 12: Health Care Provider Removals

Veterans Access, Choice and Accountability Act Section 301

"Of the health care providers who have been removed from their positions, the following: 1) The number of such health care providers who were reassigned to other positions in the Department. 2) The number of such health care providers who left the Department. 3)The number of such health care providers who left the Department and were subsequently rehired by the Department."

Section 12: Health Care Provider Removals

The legislation also requires that this report consider that of those health care providers who have been removed from their positions, how many:

1. Were reassigned to other positions in the Department;
2. Left the Department; and
3. Left the Department and were subsequently rehired by the Department.

To do so, this section of the report delves deeper into some of the information provided in Section 11, namely those employees who were removed from their positions. As previously noted, the number of employees removed in the past 2 years is broken down in Table 12.1.

Table 12.1 Employees Removed in FY 2019-2020

Loss Category	FY 2020	FY 2022	Two-Year Period
Removals	1,179	877	2,056

The first part of this section breaks these 2,056 employees into two groups: those who immediately left the Department upon removal and those who remained with the Department. The second part of the analysis focuses on those employees that left and who subsequently returned to the Department.

Part I – Reassignment vs. Leaving Department

An understanding of the term "removal" from a position as it relates to a person's status as an employee of the VA is crucial to dividing the total number of removed employees into two groups: those who, upon removal, stayed with the Department; and those who left. When an employee is removed from his or her position, he or she is simultaneously removed from the Department as well. No employee classified under the category of "removal" could occupy another position without first reentering employment with the Department. It should be noted that all such cases would not fall under the category of remaining with the Department and being reassigned to another position, but rather would fall under the third category of those who were "subsequently rehired by the Department". The first two categories thus can be summed up in Table 12.2 below:

Table 12.2 Employees Removed That Stayed or Left Department

Loss Category	FY 2021	FY 2022	Two-Year Period
Removed from Position, Left Department and Subsequently Re-Hired into Another Position in Department	3 8	1 2	50
Removed from Position and Permanently Left Department	1,141	865	2,006
Total Removals	**1,179**	**877**	**2,056**

Conclusion

Most removals fall under the category of “Removed from Position and Left Department”, amounting to 2,006 in the 2-year period reviewed, with 50 falling under the category of “Removed from Position and Reassigned to Other Position in Department.” The latter number represents those that were rehired.

Part II – Subsequent Rehires

The Department searched for each of the 2,056 removed persons amongst current health care providers employed by VHA. The results indicate that 50 of these individuals were subsequently rehired. Most of these actions were primarily technical in nature: providers whose licenses had expired, were removed from employment, were rehired and resumed providing care for Veterans after their licenses were renewed. Other scenarios included employees terminated during their probationary period for performance issues such as attendance. Probationary periods and provider license tracking are among the tools employed by the Department to ensure a rigorously evaluated and credentialed workforce. None of the rehires were (or are) in executive or other leadership positions. The Department conducts a full review of all employees’ records to confirm that there are no HR, malfeasance or performance issues outstanding.

Path Forward

Veterans Access, Choice and Accountability Act
Section 301

Path Forward
When VA presented the first edition of this report to Congress in March 2015, VHA noted that effective and efficient staffing modeling was a key element to ensure timely access to care for Veterans.

Effective clinical staffing for VHA medical facilities is a critical element of meeting the Department's goal to ensure timely health care for Veterans. Improving VHA's ability to forecast, recruit and retain medical professionals and support staff is a strategic priority. The ideal clinical staffing system will have the following characteristics:

Flexible: Local Medical Centers empowered and equipped to address staffing needs as they arise, reflecting the population of Veterans they serve; and to anticipate and meet future needs in advance of HR shortages.

Accurate: Application of staffing models and methods specific to each clinical practice, with ever-increasing effectiveness both in reflecting the current staffing state, and in projecting requirements for the future.

Data Driven: Continuous refinement of clinical staffing data collection, databases and analytical methods, where conditions in the field inform HR decision-making at all levels.

Scalable: The ability of VHA to analyze, project and address clinical staffing requirements at the enterprise level, based upon consistent and reliable facility-level data and analyses.

More effectively achieving a health care staffing system with the above characteristics will require VHA to unify three critical elements:

Workforce and Succession Planning: The detailed, facility-specific analysis of the composition of the local workforce, and the strategy by which the facility will meet the requirements of the future workforce.

Clinical Modeling: As discussed earlier in this report, there is no one-size-fits-all approach to forecasting the requirements for medical professionals and support staff across all practice areas. However, VHA can evolve each practice area's methods and tools to the point where the clinics each generate a data set that consistently informs human resource, capital asset and overall financial planning.

Budget: The more conditions in the field (both current and anticipated) are represented in the formulation of VHA's national budget, the greater the utility of the budget in projecting future capabilities required to serve the nation's Veterans.

The team was further charged with providing a methodology for predicting the surgical complexity level and specialty care staffing levels based on Veteran enrollees including a make/buy analysis for specialty care services addressing the issues of reliance on care in the community.

The goal of this work goes beyond Specialty Care. To achieve the seamlessness of local clinical/business staffing decisions, VHA needs to empower medical facilities with a comprehensive tool connecting projections of Veterans' demand and reliance upon VHA with clinical capacity and productivity, and ultimately costs, both in-house and externally referred.

It is that latter element that is critical: effective partnership between VHA and community care is essential to ensure maximum opportunities for Veterans' access and a positive health care outcome. Understanding the full costs of providing Veterans' treatment in-house contrasted with corresponding costs for community care will be an invaluable aid in efficiently allocating both current and future resources on behalf of Veterans.
As noted in the previous edition of this report, VHA will continue to work aggressively with Veterans, the Department, the Administration and with Congress to evolve clinical human resource staffing management, with a strong focus on improving and sustaining the Secretary's goals for access to care.

Department of Veterans Affairs
March 2023

Appendix A: Acronym List

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACP	American College of Physicians
AOA	American Osteopathic Association
AP	Associate Provider
APRN	Advanced Practice Registered Nurse
BHIP	Behavioral Health Interdisciplinary Program
C&P	Credentialing and Privileging
CAI	Capital Asset Inventory
CAN	Care Assessment Needs
CARDS	Consult, Assist, Review, Develop and Sustain
CBOC	Community-Based Outpatient Clinics
CEMP	Comprehensive Emergency Management Program
CMS	Centers for Medicare and Medicaid Services
DOD	Department of Defense
DWHP	Designated Women's Health Primary Care Providers
ECG	Echocardiograms
EDRP	Education Debt Reduction Program
EGD	Gastrointestinal Endoscopy
EISP	Employee Incentive Scholarship Program
ERCP	Endoscopic Retrograde Cholangiopancreatography
EUS	Endoscopic Ultrasound
EWL	Electronic Wait List
FTE	Full-Time-Equivalents
FY	Fiscal Year
GI	Gastroenterology
GMH	General Mental Health
HBPC	Home-Based Primary Care
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPEAP	Health Professionals Education Assistance Program
HR	Human Resources
HT	Health Technician
IG	Inspector General
LASI	Leading Access and Scheduling Initiative
LIPSs	Licensed Independent Providers
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MA	Medical Assistant
MC	Medical Clerk
MCG	Medical Care Group
MD	Doctor of Medicine
MGMA	Medical Group Management Association
MH	Mental Health
MHICM	Mental Health Intensive Case Management

NNEI	National Nursing Education Initiative
NP	Nurse Practitioner
NRP	National Recruitment Program
NSWS	National Survey of Women Veterans
NTE	Not to Exceed
OEF	Operation Enduring Freedom
OEM	Office of Emergency Management
OIF	Operation Iraqi Freedom
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency and Staffing
OR	Operating Room
PA	Physician Assistant
PACT Act	Promise to Address Comprehensive Toxics (PACT) Act
PAID	Personnel Accounting Integrated Data
PC	Primary Care
PCC	Patient Centered Care
PCMHI	Primary Care Mental Health Integration
PCMM	Patient Centered Management Module
PCP	Primary Care Provider
PMT	Position Management Tool
PPBE	Planning, Programming, Budget and Execution
PPR	Physician Provider Recruiter
PSB	Professional Standards Board
PTSD	Posttraumatic Stress Disorder
RN	Registered Nurse
RNCM	Registered Nurse Care Manager
RVU	Relative Value Units
SCI	Spinal Cord Injury
SCIP	Strategic Capital Investment Planning
SELRP	Specialty Education Loan Repayment Program
SLRP	Student Loan Repayment Program
SMH	Specialty Mental Health
SPARQ	Specialty Productivity Access Report Quadrant
SSR	Specialty Salary Rates
SUD	Substance Use Disorder
USUHS	Uniformed Services University of Health Sciences
VA	Department of Veterans Affairs
VALOR	VA Learning Opportunity Residency
VAMC	Department of Veterans Affairs Medical Center
VANEEP	VA National Education for Employees Program
VHA	Veterans Health Administration
VISN	Veterans Service Integrated Network
VSO	Veterans Service Organizations
WH	Women’s Health
WHP	Women’s Health Programs
WHS	Women’s Health Service

WSP	Workforce Success Planning
WVPM	Women Veteran Program Manager

Appendix B: Legislative Requirements

The table below maps this report's sections to the legislative requirements, for which this report was written.

Choice Act Section	Legislative Language	Related Report Section	Related Appendix Sections
301(d)	REPORTS	All	
301(d)(1)	IN GENERAL. —Not later than 180 days after the date of the enactment of this Act, and not later than December 31 of each even-numbered year thereafter until 2024, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report assessing the staffing of each medical facility of the Department.	All	
301(d)(2)	Each report submitted under paragraph (1) shall include the following:	All	
301(d)(2)(A)	The results of a system-wide assessment of all medical facilities of the Department to ensure the following:	Sec 1-4	
301(d)(2)(A)(i)	Appropriate staffing levels for health care professionals to meet the goals of the Secretary for timely access to care for Veterans.	1	C, D, E
301(d)(2)(A)(ii)	Appropriate staffing levels for support personnel, including clerks.	1	C, D, E
301(d)(2)(A)(iii)	Appropriate sizes for clinical panels.	2	F
301(d)(2)(A)(iv)	Appropriate numbers of full-time staff, or full-time equivalents, dedicated to direct care of patients.	3	C, D, E
301(d)(2)(A)(v)	Appropriate physical plant space to meet the capacity needs of the Department in that area.	4	G
301(d)(2)(A)(vi)	Such other factors as the Secretary considers necessary.	Sec 1-4	
301(d)(2)(B)	A plan for addressing any issues identified in the assessment described in subparagraph (A), including a timeline for addressing such issues.	5	
301(d)(2)(C)	A list of the current wait times and workload levels for the following clinics in each medical facility:	6	H, I
301(d)(2)(C)(i)	Mental Health	6	H, I
301(d)(2)(C)(ii)	Primary Care	6	H, I
301(d)(2)(C)(iii)	Gastroenterology	6	H, I
301(d)(2)(C)(iv)	Women's Health	6	H, I
301(d)(2)(C)(v)	Such other clinics as the Secretary considers appropriate.	6	

Choice Act Section	Legislative Language	Related Report Section	Related Appendix Sections
301(d)(2)(D)	A description of the results of the most current determination of the Inspector General under subsection (a) of section 7412 of title 38, United States Code, as added by subsection (a)(1) of this section, and a plan to use direct appointment authority under subsection (b) of such section 7412 to fill staffing shortages, including recommendations for improving the speed at which the credentialing and privileging process can be conducted.	7	
301(d)(2)(E)	The current staffing models of the Department for the following clinics, including recommendations for changes to such models:	8	
301(d)(2)(E)(i)	Mental health.	8	
301(d)(2)(E)(ii)	Primary care.	8	
301(d)(2)(E)(iii)	Gastroenterology.	8	
301(d)(2)(E)(iv)	Women's Health.	8	
301(d)(2)(E)(v)	Such other clinics as the Secretary considers appropriate.	8	
301(d)(2)(F)	A detailed analysis of succession planning at medical facilities of the Department, including the following:	9	
301(d)(2)(F)(i)	The number of positions in medical facilities throughout the Department that are not filled by a permanent employee.	9	J, L
301(d)(2)(F)(ii)	The length of time each position described in clause (i) remained vacant or filled by a temporary or acting employee.	9	
301(d)(2)(F)(iii)	A description of any barriers to filling the positions described in clause (i).	9	
301(d)(2)(F)(iv)	A plan for filling any positions that are vacant or filled by a temporary or acting employee for more than 180 days.	9	K
301(d)(2)(F)(v)	A plan for handling emergency circumstances, such as administrative leave or sudden medical leave for senior officials.	10	M, N
301(d)(2)(G)	The number of health care providers of the Department who have been removed from their positions, have retired, or have left their positions for another reason, disaggregated by provider type, during the 2-year period preceding the submittal of the report.	11	O, P

Choice Act Section	Legislative Language	Related Report Section	Related Appendix Sections
301(d)(2)(H)	Of the health care providers specified in subparagraph (G) who have been removed from their positions, the following:	12	
301(d)(2)(H)(i)	The number of such health care providers who were reassigned to other positions in the Department.	12	
301(d)(2)(H)(ii)	The number of such health care providers who left the Department.	12	
301(d)(2)(H)(iii)	The number of such health care providers who left the Department and were subsequently rehired by the Department.	12	

Appendix C: Occupation Listings

Clinical Occupations			
0060 Chaplain*	0602* Medical Officer	0638* Recreation/Creative Arts Therapist	0665* Speech Pathology and Audiology
0101 Social Science*	0603* Physician's Assistant	0639 Educational Therapist	0667* Orthotist and Prosthetist
0102 Social Science Aid and Technician*	0604 Chiropractor	0640* Health Aid and Technician	0668* Podiatrist
0180 Psychology*	0605* Nurse Anesthetist	0642 Nuclear Medicine Technician	0680* Dental Officer
0181 Psychology Aid and Technician*	0610* Nurse	0644* Medical Technologist	0681* Dental Assistant
0184 Sociology	0620* Practical Nurse	0645* Medical Technician	0682 Dental Hygiene
0185 Social Work*	0621* Nursing Assistant	0646 Pathology Technician	0683 Dental Laboratory Aid and Technician
0186 Social Services Aid and Assistant	0625 Autopsy Assistant	0647* Diagnostic Radiologic Technologist	0699 Medical and Health Student Trainee
0187 Social Services	0630* Dietitian and Nutritionist	0648 Therapeutic Radiologic Technologist	1301 General Physical Science
0188 Recreation Specialist	0631* Occupational Therapist	0649* Medical Instrument Technician	1306 Health Physics
0189 Recreation Aid and Assistant	0633* Physical Therapist	0651 Respiratory Therapist	1310 Physics
0199 Social Science Student Trainee	0635 Corrective Therapist	0660* Pharmacist	1311 Physical Science Technician
0440 Genetics	0636* Rehabilitation Therapy Assistant	0661* Pharmacy Technician	1320 Chemistry
0601 General Health Science*	0637 Manual Arts Therapy	0662* Optometrist	1715* Vocational Rehabilitation

Non-Clinical Occupations			
0018 Safety and Occupational Health Management	0540* Voucher Examining	1160 Financial Analysis	3502 Laboring
0019 Safety Technician	0544* Civilian Pay	1165 Loan Specialist	3511 Laboratory Working
0028 Environmental Protection Specialist	0560* Budget Analysis	1170 Realty	3566* Custodial Worker
0030 Sports Specialist	0561 Budget Clerical and Assistance	1171 Appraising	3601 Miscellaneous Structural and Finishing Work
0080 Security Administration	0593 Insurance Accounts	1173 Housing Management	3603 Masonry
0081 Fire Protection and Prevention	0599 Financial Management Student Trainee	1176 Building Management	3604 Tile Setting
0083* Police	0622* Medical Supply Aide and Technician	1199 Business and Industry Student Trainee	3605 Plastering
0085 Security Guard	0669 Medical Records Administration	1371 Cartographic Technician	3610 Insulating
0086* Security Clerical and Assistance	0670 Health System Administration	1410 Librarian	3703 Welding
0089 Emergency Management	0671* Health System Specialist	1411 Library Technician	3806 Sheet Metal Mechanic
0090 Guide	0672* Prosthetic Representative	1412 Technical Information Services	4010 Prescription Eyeglass Making
0099 General Student Trainee	0673 Hospital Housekeeping Management	1421 Archives Technician	4101 Painting and Paper Hanging
0110 Economist	0675* Medical Records Technician	1499 Library and Archives Student Trainee	4102 Painting
0150 Geographer	0679* Medical Support Assistance	1510 Actuary	4104 Sign Painting
0170 History	0690 Industrial Hygiene	1515 Operations Research	4204 Pipefitting

Non-Clinical Occupations			
0193 Archeology	0698 Environmental Health Technician	1520 Mathematics	4206 Plumbing
0201* Human Resources Management	0701 Veterinary Medical Science	1529 Mathematical Statistician	4352 Plastic Fabricating
0203* Human Resources Assistance	0704 Animal Health Technician	1530 Statistician	4417 Offset Press Operating
0260 Equal Employment Opportunity	0801* General Engineering	1531 Statistical Assistant	4605 Wood Crafting
0299 Human Resources Management Student Trainee	0802 Engineering Technician	1550 Computer Science	4607 Carpenter
0301* Miscellaneous Administration and Program	0803 Safety Engineering	1599 Mathematics and Statistics Student Trainee	4701 Miscellaneous General Maintenance and Operations Work
0302 Messenger	0804 Fire Protection Engineering	1601* General Facilities and Equipment (Title 5)	4703 Construction and Maintenance Supervisor
0303* Miscellaneous Clerk and Assistant	0807 Landscape Architecture	1603 Equipment, Facilities and Service Assistance	4737 General Equipment Mechanic
0304 Information Receptionist	0808 Architecture	1630 Cemetery Administration Services	4742 Utility Systems Repairer-Operator
0305* Mail and File	0809 Construction Control	1640 Facility Management	4749* Maintenance Mechanic
0306 Government Information Specialist	0810 Civil Engineering	1654 Printing Management	4754 Cemetery Caretaking
0308 Records and Information Management	0819 Environmental Engineering	1658 Laundry and Dry Cleaning Plant Management	4801 Miscellaneous General Equipment Maintenance
0309 Correspondence Clerk	0830 Mechanical Engineering	1667 Steward	4804 Locksmithing
0313 Work Unit Supervising	0850 Electrical Engineering	1670 Equipment Specialist	4805 Medical Equipment Repairing

Non-Clinical Occupations			
0318* Secretary	0854 Computer Engineering	1699 Equipment and Facilities Management Student Trainee	5003 Gardening
0322 Clerk-Typist	0855 Electronics Engineering	1701 General Education and Training	5026 Pest Controller
0326 Office Automation Clerical and Assistance	0856 Electronics Technician	1702 Education and Training Technician	5048 Animal Caretaking
0332 Computer Operation	0858* Biomedical Engineering	1712 Training Instruction	5301 Miscellaneous Industrial Equipment Maintenance
0335 Computer Clerk and Assistant	0895 Industrial Engineering Technical	1720 Education Program	5306* Air Conditioning Equipment Mechanic
0340* Program Management	0896 Industrial Engineering	1725 Public Health Educator	5309 Heating and Boiler Plant Equipment Mechanic
0341* Administrative Officer	0899 Engineering and Architecture Student Trainee	1740 Education Services	5313 Elevator Mechanic
0342 Support Services Administration	0901 General Legal and Kindred Administration	1750 Instructional Systems	5317 Laundry and Dry Cleaning Equipment Repairing
0343* Management and Program Analysis	0904 Law Clerk	1801 General Inspection, Investigation, Enforcement and Compliance Series	5352 Industrial Equipment Mechanic
0344* Management and Program Clerical and Assistance	0905 General Attorney	1810 General Investigating	5378 Powered Support Systems Mechanic
0346 Logistics Management	0930 Hearings and Appeals	1811 Criminal Investigating	5402 Boiler Plant Operator
0350 Equipment Operator	0950 Paralegal Specialist	1910 Quality Assurance	5406 Utility Systems Operator
0356 Data Transcriber	0962* Contact Representative	2001 General Supply	5407 Electrical Power Controlling
0360 Equal Opportunity Compliance	0963 Legal Instruments Examining	2003* Supply Program Management	5408 Wastewater Treatment Plant Operator

Non-Clinical Occupations			
0361 Equal Opportunity Assistance	0986 Legal Assistance	2005* Supply Clerical and Technician	5409 Water Treatment Plant Operator
0382 Telephone Operating	0996 Veterans Claims Examining	2010* Inventory Management	5415 Air-Conditioning Equipment Operator
0390 Telecommunications Processing	0998* Claims Assistance and Examining	2030 Distribution Facilities and Storage Management	5703* Motor Vehicle Operator
0391 Telecommunications	0999 Legal Occupations Student Trainee	2091 Sales Store Clerical	5705 Tractor Operator
0392 General Telecommunications	1001 General Arts and Information	2099 Supply Student Trainee	5716 Engineering Equipment Operating
0394 Communications Clerical	1008 Interior Design	2101 Transportation Specialist	5803 Heavy Mobile Equipment Mechanic
0399 Administration and Office Support Student Trainee	1020 Illustrating	2102 Transportation Clerk and Assistant	5806 Mobile Equipment Servicing
0401 General Biological Science	1035 Public Affairs	2130 Traffic Management	5823 Automotive Mechanic
0403 Microbiology	1040 Language Specialist	2151 Dispatching	6904 Tools and Parts Attending
0404 Biological Science Technician	1051 Music Specialist	2210 Information Technology Management	6907* Materials Handler
0405 Pharmacology	1060 Photography	2299 Information Technology Student Trainee	6913 Hazardous Waste Disposer
0413 Physiology	1071 Audiovisual Production	2502 Telecommunications Mechanic	7301 Miscellaneous Laundry, Dry Cleaning and Pressing
0415 Toxicology	1082 Writing and Editing	2604 Electronics Mechanic	7304* Laundry Working
0437 Horticulture	1083 Technical Writing and Editing	2606 Electronic Industrial Controls Mechanic	7305 Laundry Machine Operating
0459 Irrigation System Operation	1084 Visual Information	2608 Digital Computer Mechanic	7401 Miscellaneous Food Preparation and Serving

Non-Clinical Occupations			
0471 Agronomy	1087 Editorial Assistance	2610 Electronic Integrated Systems Mechanic	7404* Cook
0499 Biological Science Student Trainee	1099 Information and Arts Student Trainee	2614 Electronics Mechanic (Abolished)	7408* Food Service Worker
0501* Financial Administration and Program	1101 General Business and Industry	2805* Electrician	7601 Miscellaneous Personal Services
0503* Financial Clerical and Assistance	1102* Contracting	2810 Electrician (High Voltage)	7603 Barbering
0505 Financial Management	1104 Property Disposal	2854 Electrical Equipment Repairer	7644 Sales Clerk
0510 Accounting	1105* Purchasing	3111 Sewing Machine Operating	0000 Miscellaneous
0511 Auditing	1106* Procurement Clerical and Technician	3359 Instrument Mechanic	
0525* Accounting Technician	1107 Property Disposal Clerical and Technician	3414 Machining	
0530 Cash Processing	1109 Grants Management	3501 Misc General Services and Support Work	

* Indicates occupation is included in the occupations considered for the national shortage list

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Appendix D: Baseline Staffing Figures

VHA Clinical Baseline (FTE) - (P=Physicians, O=Other)											
VISN	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
1	174.4	822	157.3	1170.3	598.5	2654.4	19	2167	7763	3066.8	10829.7
2	60.3	435.8	47.1	550.2	279.4	1612.3	10.1	1266.3	4261.6	1388.2	5649.8
3	166.5	976.6	121.5	841.6	605.7	2329.4	15.2	2167.7	7224.3	2615.4	9839.7
4	181.1	1107	114.6	1052	550	2880.9	16.7	2170.9	8073.1	3183.8	11256.9
5	90.2	576.1	58.7	689.2	335.2	1539.5	13.8	1292.3	4595	1536.9	6131.9
6	277.3	1894.6	157.6	1193.1	686.7	3488.4	24.9	2820.9	10543.4	2874.3	13417.7
7	270.7	1458.4	187.4	1551.1	652.7	3529.5	19.7	2859.5	10529	3153.4	13682.5
8	481.9	2632.2	266.6	1739.8	1256	5646.5	43.5	4599.1	16665.8	4739	21404.8
9	222.7	1523.9	100.3	1003.9	573.4	2830	23.1	2467.5	8744.7	2441.2	11185.9
10	160	1444.9	89.6	1052.9	446	2470	13.2	1753.3	7429.8	2077.1	9506.9
11	171	1241.4	78.8	1000.4	467.1	3040.1	12.9	2077	8088.7	2459.8	10548.5
12	167.3	1387.7	123.4	1019.5	622.8	3193.9	13.6	2754.8	9283.1	3063.9	12347
15	151.6	1005.9	87.1	848	434.9	2652.4	16.9	1785.4	6982.2	2225.5	9207.7
16	328	2128.1	184.9	1769.8	865.9	4904.3	37.4	3989.4	14207.9	3903.8	18111.6
17	191.9	1305.2	119.4	968.5	480.5	2683.4	18.2	2330.9	8098	2411.4	10509.4
18	174.3	1217.2	101.2	842.1	479.3	2553.3	14.5	1827	7209	2089.3	9298.3
19	124.5	996.7	70.9	712.1	336.4	1581	13.7	1163.6	4998.8	1433	6431.8
20	166.4	1132	105.4	1141.6	544.1	2767.5	15.2	1751.4	7623.7	2172	9795.7
21	181.9	1068.3	139.5	949.5	757.7	2861.3	19.4	2368.7	8346.4	2336.9	10683.3
22	184.6	1278.3	152.3	1101.7	802.3	3446.6	21.6	2656.5	9643.9	2918.1	12562
23	180	1320.1	90.2	1127.9	516.8	3265.5	15.9	2227.8	8744.1	2646.4	11390.4
Total FTEs	**4106.6**	**26952.6**	**2553.8**	**22325.1**	**12291.4**	**61930.3**	**398.5**	**48497**	**179055.3**	**54736.1**	**233791.5**

VHA Clinical Baseline (FTE) - (P=Physicians, O=Other)							
VISN	Primary Care	Mental Health	Specialty Care	Clinical Support Services	Grand Total	Facility Support	Grand Total Plus Facility Support
1	996.4	1327.6	3252.9	2186	7763	3066.8	10829.7
2	496.2	597.4	1891.7	1276.5	4261.6	1388.2	5649.8
3	1143.2	963.1	2935.2	2182.9	7224.3	2615.4	9839.7
4	1288.1	1166.6	3430.8	2187.6	8073.1	3183.8	11256.9
5	666.3	747.9	1874.7	1306.1	4595	1536.9	6131.9
6	2171.9	1350.6	4175	2845.8	10543.4	2874.3	13417.7
7	1729.1	1738.5	4182.3	2879.2	10529	3153.4	13682.5
8	3114.2	2006.4	6902.5	4642.7	16665.8	4739	21404.8
9	1746.6	1104.1	3403.3	2490.6	8744.7	2441.2	11185.9
10	1604.8	1142.4	2916	1766.5	7429.8	2077.1	9506.9
11	1412.3	1079.2	3507.3	2089.9	8088.7	2459.8	10548.5
12	1555	1143	3816.7	2768.5	9283.1	3063.9	12347
15	1157.5	935.1	3087.3	1802.3	6982.2	2225.5	9207.7
16	2456.1	1954.7	5770.2	4026.8	14207.9	3903.8	18111.6
17	1497.1	1087.9	3163.9	2349.1	8098	2411.4	10509.4
18	1391.5	943.3	3032.7	1841.6	7209	2089.3	9298.3
19	1121.1	783	1917.5	1177.2	4998.8	1433	6431.8
20	1298.5	1247	3311.6	1766.6	7623.7	2172	9795.7
21	1250.2	1089	3619.1	2388.1	8346.4	2336.9	10683.3
22	1462.9	1254	4248.9	2678.1	9643.9	2918.1	12562
23	1500.1	1218.1	3782.3	2243.6	8744.1	2646.4	11390.4
Total FTEs	**31059.2**	**24878.9**	**74221.7**	**48895.6**	**179055.3**	**54736.1**	**233791.5**

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
VISN 1	**174.4**	**822**	**157.3**	**1170.3**	**598.5**	**2654.4**	**19**	**2167**	**7763**	**3066.8**	**10829.7**
(V01) (402) Togus, ME	23.9	137.8	8.8	85.4	66.8	324.1	2	217	865.8	247.4	1113.2
(V01) (405) White River Junction, VT	11.3	91.2	10	77.8	52.3	199.8	2.4	119	563.8	232.6	796.4
(V01) (518) Bedford, MA	10.7	56.6	16.6	196.4	18.2	172.6		298.4	769.4	309.9	1079.3
(V01) (523) VA Boston HCS, MA	27.7	133.1	45.5	285.8	196.7	807.9	5.6	744.3	2246.6	977.5	3224.1
(V01) (608) Manchester, NH	13.1	73	3.8	46.8	25.8	148.9	-	72.3	383.6	176.6	560.2
(V01) (631) VA Central Western Massachusetts HCS	18.7	99	12.3	91.5	17.1	122.1	-	134.5	495.2	159.1	654.3
(V01) (650) Providence, RI	26.1	85.8	15.8	116.3	62.8	284.8	2.6	177.7	771.8	317.1	1088.9
(V01) (689) VA Connecticut HCS, CT	42.8	145.6	44.7	270.3	158.8	594.3	6.4	403.8	1666.7	646.5	2313.3
VISN 2	**60.3**	**435.8**	**47.1**	**550.2**	**279.4**	**1612.3**	**10.1**	**1266.3**	**4261.6**	**1388.2**	**5649.8**
(V02) (528) Albany, NY	13.9	50.4	10.5	94.7	84.8	360.6	2.7	249.5	867.2	250.7	1117.9
(V02) (528) Bath, NY	6.5	40.6	2	86	10.3	134.7	0.3	136.5	416.8	186.8	603.6
(V02) (528) Canandaigua, NY	7.2	63.9	6.8	98.4	16.7	203.1	0.2	145.9	542.2	227.4	769.6
(V02) (528) Syracuse, NY	17.4	88.5	12.2	110.1	78.3	416.6	2.9	306.3	1032.3	279.2	1311.6
(V02) (528) Western New York, NY	15.4	192.5	15.6	161	89.2	497.3	4	428.1	1403.1	444	1847.1
VISN 3	**166.5**	**976.6**	**121.5**	**841.6**	**605.7**	**2329.4**	**15.2**	**2167.7**	**7224.3**	**2615.4**	**9839.7**
(V03) (526) Bronx, NY	14.1	67.7	20.7	135.5	132.1	398.1	3.4	374.4	1145.8	372.1	1518
(V03) (561) New Jersey HCS, NJ	60.2	356.6	33.8	180.8	155.1	527.6	3.1	498.3	1815.5	550.6	2366.2
(V03) (620) VA Hudson Valley HCS, NY	19.8	131.7	22.5	128.4	51.7	232.9	1	247.3	835.3	437.8	1273.1
(V03) (630) New York Harbor HCS, NY	43.2	242.8	30.2	257.4	189.9	798.5	6	685.6	2253.4	841.9	3095.3
(V03) (632) Northport, NY	29.3	177.9	14.3	139.5	77	372.3	1.7	362.1	1174.2	413	1587.1

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
VISN 4	**181.1**	**1107**	**114.6**	**1052**	**550**	**2880.9**	**16.7**	**2170.9**	**8073.1**	**3183.8**	**11256.9**
(V04) (460) Wilmington, DE	16.1	78.7	8.5	75.1	40.7	229.4	-	132	580.5	224.3	804.7
(V04) (503) Altoona, PA	11	97.9	3.6	34.1	15	147.7	0.9	81.3	391.5	180.2	571.7
(V04) (529) Butler, PA	9.6	36.2	1.9	64.8	7.1	96.5	-	95.8	312	158.9	470.9
(V04) (540) Clarksburg, WV	14.5	103.9	5.6	63.5	38.4	194.1	0.8	154.3	575	194.5	769.5
(V04) (542) Coatesville, PA	17.9	90.4	10.3	208.2	15.1	238.7	-	217.3	797.9	357.1	1155
(V04) (562) Erie, PA	10.8	97.4	4.5	62.6	19.6	149.6	0.8	82.9	428.1	171.2	599.3
(V04) (595) Lebanon, PA	26.3	181.5	14.7	129.4	60.7	290.7	2	179	884.3	335.7	1220
(V04) (642) Philadelphia, PA	27.2	159.9	35.3	174.2	154.5	531.6	4.7	320.7	1408.1	453.8	1862
(V04) (646) Pittsburgh, PA	23.4	188.5	24.5	165.2	136.5	735.1	6.6	708.9	1988.8	773.8	2762.6
(V04) (693) Wilkes-Barre, PA	24.4	72.5	5.8	74.8	62.2	267.5	0.9	198.7	706.9	334.3	1041.2
VISN 5	**90.2**	**576.1**	**58.7**	**689.2**	**335.2**	**1539.5**	**13.8**	**1292.3**	**4595**	**1536.9**	**6131.9**
(V05) (512) Baltimore HCS, MD	41.4	282.9	23.8	334.5	116.9	571.9	6.7	568.3	1946.4	648.7	2595.1
(V05) (613) Martinsburg, WV	21.7	115	11	153.5	66.3	416.6	2.4	278.6	1065	436.6	1501.6
(V05) (688) Washington, DC	27.1	178.2	23.9	201.2	152	551	4.7	445.4	1583.6	451.6	2035.1
VISN 6	**277.3**	**1894.6**	**157.6**	**1193.1**	**686.7**	**3488.4**	**24.9**	**2820.9**	**10543.4**	**2874.3**	**13417.7**
(V06) (517) Beckley, WV	7.6	115.1	3.7	50.1	24.9	193.1	-	116	510.5	158.9	669.4
(V06) (558) Durham, NC	44.5	439.3	33.4	193.8	134.7	689.5	4.7	571.2	2111.3	507.8	2619.1
(V06) (565) Fayetteville, NC	35.1	279.3	23.3	121.5	63.1	306	1.7	223.1	1053.1	241.4	1294.5
(V06) (590) Hampton, VA	24.8	171.5	16.6	199.2	50.5	330.5	2.7	296.8	1092.7	325.3	1418
(V06) (637) Asheville, NC	33.9	180.2	13.1	128.5	69.6	368	3	354.3	1150.5	293.4	1443.9
(V06) (652) Richmond, VA	41.5	243.7	19.1	142.5	148.7	647	5.8	594.4	1842.8	470.8	2313.6
(V06) (658) Salem, VA	17.9	165.4	25.4	134.9	75.2	406.3	1.5	313.8	1140.6	415.5	1556
(V06) (659) Salisbury, NC	72.1	300	23	222.5	119.8	548	5.5	351.1	1642	461.1	2103.1

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
VISN 7	**270.7**	**1458.4**	**187.4**	**1551.1**	**652.7**	**3529.5**	**19.7**	**2859.5**	**10529**	**3153.4**	**13682.5**
(V07) (508) Atlanta, GA	66.7	332.9	57.6	437.6	171.3	870.8	4.6	657	2598.4	592.1	3190.4
(V07) (509) Augusta, GA	21.8	166	19	122.6	86.8	550.7	1.7	515.0	1483.6	498.4	1982.1
(V07) (521) Birmingham, AL	37.6	208.4	22.5	173	126	532.7	4.1	354.3	1458.7	362.3	1821
(V07) (534) Charleston, SC	41.9	187.2	35.2	190	85.6	398.1	3.4	271.2	1212.6	374.7	1587.3
(V07) (544) Columbia, SC	50.4	254.5	20.3	179.9	86	517.1	2.8	340	1451.0	442	1893
(V07) (557) Dublin, GA	24.6	134.1	2.7	130.5	31.2	189.1	0.5	277.2	789.8	275.4	1065.3
(V07) (619) Central Alabama Veterans HCS, AL	21.1	110.1	12.9	178.2	50.2	295.4	2.6	222.1	892.6	388.1	1280.7
(V07) (679) Tuscaloosa, AL	6.6	65.3	17.2	139.2	15.7	175.6	-	222.6	642.2	220.5	862.7
VISN 8	**481.9**	**2632.2**	**266.6**	**1739.8**	**1256**	**5646.5**	**43.5**	**4599.1**	**16665.8**	**4739**	**21404.8**
(V08) (516) Bay Pines, FL	73.1	446.9	36.7	242.8	173.8	776.8	6	644.6	2400.8	785.1	3185.8
(V08) (546) Miami, FL	34.2	305.8	39.5	182.8	135.1	588.5	3.4	470.9	1760.1	507.8	2267.9
(V08) (548) West Palm Beach, FL	25.5	18	2	140.7	125.7	567.1	3.8	503	1574.8	529.1	2104
(V08) (573) Gainesville, FL	129.8	562.5	50.5	367.7	255.2	1380.1	8	946.1	3699.8	882.4	4582.2
(V08) (672) San Juan, PR	58.6	378.6	49.5	202.3	245.3	709.2	3.6	756.7	2403.9	605.2	3009.1
(V08) (673) Tampa, FL	82.9	449.4	42.9	273.8	200.7	1048.6	14.8	993.8	3106.8	820.1	3926.9
(V08) (675) Orlando, FL	77.9	301.2	26.6	329.7	120.1	576.3	4.0	284	1719.6	609.3	2328.9
VISN 9	**222.7**	**1523.9**	**100.3**	**1003.9**	**573.4**	**2830**	**23.1**	**2467.5**	**8744.7**	**2441.2**	**11185.9**
(V09) (581) Huntington, WV	17.9	86.6	5.4	89.9	62.3	264.6	2	173.5	702.2	314.3	1016.5
(V09) (596) Lexington, KY	33.1	274.5	9	129.4	85.9	417.1	3	329.1	1281	372	1653
(V09) (603) Louisville, KY	36.5	189.1	14.8	178.5	56.1	404.3	3.9	259.8	1143	336.5	1479.5
(V09) (614) Memphis, TN	37.3	266.7	18.9	164.9	106.8	507.9	5.7	447.4	1555.6	396.4	1952
(V09) (621) Mountain Home, TN	43.2	295.8	21.6	176.5	73.6	432.3	4.1	499.5	1546.6	376.8	1923.4

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
(V09) (626) Middle Tennessee HCS, TN	54.7	411.3	30.4	264.7	188.7	803.8	4.5	758.2	2516.3	645.2	3161.5
VISN 10	**160**	**1444.9**	**89.6**	**1052.9**	**446**	**2470**	**13.2**	**1753.3**	**7429.8**	**2077.1**	**9506.9**
(V10) (538) Chillicothe, OH	11.2	156.1	9.7	157.1	28.1	221.3	-	258.4	841.9	387.3	1229.3
(V10) (539) Cincinnati, OH	35.4	210.4	23.3	220.9	93.2	475.1	3.7	315.5	1377.5	392.5	1770
(V10) (541) Cleveland, OH	59	665.3	35.7	400.2	179.6	1001.7	5.4	740.6	3087.4	676.9	3764.2
(V10) (552) Dayton, OH	26.5	263.6	8.3	164.9	85.9	477.3	2.4	395	1423.9	408.5	1832.3
(V10) (757) Columbus, OH	27.9	149.6	12.5	109.7	59.3	294.5	1.8	43.8	699.2	211.9	911
VISN 11	**171**	**1241.4**	**78.8**	**1000.4**	**467.1**	**3040.1**	**12.9**	**2077.**	**8088.7**	**2459.8**	**10548.5**
(V11) (506) Ann Arbor, MI	43.2	265.1	19	167.3	110.9	611.1	3.9	359.3	1579.8	416.6	1996.4
(V11) (515) Battle Creek, MI	21.3	178.8	14.2	173.6	26.3	268.6	-	274.8	957.6	293.7	1251.4
(V11) (550) Danville, IL	18	157.5	7.3	118.8	32.2	308.3	1	282.3	925.5	310	1235.6
(V11) (553) Detroit, MI	23.7	138.8	13.7	158.2	95.8	462.1	3.4	323.4	1219.1	417.2	1636.3
(V11) (583) Indianapolis, IN	32.2	168.5	9.7	187.1	131.2	839.6	3.4	445.1	1816.8	476.9	2293.7
(V11) (610) Northern Indiana HCS, IN	16.6	185.1	7.9	109.6	45.9	286.7	1.2	286.8	939.8	322.3	1262.1
(V11) (655) Saginaw, MI	15.9	147.6	7	85.8	24.8	263.8	-	105.3	650.2	223	873.1
VISN 12	**167.3**	**1387.7**	**123.4**	**1019.5**	**622.8**	**3193.9**	**13.6**	**2754.8**	**9283.1**	**3063.9**	**12347**
(V12) (537) Jesse Brown VAMC (Chicago), IL	30.2	225.5	26.2	173	126.1	494.4	1.8	385.2	1462.5	455.1	1917.6
(V12) (556) Captain James A Lovell FHCC	27	158.3	16.1	152	96	437.2	1	297.6	1185.2	511	1696.2
(V12) (578) Hines, IL	36.4	306.5	34.9	174.4	162.2	731.7	4.6	671.3	2122	655.9	2777.9
(V12) (585) Iron Mountain, MI	6.9	81.4	1.8	44.1	16	138.4	-	89.7	378.4	153.6	531.9

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
(V12) (607) Madison, WI	17.7	137.1	10.2	127.9	73.9	409.1	2.5	354.6	1132.9	318.8	1451.7
(V12) (676) Tomah, WI	6	134.2	7.7	86.5	18.4	161.8	-	239.6	654.3	237.4	891.6
(V12) (695) Milwaukee, WI	43	344.8	26.4	261.6	130.2	821.3	3.7	716.8	2347.9	732.1	3080
VISN 15	**151.6**	**1005.9**	**87.1**	**848**	**434.9**	**2652.4**	**16.9**	**1785.4**	**6982.2**	**2225.5**	**9207.7**
(V15) (589) Columbia, MO	30	144.8	8.9	88.5	58.1	336.7	1.1	253.3	921.3	263	1184.3
(V15) (589) Eastern KS HCS, KS	19.9	142.5	18.1	193.3	51.8	385.4	3	302.7	1116.6	397.6	1514.2
(V15) (589) Kansas City, MO	2	163.9	12.7	102.3	81.3	468.9	5.9	267.4	1125.4	340.8	1466.3
(V15) (589) Wichita, KS	12.8	99.8	4.6	75.1	41.5	284	-	133.9	651.7	204.3	855.9
(V15) (657) Marion, IL	29.9	168.6	9.7	133.4	52.1	332.7	1.9	215.2	943.5	275	1218.5
(V15) (657) Poplar Bluff, MO	13.4	82.9	4.7	62.1	10.9	96.5	0.1	90.3	360.9	163.9	524.8
(V15) (657) St. Louis, MO	22.6	203.5	28.4	193.4	139.1	748.2	5.1	522.5	1862.7	580.9	2443.6
VISN 16	**328.0**	**2128.1**	**184.9**	**1769.8**	**865.9**	**4904.3**	**37.4**	**3989.4**	**14207.9**	**3903.8**	**18111.6**
(V16) (502) Alexandria, LA	13.8	109.2	6.2	113.7	32.6	277.3	2	231.9	786.6	288.6	1075.2
(V16) (520) Gulf Coast HCS, MS	37.4	181.1	19.6	236.3	81.9	595.2	2.8	371.4	1525.6	438.5	1964.1
(V16) (564) Fayetteville, AR	35.4	194.7	11	136.1	63	364.6	2	235.8	1042.5	251.7	1294.2
(V16) (580) Houston, TX	66.6	422.7	53.7	325.4	207.9	1081.7	7.6	1072.8	3238.4	631.5	3869.8
(V16) (586) Jackson, MS	8.5	138.2	9.8	172.6	82.3	455.9	3.3	465	1335.6	428.5	1764
(V16) (598) Little Rock, AR	38.7	295.1	27.5	299.8	133.1	763.1	7.5	700.6	2265.3	568.4	2833.7
(V16) (623) Muskogee, OK	32.5	180.2	14.9	86.1	47.1	236.4	2.9	213.5	813.5	252.7	1066.2
(V16) (629) New Orleans, LA	28.3	176.2	14.9	140.4	54	293.3	2.3	55.2	764.6	352.9	1117.5
(V16) (635) Oklahoma City, OK	42.4	236.9	18.3	139.7	92.5	496.2	3.3	417.9	1447	391.9	1838.9
(V16) (667) Shreveport, LA	24.5	193.9	9	119.8	71.5	340.7	3.9	225.4	988.7	299.2	1287.9
VISN 17	**191.9**	**1305.2**	**119.4**	**968.5**	**480.5**	**2683.4**	**18.2**	**2330.9**	**8098.0**	**2411.4**	**10509.4**

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
(V17) (549) Dallas, TX	61.2	409.5	49.5	386.2	169.5	995.6	7.6	920.4	2999.5	884.7	3884.2
(V17) (671) San Antonio, TX	49.6	366.3	29.7	198.1	147.6	804.9	5.7	731.2	2333.1	654	2987.1
(V17) (674) Temple, TX	61.3	371.6	33.9	305.1	138.0	753.4	4.1	638.1	2305.5	736.1	3041.5
(V17) (740) VA Texas Valley Coastal Bend HCS	19.8	157.9	6.3	79.1	25.4	129.5	0.8	41.2	459.9	136.7	596.6
VISN 18	**174.3**	**1217.2**	**101.2**	**842.1**	**479.3**	**2553.3**	**14.5**	**1827.0**	**7209.0**	**2089.3**	**9298.3**
(V18) (501) New Mexico HCS	30.6	225.1	25.4	215.8	121.4	582.3	3.5	445.3	1649.5	432.1	2081.6
(V18) (504) Amarillo, TX	17.3	99.9	7.4	70.8	32	217.8	1	225.6	671.9	239.2	911
(V18) (519) Big Spring, TX	10.2	60.6	3.9	40.9	6.6	105.1	1	66.6	294.9	159.7	454.6
(V18) (644) Phoenix, AZ	58.8	357.4	33.9	181.5	132.1	661.6	4.8	474.7	1904.7	439.3	2344
(V18) (649) Northern Arizona HCS	11	106.7	3.7	113	30.2	215.3	-	160.8	640.8	207.8	848.6
(V18) (678) Southern Arizona HCS	30	242.9	19.9	139.5	117'	582.4	4.3	413.9	1549.8	452.1	2001.9
(V18) (756) El Paso, TX	16.4	124.6	7	80.5	40'	188.9	-	40.1	497.4	159.2	656.6
VISN 19	**124.5**	**996.7**	**70.9**	**712.1**	**336.4**	**1581'**	**13.7**	**1163.6**	**4998.8**	**1433**	**6431.8**
(V19) (436) Montana HCS	34.2	205.8	8	77.4	38.9	219.4	2.6	169.9	756.1	240.7	996.8
(V19) (442) Cheyenne, WY	8	93.3	3.4	46.2	26'	143.6	-	102.9	423.5	118.9	542.4
(V19) (554) Denver, CO	54.5	302.4	32.6	301.1	140.5	523.7	7	391.7	1753.4	392.2	2145.7
(V19) (575) Grand Junction, CO	5	58.7	5	36.7	15.9	145.9	-	107.4	374.6	115	489.7
(V19) (660) Salt Lake City, UT	17.9	274.9	17.9	179.6	109.3	466.9	4.1	275.3	1346	415	1761
(V19) (666) Sheridan, WY	4.8	61.5	4	71.1	5.7	81.6	-	116.5	345.2	151.1	496.3
VISN 20	**166.4**	**1132**	**105.4**	**1141.6**	**544.1**	**2767.5**	**15.2**	**1751.4**	**7623.7**	**2172**	**9795.7**
(V20) (463) Anchorage, AK	8.8	86.2	4.4	61.8	12.5	84.1	-	13.2	270.9	102.3	373.2
(V20) (531) Boise, ID	16.4	137.8	10.6	91.4	45	245.9	2	153.6	702.7	226.1	928.7
(V20) (648) Portland, OR	53.1	316.4	30.7	256.6	206.8	903.5	6.4	616.9	2390.4	616.2	3006.6

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
(V20) (653) Roseburg, OR	10.5	104	4.6	72.7	24.4	209.8	-	136	562	180.4	742.4
(V20) (663) VA Puget Sound, WA	43	248.9	44.3	336.2	195	905	5.9	621.9	2400.1	555.8	2955.9
(V20) (668) Spokane, WA	13.4	100.7	6.6	104.8	39.8	221.7	0.9	140.3	628.1	168.9	797
(V20) (687) Walla Walla, WA	7.4	72.8	1.6	68.1	5.8	73.7	-	24	253.4	166.6	420
(V20) (692) White City, OR	13.8	65.2	2.7	150.1	14.8	123.9	-	45.6	416.1	155.7	571.8
VISN 21	**181.9**	**1068.3**	**139.5**	**949.5**	**757.7**	**2861.3**	**19.4**	**2368.7**	**8346.4**	**2336.9**	**10683.3**
(V21) (459) Honolulu, HI	18	73.1	17.2	116.9	40.2	216.7	-	79.4	561.6	165.4	727
(V21) (570) Fresno, CA	13.9	63.3	10.4	60.4	58.4	310.6	1.9	203.4	722.4	262.2	984.6
(V21) (612) N. California, CA	39.9	296.3	25.7	208.9	193.4	646.9	4.9	375.1	1791.2	552	2343.2
(V21) (640) Palo Alto, CA	55	267.4	43	301.7	224.6	818	6	953.3	2668.8	662.2	3331
(V21) (654) Reno, NV	32.9	167.3	10.3	89.3	60.5	269.6	1.3	237.8	869	244.6	1113.6
(V21) (662) San Francisco, CA	22.2	200.8	32.9	172.2	180.6	599.5	5.3	519.8	1733.4	450.5	2183.9
VISN 22	**184.6**	**1278.3**	**152.3**	**1101.7**	**802.3**	**3446.6**	**21.6**	**2656.5**	**9643.9**	**2918.1**	**12562**
(V22) (593) Las Vegas, NV	34	266.2	18.9	94.9	108.9	539.5	1.9	333.5	1397.8	460.6	1858.4
(V22) (600) Long Beach, CA	21.3	176.1	24.3	148.2	111.6	504.4	4	467.2	1457.1	553.5	2010.5
(V22) (605) Loma Linda, CA	17.7	215.7	10.9	169.2	154	608.9	4.2	502.8	1683.5	466.8	2150.3
(V22) (664) San Diego, CA	46.8	218.9	32.7	257.4	177.5	789.5	6.8	452.2	1981.9	525.5	2507.4
(V22) (691) Greater Los Angeles HCS	64.8	401.4	65.5	432	250.2	1004.2	4.7	900.7	3123.6	911.8	4035.4
VISN 23	**180**	**1320.1**	**90.2**	**1127.9**	**516.8**	**3265.5**	**15.9**	**2227.8**	**8744.1**	**2646.4**	**11390.4**
(V23) (437) Fargo, ND	14.6	107	6.5	73.4	48.4	261.2	1.9	149	662.1	200.2	862.3
(V23) (438) Sioux Falls, SD	14.3	103	5.8	48	38.2	254	-	176.6	639.9	190	829.8
(V23) (568) Black Hills HCS, SD	7.7	68.5	5.3	105.4	28.3	262.1	-	157.5	634.8	294	928.8
(V23) (618) Minneapolis, MN	46.1	228	31.5	267.8	183.9	969	6.7	668	2400.9	630.4	3031.3

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)											
Facilities	Primary Care		Mental Health		Specialty Care		Clinical Support Services		Grand Total	Facility Support	Grand Total Plus Facility Support
	P	O	P	O	P	O	P	O			
(V23) (636) Central Iowa, IA	21.6	180.6	6.5	149.3	38.4	289.4	-	235.3	921.1	268.4	1189.5
(V23) (636) Iowa City, IA	28.9	226.6	12.6	147.8	80.4	402.6	4.1	223	1126	324.2	1450.1
(V23) (636) Nebraska-W Iowa, NE	28.8	252.2	16.4	153.9	67.5	479.2	3.2	324.9	1326.2	411.8	1737.9
(V23) (656) St. Cloud, MN	18	154.3	5.6	182.3	31.7	347.8	-	293.5	1033.3	327.5	1360.7
Total FTEs	**4106.6**	**26952.6**	**2553.8**	**22325.1**	**12291.4**	**61930.3**	**398.5**	**48497**	**179055.3**	**54736.1**	**233791.5**

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
VISN 1	**996.4**	**1327.6**	**3252.9**	**2186**	**7763**	**3066.8**	**10829.7**
(V01) (402) Togus, ME	161.7	94.2	390.9	219	865.8	247.4	1113.2
(V01) (405) White River Junction, VT	102.5	87.8	252.1	121.4	563.8	232.6	796.4
(V01) (518) Bedford, MA	67.3	213	190.8	298.4	769.4	309.9	1079.3
(V01) (523) VA Boston HCS, MA	160.8	331.3	1004.6	749.9	2246.6	977.5	3224.1
(V01) (608) Manchester, NH	86.1	50.5	174.6	72.3	383.6	176.6	560.2
(V01) (631) VA Central Western Massachusetts HCS	117.7	103.7	139.2	134.5	495.2	159.1	654.3
(V01) (650) Providence, RI	111.9	132.1	347.5	180.3	771.8	317.1	1088.9
(V01) (689) VA Connecticut HCS, CT	188.4	315	753.2	410.2	1666.7	646.5	2313.3
VISN 2	**496.2**	**597.4**	**1891.7**	**1276.5**	**4261.6**	**1388.2**	**5649.8**
(V02) (528) Albany, NY	64.3	105.2	445.4	252.3	867.2	250.7	1117.9
(V02) (528) Bath, NY	47	88	145	136.8	416.8	186.8	603.6
(V02) (528) Canandaigua, NY	71.1	105.2	219.8	146.1	542.2	227.4	769.6
(V02) (528) Syracuse, NY	105.8	122.4	494.9	309.2	1032.3	279.2	1311.6
(V02) (528) Western New York, NY	207.9	176.6	586.5	432.1	1403.1	444	1847.1
VISN 3	**1143.2**	**963.1**	**2935.2**	**2182.9**	**7224.3**	**2615.4**	**9839.7**
(V03) (526) Bronx, NY	81.7	156.2	530.2	377.8	1145.8	372.1	1518
(V03) (561) New Jersey HCS, NJ	416.8	214.6	682.7	501.4	1815.5	550.6	2366.2
(V03) (620) VA Hudson Valley HCS, NY	151.5	150.9	284.6	248.3	835.3	437.8	1273.1
(V03) (630) New York Harbor HCS, NY	285.9	287.6	988.3	691.5	2253.4	841.9	3095.3

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V03) (632) Northport, NY	207.2	153.8	449.3	363.8	1174.2	413	1587.1
VISN 4	**1288.1**	**1166.6**	**3430.8**	**2187.6**	**8073.1**	**3183.8**	**11256.9**
(V04) (460) Wilmington, DE	94.8	83.6	270.1	132	580.5	224.3	804.7
(V04) (503) Altoona, PA	108.9	37.7	162.7	82.2	391.5	180.2	571.7
(V04) (529) Butler, PA	45.8	66.7	103.6	95.8	312	158.9	470.9
(V04) (540) Clarksburg, WV	118.4	69.1	232.4	155.1	575	194.5	769.5
(V04) (542) Coatesville, PA	108.3	218.5	253.7	217.3	797.9	357.1	1155
(V04) (562) Erie, PA	108.2	67.1	169.2	83.6	428.1	171.2	599.3
(V04) (595) Lebanon, PA	207.8	144.1	351.4	181	884.3	335.7	1220
(V04) (642) Philadelphia, PA	187.1	209.5	686.1	325.4	1408.1	453.8	1862
(V04) (646) Pittsburgh, PA	211.9	189.7	871.6	715.5	1988.8	773.8	2762.6
(V04) (693) Wilkes-Barre, PA	96.9	80.6	329.8	199.6	706.9	334.3	1041.2
VISN 5	**666.3**	**747.9**	**1874.7**	**1306.1**	**4595**	**1536.9**	**6131.9**
(V05) (512) Baltimore HCS, MD	324.3	358.3	688.8	575	1946.4	648.7	2595.1
(V05) (613) Martinsburg, WV	136.7	164.4	482.9	281	1065	436.6	1501.6
(V05) (688) Washington, DC	205.3	225.1	703.1	450.1	1583.6	451.6	2035.1
VISN 6	**2171.9**	**1350.6**	**4175**	**2845.8**	**10543.4**	**2874.3**	**13417.7**
(V06) (517) Beckley, WV	122.7	53.8	218	116	510.5	158.9	669.4
(V06) (558) Durham, NC	483.9	227.2	824.3	575.9	2111.3	507.8	2619.1
(V06) (565) Fayetteville, NC	314.4	144.8	369.1	224.8	1053.1	241.4	1294.5
(V06) (590) Hampton, VA	196.3	215.9	381	299.5	1092.7	325.3	1418
(V06) (637) Asheville, NC	214.1	141.5	437.5	357.3	1150.5	293.4	1443.9
(V06) (652) Richmond, VA	285.2	161.7	795.7	600.2	1842.8	470.8	2313.6
(V06) (658) Salem, VA	183.3	160.3	481.6	315.3	1140.6	415.5	1556

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V06) (659) Salisbury, NC	372.1	245.4	667.8	356.6	1642	461.1	2103.1
VISN 7	**1729.1**	**1738.5**	**4182.3**	**2879.2**	**10529**	**3153.4**	**13682.5**
(V07) (508) Atlanta, GA	399.6	495.2	1042.1	661.5	2598.4	592.1	3190.4
(V07) (509) Augusta, GA	187.9	141.6	637.5	516.7	1483.6	498.4	1982.1
(V07) (521) Birmingham, AL	246.1	195.5	658.7	358.5	1458.7	362.3	1821
(V07) (534) Charleston, SC	229	225.2	483.7	274.7	1212.6	374.7	1587.3
(V07) (544) Columbia, SC	304.9	200.2	603.1	342.8	1451	442	1893
(V07) (557) Dublin, GA	158.6	133.2	220.3	277.7	789.8	275.4	1065.3
(V07) (619) Central Alabama Veterans HCS, AL	131.1	191.1	345.6	224.7	892.6	388.1	1280.7
(V07) (679) Tuscaloosa, AL	71.9	156.5	191.3	222.6	642.2	220.5	862.7
VISN 8	**3114.2**	**2006.4**	**6902.5**	**4642.7**	**16665.8**	**4739**	**21404.8**
(V08) (516) Bay Pines, FL	520	279.5	950.6	650.6	2400.8	785.1	3185.8
(V08) (546) Miami, FL	339.9	222.3	723.6	474.3	1760.1	507.8	2267.9
(V08) (548) West Palm Beach, FL	213.5	161.7	692.8	506.8	1574.8	529.1	2104
(V08) (573) Gainesville, FL	692.2	418.2	1635.3	954.1	3699.8	882.4	4582.2
(V08) (672) San Juan, PR	437.2	251.8	954.6	760.3	2403.9	605.2	3009.1
(V08) (673) Tampa, FL	532.2	316.7	1249.3	1008.6	3106.8	820.1	3926.9
(V08) (675) Orlando, FL	379.1	356.3	696.3	287.9	1719.6	609.3	2328.9
VISN 9	**1746.6**	**1104.1**	**3403.3**	**2490.6**	**8744.7**	**2441.2**	**11185.9**
(V09) (581) Huntington, WV	104.6	95.3	326.9	175.5	702.2	314.3	1016.5
(V09) (596) Lexington, KY	307.5	138.4	503	332.1	1281	372	1653
(V09) (603) Louisville, KY	225.6	193.3	460.4	263.7	1143.0	336.5	1479.5
(V09) (614) Memphis, TN	303.9	183.9	614.7	453.1	1555.6	396.4	1952

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V09) (621) Mountain Home, TN	339	198.1	505.9	503.6	1546.6	376.8	1923.4
(V09) (626) Middle Tennessee HCS, TN	466	295.2	992.5	762.7	2516.3	645.2	3161.5
VISN 10	**1604.8**	**1142.4**	**2916**	**1766.5**	**7429.8**	**2077.1**	**9506.9**
(V10) (538) Chillicothe, OH	167.3	166.8	249.4	258.4	841.9	387.3	1229.3
(V10) (539) Cincinnati, OH	245.8	244.3	568.3	319.2	1377.5	392.5	1770
(V10) (541) Cleveland, OH	724.2	435.9	1181.3	745.9	3087.4	676.9	3764.2
(V10) (552) Dayton, OH	290.0	173.2	563.2	397.4	1423.9	408.5	1832.3
(V10) (757) Columbus, OH	177.5	122.2	353.8	45.6	699.2	211.9	911
VISN 11	**1412.3**	**1079.2**	**3507.3**	**2089.9**	**8088.7**	**2459.8**	**10548.5**
(V11) (506) Ann Arbor, MI	308.3	186.3	722	363.2	1579.8	416.6	1996.4
(V11) (515) Battle Creek, MI	200.1	187.8	294.9	274.8	957.6	293.7	1251.4
(V11) (550) Danville, IL	175.5	126.2	340.5	283.3	925.5	310	1235.6
(V11) (553) Detroit, MI	162.5	171.9	557.9	326.8	1219.1	417.2	1636.3
(V11) (583) Indianapolis, IN	200.8	196.8	970.7	448.5	1816.8	476.9	2293.7
(V11) (610) Northern Indiana HCS, IN	201.7	117.5	332.6	288	939.8	322.3	1262.1
(V11) (655) Saginaw, MI	163.5	92.8	288.6	105.3	650.2	223	873.1
VISN 12	**1555**	**1143**	**3816.7**	**2768.5**	**9283.1**	**3063.9**	**12347**
(V12) (537) Jesse Brown VAMC (Chicago), IL	255.7	199.2	620.5	387	1462.5	455.1	1917.6
(V12) (556) Captain James A Lovell FHCC	185.3	168.2	533.1	298.6	1185.2	511	1696.2
(V12) (578) Hines, IL	342.9	209.3	893.9	675.9	2122	655.9	2777.9
(V12) (585) Iron Mountain, MI	88.3	45.9	154.4	89.7	378.4	153.6	531.9

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V12) (607) Madison, WI	154.7	138.1	483	357.1	1132.9	318.8	1451.7
(V12) (676) Tomah, WI	140.2	94.2	180.2	239.6	654.3	237.4	891.6
(V12) (695) Milwaukee, WI	387.8	288	951.5	720.5	2347.9	732.1	3080
VISN 15	**1157.5**	**935.1**	**3087.3**	**1802.3**	**6982.2**	**2225.5**	**9207.7**
(V15) (589) Columbia, MO	174.8	97.4	394.8	254.3	921.3	263	1184.3
(V15) (589) Eastern KS HCS, KS	162.4	211.4	437.2	305.7	1116.6	397.6	1514.2
(V15) (589) Kansas City, MO	186.9	115.0	550.3	273.3	1125.4	340.8	1466.3
(V15) (589) Wichita, KS	112.6	79.6	325.5	133.9	651.7	204.3	855.9
(V15) (657) Marion, IL	198.4	143.1	384.8	217.1	943.5	275.0	1218.5
(V15) (657) Poplar Bluff, MO	96.3	66.8	107.4	90.4	360.9	163.9	524.8
(V15) (657) St. Louis, MO	226.1	221.8	887.3	527.6	1862.7	580.9	2443.6
VISN 16	**2456.1**	**1954.7**	**5770.2**	**4026.8**	**14207.9**	**3903.8**	**18111.6**
(V16) (502) Alexandria, LA	122.9	119.9	309.9	233.9	786.6	288.6	1075.2
(V16) (520) Gulf Coast HCS, MS	218.5	255.9	677.1	374.1	1525.6	438.5	1964.1
(V16) (564) Fayetteville, AR	230.1	147.1	427.6	237.8	1042.5	251.7	1294.2
(V16) (580) Houston, TX	489.3	379.1	1289.6	1080.4	3238.4	631.5	3869.8
(V16) (586) Jackson, MS	146.7	182.4	538.2	468.2	1335.6	428.5	1764
(V16) (598) Little Rock, AR	333.8	327.3	896.2	708.1	2265.3	568.4	2833.7
(V16) (623) Muskogee, OK	212.7	101	283.5	216.4	813.5	252.7	1066.2
(V16) (629) New Orleans, LA	204.5	155.3	347.2	57.5	764.6	352.9	1117.5
(V16) (635) Oklahoma City, OK	279.3	158	588.7	421.1	1447	391.9	1838.9
(V16) (667) Shreveport, LA	218.4	128.8	412.2	229.2	988.7	299.2	1287.9
VISN 17	**1497.1**	**1087.9**	**3163.9**	**2349.1**	**8098**	**2411.4**	**10509.4**
(V17) (549) Dallas, TX	470.6	435.7	1165.1	928	2999.5	884.7	3884.2

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V17) (671) San Antonio, TX	415.9	227.9	952.5	736.9	2333.1	654	2987.1
(V17) (674) Temple, TX	432.9	339	891.4	642.2	2305.5	736.1	3041.5
(V17) (740) VA Texas Valley Coastal Bend HCS	177.7	85.3	154.9	42.0	459.9	136.7	596.6
VISN 18	**1391.5**	**943.3**	**3032.7**	**1841.6**	**7209**	**2089.3**	**9298.3**
(V18) (501) New Mexico HCS	255.7	241.2	703.8	448.8	1649.5	432.1	2081.6
(V18) (504) Amarillo, TX	117.3	78.2	249.8	226.6	671.9	239.2	911
(V18) (519) Big Spring, TX	70.8	44.8	111.7	67.6	294.9	159.7	454.6
(V18) (644) Phoenix, AZ	416.2	215.4	793.8	479.4	1904.7	439.3	2344
(V18) (649) Northern Arizona HCS	117.8	116.7	245.5	160.8	640.8	207.8	848.6
(V18) (678) Southern Arizona HCS	272.9	159.4	699.3	418.2	1549.8	452.1	2001.9
(V18) (756) El Paso, TX	141	87.5	228.8	40.1	497.4	159.2	656.6
VISN 19	**1121.1**	**783**	**1917.5**	**1177.2**	**4998.8**	**1433.0**	**6431.8**
(V19) (436) Montana HCS	240	85.3	258.3	172.5	756.1	240.7	996.8
(V19) (442) Cheyenne, WY	101.4	49.6	169.6	102.9	423.5	118.9	542.4
(V19) (554) Denver, CO	356.9	333.7	664.1	398.7	1753.4	392.2	2145.7
(V19) (575) Grand Junction, CO	63.8	41.7	161.8	107.4	374.6	115	489.7
(V19) (660) Salt Lake City, UT	292.9	197.5	576.2	279.3	1346	415	1761
(V19) (666) Sheridan, WY	66.3	75.1	87.3	116.5	345.2	151.1	496.3
VISN 20	**1298.5**	**1247**	**3311.6**	**1766.6**	**7623.7**	**2172**	**9795.7**
(V20) (463) Anchorage, AK	95.0	66.2	96.5	13.2	270.9	102.3	373.2
(V20) (531) Boise, ID	154.2	102.0	291.0	155.6	702.7	226.1	928.7
(V20) (648) Portland, OR	369.5	287.3	1110.3	623.3	2390.4	616.2	3006.6
(V20) (653) Roseburg, OR	114.5	77.3	234.2	136.0	562.0	180.4	742.4

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V20) (663) VA Puget Sound, WA	291.9	380.5	1099.9	627.8	2400.1	555.8	2955.9
(V20) (668) Spokane, WA	114.1	111.4	261.5	141.2	628.1	168.9	797
(V20) (687) Walla Walla, WA	80.2	69.7	79.5	24.0	253.4	166.6	420
(V20) (692) White City, OR	79	152.8	138.6	45.6	416.1	155.7	571.8
VISN 21	**1250.2**	**1089**	**3619.1**	**2388.1**	**8346.4**	**2336.9**	**10683.3**
(V21) (459) Honolulu, HI	91.2	134.1	256.9	79.4	561.6	165.4	727
(V21) (570) Fresno, CA	77.2	70.9	369.1	205.3	722.4	262.2	984.6
(V21) (612) N. California, CA	336.2	234.6	840.3	380.0	1791.2	552.0	2343.2
(V21) (640) Palo Alto, CA	322.4	344.7	1042.6	959.2	2668.8	662.2	3331
(V21) (654) Reno, NV	200.2	99.6	330.1	239.1	869	244.6	1113.6
(V21) (662) San Francisco, CA	223	205.1	780.1	525.1	1733.4	450.5	2183.9
VISN 22	**1462.9**	**1254.0**	**4248.9**	**2678.1**	**9643.9**	**2918.1**	**12562**
(V22) (593) Las Vegas, NV	300.3	113.8	648.4	335.4	1397.8	460.6	1858.4
(V22) (600) Long Beach, CA	197.4	172.5	616.0	471.2	1457.1	553.5	2010.5
(V22) (605) Loma Linda, CA	233.3	180.1	763.0	507.1	1683.5	466.8	2150.3
(V22) (664) San Diego, CA	265.8	290.1	967	459.0	1981.9	525.5	2507.4
(V22) (691) Greater Los Angeles HCS	466.1	497.5	1254.5	905.4	3123.6	911.8	4035.4
VISN 23	**1500.1**	**1218.1**	**3782.3**	**2243.6**	**8744.1**	**2646.4**	**11390.4**
(V23) (437) Fargo, ND	121.6	80	309.6	150.9	662.1	200.2	862.3
(V23) (438) Sioux Falls, SD	117.3	53.8	292.2	176.6	639.9	190.0	829.8
(V23) (568) Black Hills HCS, SD	76.2	110.6	290.5	157.5	634.8	294.0	928.8
(V23) (618) Minneapolis, MN	274	299.3	1152.9	674.7	2400.9	630.4	3031.3
(V23) (636) Central Iowa, IA	202.2	155.8	327.8	235.3	921.1	268.4	1189.5
(V23) (636) Iowa City, IA	255.5	160.4	483.0	227.1	1126.0	324.2	1450.1

VHA Clinical Baseline (FTE) (P=Physicians, O=Other)							
Facilities	**Primary Care**	**Mental Health**	**Specialty Care**	**Clinical Support Services**	**Grand Total**	**Facility Support**	**Grand Total Plus Facility Support**
(V23) (636) Nebraska-W Iowa, NE	281	170.2	546.8	328.1	1326.2	411.8	1737.9
(V23) (656) St. Cloud, MN	172.3	187.9	379.5	293.5	1033.3	327.5	1360.7
Total FTEs	**31059.2**	**24878.9**	**74221.7**	**48895.6**	**179055.3**	**54736.1**	**233791.5**

Appendix E: Projected Staffing Levels – By Facility

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VHA	NATIONAL	227,235	251,502	135,934	151,866
VISN 01	(402) HCS Togus Maine	949	968	509	537
VISN 01	(405) MROC White River Junction Vermont	761	820	426	476
VISN 01	(518) MC Bedford Massachusetts	982	1,055	493	452
VISN 01	(523) HCS Boston Massachusetts	3,028	3,301	1,879	2,217
VISN 01	(608) MC Manchester New Hampshire	584	721	356	406
VISN 01	(631) MC Leeds Massachusetts	615	628	394	432
VISN 01	(650) MC Providence Rhode Island	984	1,020	586	618
VISN 01	(689) HCS West Haven Connecticut	2,009	2,072	1,118	1,204
VISN 02	(526) MC Bronx New York	1,288	1,293	595	618
VISN 02	(528) HCS Buffalo New York	1,433	1,459	756	874
VISN 02	(528D) MC Albany New York	908	946	438	417
VISN 02	(528E) MC Syracuse New York	1,262	1,376	623	662
VISN 02	(528N) MC Bath New York	908	910	712	716
VISN 02	(561) HCS East Orange New Jersey	1,882	1,978	1,076	1,077

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 02	(620) HCS Montrose New York	729	691	669	645
VISN 02	(630) HCS New York	2,130	2,087	1,236	1,110
VISN 02	(632) MC Northport New York	1,160	1,156	578	528
VISN 04	(460) MROC Wilmington Delaware	763	862	422	479
VISN 04	(503) MC Altoona Pennsylvania	535	720	378	424
VISN 04	(529) MC Butler Pennsylvania	454	558	316	343
VISN 04	(542) MC Coatesville Pennsylvania	678	651	519	505
VISN 04	(562) MC Erie Pennsylvania	502	582	310	346
VISN 04	(595) MC Lebanon Pennsylvania	1,102	1,264	649	704
VISN 04	(642) MC Philadelphia Pennsylvania	1,894	2,040	806	773
VISN 04	(646) HCS Pittsburgh Pennsylvania	2,523	2,714	1,354	1,341
VISN 04	(693) MC Wilkes Barre Pennsylvania	848	895	542	539
VISN 05	(512) HCS Baltimore Maryland	2,183	2,334	1,264	1,228
VISN 05	(517) MC Beckley West Virginia	532	585	309	346
VISN 05	(540) MC Clarksburg West Virginia	731	833	407	508

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 05	(581) MC Huntington West Virginia	923	1,030	512	551
VISN 05	(613) MC Martinsburg West Virginia	1,374	1,634	790	833
VISN 05	(688) MC Washington District of Columbia	1,943	2,245	849	883
VISN 06	(558) MC Durham North Carolina	2,641	2,851	1,139	1,262
VISN 06	(565) MC Fayetteville North Carolina	1,542	1,827	824	918
VISN 06	(590) MC Hampton Virginia	1,583	1,920	745	924
VISN 06	(637) MC Asheville North Carolina	1,466	1,651	676	764
VISN 06	(652) MC Richmond Virginia	2,753	3,105	1,125	1,264
VISN 06	(658) MC Salem Virginia	1,178	1,198	721	737
VISN 06	(659) MC Salisbury North Carolina	2,269	2,595	1,059	1,075
VISN 07	(508) MC Atlanta Georgia	3,436	4,017	1,825	2,204
VISN 07	(509) MC Augusta Georgia	1,734	1,834	961	1,015
VISN 07	(521) MC Birmingham Alabama	1,940	2,116	957	1,148
VISN 07	(534) MC Charleston South Carolina	2,052	2,490	1,120	1,420
VISN 07	(544) MC Columbia South Carolina	1,938	2,210	1,054	1,188
VISN 07	(557) MC Dublin Georgia	1,149	1,487	665	851

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 07	(619) HCS Montgomery Alabama	1,060	1,070	821	899
VISN 07	(679) MC Tuscaloosa Alabama	749	854	410	430
VISN 08	(516) MC Bay Pines Florida	2,973	3,482	1,844	2,141
VISN 08	(546) MC Miami Florida	2,019	2,214	1,103	1,218
VISN 08	(548) MC West Palm Beach Florida	1,797	1,875	965	1,034
VISN 08	(573) HCS Gainesville Florida	3,977	4,058	2,073	2,314
VISN 08	(672) MC San Juan Puerto Rico	2,769	3,067	1,252	1,408
VISN 08	(673) MC Tampa Florida	4,077	4,755	1,827	2,191
VISN 08	(675) MC Orlando Florida	3,274	3,795	1,493	1,698
VISN 09	(596) MC Lexington Kentucky	1,392	1,499	849	942
VISN 09	(603) MC Louisville Kentucky	1,424	1,584	607	629
VISN 09	(614) MC Memphis Tennessee	1,624	1,731	928	1,067
VISN 09	(621) MC Mountain Home Tennessee	1,786	2,044	862	877
VISN 09	(626) HCS Nashville Tennessee	3,088	3,323	1,377	1,434
VISN 10	(506) HCS Ann Arbor Michigan	1,911	2,059	842	900
VISN 10	(515) MC Battle Creek Michigan	1,046	1,107	617	619

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 10	(538) MC Chillicothe Ohio	893	889	556	543
VISN 10	(539) MC Cincinnati Ohio	1,671	1,784	715	723
VISN 10	(541) MC Cleveland Ohio	3,480	3,611	1,672	1,731
VISN 10	(552) MC Dayton Ohio	1,486	1,490	850	822
VISN 10	(553) MC Detroit Michigan	1,307	1,392	704	707
VISN 10	(583) MC Indianapolis Indiana	2,110	2,302	1,070	1,134
VISN 10	(610) HCS Marion Indiana	1,171	1,283	778	847
VISN 10	(655) MC Saginaw Michigan	774	795	468	531
VISN 10	(757) OPC Columbus Ohio	900	986	445	453
VISN 12	(537) HCS Chicago Illinois	1,911	2,079	828	863
VISN 12	(550) MC Danville Illinois	848	818	579	612
VISN 12	(556) FHCC North Chicago Illinois	1,363	1,434	857	900
VISN 12	(578) MC Hines Illinois	2,796	3,116	1,357	1,540
VISN 12	(585) MC Iron Mountain Michigan	458	495	272	307
VISN 12	(607) MC Madison Wisconsin	1,621	1,879	709	837
VISN 12	(676) MC Tomah Wisconsin	817	921	453	503
VISN 12	(695) MC Milwaukee Wisconsin	2,796	3,050	1,439	1,464
VISN 15	(589) HCS Kansas City Missouri	1,467	1,640	783	819

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 15	(589CA) MC Columbia Missouri	1,169	1,373	588	639
VISN 15	(589EA) HCS Topeka Kansas	1,266	1,409	785	907
VISN 15	(589WA) Wichita Kansas	861	1,017	501	676
VISN 15	(657) HCS St Louis Missouri	2,185	2,343	1,246	1,345
VISN 15	(657MA) MC Marion Illinois	1,027	1,108	568	660
VISN 15	(657PA) MC Poplar Bluff Missouri	462	517	322	382
VISN 16	(502) MC Alexandria Louisiana	752	788	498	480
VISN 16	(520) MC Biloxi Mississippi	1,673	1,922	954	1,072
VISN 16	(564) MC Fayetteville Arizona	1,146	1,411	671	904
VISN 16	(580) MC Houston Texas	4,089	4,682	1,537	1,613
VISN 16	(586) MC Jackson Mississippi	1,231	1,247	679	708
VISN 16	(598) MC Little Rock Arizona	2,365	2,489	1,062	1,024
VISN 16	(629) MC New Orleans Louisiana	1,732	2,201	1,105	1,240
VISN 16	(667) MC Shreveport Louisiana	1,035	1,118	561	646
VISN 17	(504) MC Amarillo Texas	836	974	459	538
VISN 17	(519) MC Big Spring Texas	396	491	305	318
VISN 17	(549) HCS Dallas Texas	4,104	4,655	1,844	1,923
VISN 17	(671) HCS San Antonio Texas	3,159	3,698	1,485	1,663

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 17	(674) HCS Temple Texas	2,849	3,141	1,648	1,656
VISN 17	(740) HCS Harlingen Texas	716	913	455	665
VISN 17	(756) OC El Paso Texas	667	779	486	600
VISN 19	(436) HCS Fort Harrison Montana	834	945	550	680
VISN 19	(442) MROC Cheyenne Wyoming	656	751	367	408
VISN 19	(554) HCS Denver Colorado	2,499	2,912	1,205	1,366
VISN 19	(575) MC GR Junction Colorado	539	692	312	379
VISN 19	(623) MC Muskogee Oklahoma	1,042	1,203	624	792
VISN 19	(635) MC Oklahoma City Oklahoma	1,829	2,084	892	1,071
VISN 19	(660) HCS Salt Lake City Utah	1,902	2,141	1,065	1,511
VISN 19	(666) HCS Sheridan Wyoming	439	556	303	348
VISN 20	(463) HCSRO Anchorage Alaska	373	450	311	402
VISN 20	(531) MC Boise Idaho	1,056	1,294	522	645
VISN 20	(648) MC Portland Oregon	2,879	3,243	1,550	1,759
VISN 20	(653) HCS Roseburg Oregon	747	808	527	634
VISN 20	(663) HCS Seattle Washington	3,072	3,439	1,325	1,463

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 20	(668) MC Spokane Washington	889	1,058	468	594
VISN 20	(687) MC Walla Walla Washington	300	328	388	534
VISN 20	(692) SORCC White City Oregon	459	595	379	510
VISN 21	(358) RO Manila Philippines	35	55	33	38
VISN 21	(459) HCS Honolulu Hawaii	906	1,200	518	804
VISN 21	(570) HCS Fresno California	1,152	1,422	624	751
VISN 21	(593) MC Las Vegas Nevada	1,977	2,497	1,046	1,225
VISN 21	(612) HCS Martinez California	2,728	3,339	1,553	2,123
VISN 21	(640) HCS Palo Alto California	3,441	3,765	1,516	1,665
VISN 21	(654) HCS Reno Nevada	1,082	1,228	621	740
VISN 21	(662) MC San Francisco California	2,077	2,340	997	1,120
VISN 22	(501) HCS Albuquerque New Mexico	1,841	1,948	913	969
VISN 22	(600) HCS Long Beach California	2,533	3,116	968	1,037
VISN 22	(605) MC Loma Linda California	2,272	2,703	1,084	1,291
VISN 22	(644) MC Phoenix Arizona	2,589	2,991	1,231	1,271
VISN 22	(649) HCS Prescott Arizona	748	801	460	480
VISN 22	(664) HCS San Diego California	2,587	2,974	1,189	1,271

VISN	Station	Clinical Occupations		Non-Clinical Occupations	
		FY 2020	FY 2023 Projection	FY 2020	FY 2023 Projection
VISN 22	(678) HCS Tucson Arizona	2,019	2,346	954	1,071
VISN 22	(691) HCS W/Los Angeles California	3,522	3,803	1,730	1,717
VISN 23	(437) HCS Fargo North Dakota	822	882	431	469
VISN 23	(438) HCS Sioux Falls South Dakota	719	729	413	469
VISN 23	(568) HCS Fort Meade South Dakota	692	722	488	497
VISN 23	(618) HCS Minneapolis Minnesota	2,952	3,082	1,254	1,267
VISN 23	(636) HCS Omaha Nebraska	1,624	1,819	852	949
VISN 23	(636D) HCS Des Moines Iowa	1,084	1,154	537	576
VISN 23	(636I) MC Iowa City Iowa	1,412	1,447	678	749
VISN 23	(656) HCS St Cloud Minnesota	1,175	1,222	671	705

Appendix F: Appropriate Panel Sizes by Facility

(As of November 2022)

Column	Definition
PCP Panel Size	The average actual number of patients under a PCP's care (measured).
PCP Capacity Average	PCP average maximum number of patients that could be under a PCP's care (calculated).

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V01) (402) Togus, Maine	879	975	81%
(V01) (402GA) Caribou, Maine	990	1,038	88%
(V01) (402GB) Calais, Maine	873	846	77%
(V01) (402GC) Rumford, Maine	1,181	1,250	94%
(V01) (402GE) Lewiston, Maine	985	1,093	89%
(V01) (402GF) Lincoln, Maine	890	865	72%
(V01) (402HB) Bangor, Maine	3,368	1,075	84%
(V01) (402HC) Portland, Maine	970	1,166	79%
(V01) (402HL) Bingham, Maine - Mobile	425	1,018	42%
(V01) (402QA) Fort Kent, Maine	945	1,140	83%
(V01) (402QB) Houlton, Maine	750	1,195	63%
(V01) (405) White River Junction, Vermont	750	900	60%
(V01) (405GA) Bennington, Vermont	604	915	52%
(V01) (405GC) Brattleboro, Vermont	754	816	79%
(V01) (405HA) Burlington Lakeside, Vermont	643	906	52%
(V01) (405HC) Littleton, New Hampshire	694	923	71%
(V01) (405HE) Keene, New Hampshire	1,169	812	105%
(V01) (405HF) Rutland, Vermont	853	920	80%
(V01) (518) Bedford, Massachusetts (Edith Nourse Rogers)	1,090	1,120	91%
(V01) (518GA) Lynn, Massachusetts	935	1,039	90%
(V01) (518GB) Haverhill, Massachusetts	873	1,084	81%
(V01) (518GE) Gloucester, Massachusetts	701	891	67%
(V01) (523) Jamaica Plain, Massachusetts	910	1,156	78%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V01) (523A4) West Roxbury, Massachusetts	515	1,115	48%
(V01) (523A5) Brockton, Massachusetts	892	1,045	77%
(V01) (523BY) Lowell, Massachusetts	836	934	72%
(V01) (523BZ) Causeway, Massachusetts	729	960	65%
(V01) (523GA) Framingham, Massachusetts	1,036	1,083	90%
(V01) (523GC) Quincy, Massachusetts	884	893	76%
(V01) (523GD) Plymouth, Massachusetts	714	1,088	63%
(V01) (608) Manchester, New Hampshire	944	1,062	94%
(V01) (608GA) Portsmouth, New Hampshire	1,134	979	101%
(V01) (608GC) Somersworth, New Hampshire	960	1,185	81%
(V01) (608GD) Conway, New Hampshire	997	1,189	84%
(V01) (608HA) Tilton, New Hampshire	1,102	920	91%
(V01) (631) Central Western Massachusetts, Massachusetts (Edward P. Boland)	1,349	1,072	94%
(V01) (631BY) Springfield, Massachusetts	1,019	1,104	80%
(V01) (631GC) Pittsfield, Massachusetts	788	1,095	61%
(V01) (631GD) Greenfield, Massachusetts	735	1,096	58%
(V01) (631GE) Worcester, Massachusetts	904	1,066	78%
(V01) (631GF) Fitchburg, Massachusetts	881	1,065	76%
(V01) (650) Providence, Rhode Island	720	1,101	91%
(V01) (650GA) New Bedford, Massachusetts	1,076	993	99%
(V01) (650GB) Hyannis, Massachusetts	1,042	956	102%
(V01) (650GD) Middletown, Rhode Island	1,229	1,151	107%
(V01) (689) West Haven, Connecticut	559	1,000	53%
(V01) (689A4) Newington, Connecticut	761	940	84%
(V01) (689GA) Waterbury, Connecticut	722	1,069	60%
(V01) (689GB) Stamford, Connecticut	650	1,044	62%
(V01) (689GC) Willimantic, Connecticut	683	1,001	67%
(V01) (689GD) Winsted, Connecticut	885	914	85%
(V01) (689GE) Danbury, Connecticut	729	930	69%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V01) (689HC) New London, Connecticut (John J. McGuirk)	876	990	76%
(V02) (526) Bronx, New York (James J. Peters)	695	1,092	64%
(V02) (526GA) White Plains, New York	753	1,150	68%
(V02) (526GB) Yonkers, New York	773	1,368	60%
(V02) (526GD) Sunnyside, New York (Thomas P. Noonan Jr.)	710	1,368	54%
(V02) (528) Buffalo, New York	1,085	1,024	89%
(V02) (528A4) Batavia, New York	979	1,051	84%
(V02) (528A5) Canandaigua, New York	1,047	1,036	86%
(V02) (528A6) Bath, New York	919	1,031	80%
(V02) (528A7) Syracuse, New York	961	965	91%
(V02) (528A8) Albany, New York (Samuel S. Stratton)	879	1,108	74%
(V02) (528G2) Westport, New York	960	1,313	73%
(V02) (528G3) Bainbridge, New York	1,171	1,186	99%
(V02) (528G4) Elmira, New York	1,085	991	94%
(V02) (528G5) Auburn, New York	838	1,041	69%
(V02) (528G6) Fonda, New York	1,154	1,187	97%
(V02) (528G7) Catskill, New York	1,000	1,192	84%
(V02) (528G8) Wellsville, New York	979	1,006	97%
(V02) (528G9) Tompkins County, NY	1,110	992	97%
(V02) (528GB) Jamestown, New York	790	944	75%
(V02) (528GC) Dunkirk, New York	858	966	77%
(V02) (528GD) Niagara Falls, New York	863	1,173	73%
(V02) (528GK) Lockport, New York	1,163	955	99%
(V02) (528GL) Potsdam, New York	1,046	1,025	87%
(V02) (528GM) Rome, New York (Donald J. Mitchell)	889	994	83%
(V02) (528GN) Binghamton, New York	23,103	1,130	102%
(V02) (528GO) Watertown, New York	1,595	924	138%
(V02) (528GP) Oswego, New York	1,043	936	96%
(V02) (528GQ) West Seneca, New York	1,231	901	114%
(V02) (528GR) Olean, New York	954	883	93%
(V02) (528GT) Glens Falls, New York	1,251	1,006	112%
(V02) (528GV) Plattsburgh, New York	950	987	92%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V02) (528GW) Schenectady, New York	1,031	987	90%
(V02) (528GY) Clifton Park, New York	1,188	963	108%
(V02) (528GZ) Kingston, New York	1,061	986	94%
(V02) (528QC) Rochester Calkins, New York	1,126	1,037	96%
(V02) (528QE) Coudersport, Pennsylvania	650	1,080	60%
(V02) (528QF) Wellsboro, Pennsylvania	1,044	1,127	93%
(V02) (528QK) Saranac Lake, New York	1,185	1,308	91%
(V02) (561) East Orange, New Jersey	972	1,085	83%
(V02) (561A4) Lyons, New Jersey	748	945	75%
(V02) (561BZ) Brick, New Jersey (James J. Howard)	993	1,128	84%
(V02) (561GA) Hamilton, New Jersey	1,007	1,051	93%
(V02) (561GD) Hackensack, New Jersey	859	1,059	73%
(V02) (561GE) Jersey City, New Jersey	968	1,152	78%
(V02) (561GF) Piscataway, New Jersey	1,002	1,123	89%
(V02) (561GH) Morristown, New Jersey	1,432	1,138	89%
(V02) (561GI) Tinton Falls, New Jersey	1,475	983	88%
(V02) (561GJ) Paterson, New Jersey	768	1,141	68%
(V02) (561GK) Sussex, New Jersey	867	1,034	68%
(V02) (620) Montrose, New York (Franklin Delano Roosevelt)	1,066	1,154	85%
(V02) (620A4) Castle Point, New York	989	1,110	97%
(V02) (620GA) New City, New York	948	1,193	79%
(V02) (620GB) Carmel, New York	917	983	90%
(V02) (620GD) Goshen, New York	992	1,185	84%
(V02) (620GE) Port Jervis, New York	1,063	1,108	96%
(V02) (620GF) Monticello, New York	1,189	1,306	91%
(V02) (620GG) Poughkeepsie, New York	1,061	993	90%
(V02) (620GH) Eastern Dutchess, New York	875	1,190	74%
(V02) (630) Manhattan, New York (Margaret Cochran Corbin Campus)	1,083	1,013	91%
(V02) (630A4) Brooklyn, New York	954	976	75%
(V02) (630A5) St. Albans, New York	1,002	960	100%
(V02) (630GB) Staten Island, New York	959	1,042	92%
(V02) (632) Northport, New York	731	1,038	70%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V02) (632GA) East Meadow, New York	1,044	1,049	91%
(V02) (632HA) Valley Stream, New York	973	1,253	78%
(V02) (632HB) Riverhead, New York	821	1,136	72%
(V02) (632HC) Bay Shore, New York	1,032	1,141	95%
(V02) (632HD) Patchogue, New York	970	971	91%
(V04) (460) Wilmington, Delaware	1,097	1,140	91%
(V04) (460GA) Sussex County, Delaware	993	997	83%
(V04) (460GC) Kent County, Delaware	1,092	1,207	87%
(V04) (460GD) Cape May County, New Jersey	1,010	1,097	81%
(V04) (460HE) Atlantic County, New Jersey	1,153	965	100%
(V04) (460HG) Cumberland County, New Jersey	1,057	1,294	81%
(V04) (503) Altoona, PA (James E. Van Zandt)	997	1,015	83%
(V04) (503GA) Johnstown, Pennsylvania	1,093	967	93%
(V04) (503GB) DuBois, Pennsylvania	1,157	991	90%
(V04) (503GC) State College, Pennsylvania	956	944	85%
(V04) (503GD) Huntingdon County, Pennsylvania	688	1,040	60%
(V04) (503GE) Indiana County, Pennsylvania	987	902	82%
(V04) (529) Duffy Road, Pennsylvania (Abie Abraham)	850	1,000	74%
(V04) (529GA) Hermitage, Pennsylvania (Michael A. Marzano)	941	890	91%
(V04) (529GB) Lawrence County, Pennsylvania	842	990	76%
(V04) (529GC) Armstrong County, Pennsylvania	951	1,073	89%
(V04) (529GD) Clarion County, Pennsylvania	1,243	885	114%
(V04) (529GF) Cranberry Township, Pennsylvania	1,277	885	119%
(V04) (542) Coatesville, Pennsylvania	1,028	1,038	81%
(V04) (542GA) Delaware County, Pennsylvania	1,052	1,106	87%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V04) (542GE) West Norriton, Pennsylvania	950	1,111	81%
(V04) (562) Erie, Pennsylvania	922	977	81%
(V04) (562GA) Crawford County, Pennsylvania	792	991	70%
(V04) (562GB) Ashtabula County, Ohio	1,150	1,072	90%
(V04) (562GC) McKean County, Pennsylvania	1,020	1,189	86%
(V04) (562GD) Venango County, Pennsylvania	977	1,005	86%
(V04) (562GE) Warren County, Pennsylvania	1,204	1,036	102%
(V04) (595) Lebanon, Pennsylvania	1,022	1,011	84%
(V04) (595GA) Cumberland County, Pennsylvania	1,228	1,056	101%
(V04) (595GC) Lancaster County, Pennsylvania	1,061	1,144	90%
(V04) (595GD) Berks County, Pennsylvania	1,198	1,091	100%
(V04) (595GE) York, Pennsylvania	1,089	1,127	97%
(V04) (595GF) Schuylkill County, Pennsylvania	888	940	81%
(V04) (595QA) Annville, Pennsylvania (Fort Indiantown Gap)	823	893	69%
(V04) (642) Philadelphia, Pennsylvania (Corporal Michael J. Crescenz)	856	1,024	77%
(V04) (642GA) Burlington County, New Jersey	1,112	1,084	92%
(V04) (642GC) Horsham, Pennsylvania (Victor J. Saracini)	1,000	1,050	83%
(V04) (642GD) Gloucester County, New Jersey	983	848	97%
(V04) (642GF) Camden, New Jersey	814	1,092	73%
(V04) (642GH) West Philadelphia, Pennsylvania	593	1,107	53%
(V04) (646) Pittsburgh, Pennsylvania	751	1,061	62%
(V04) (646A4) Heinz, Pennsylvania (H. John Heinz III)	615	985	65%
(V04) (646GA) Belmont County, Ohio	1,563	1,001	126%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V04) (646GB) Westmoreland County, Pennsylvania	1,479	949	112%
(V04) (646GC) Beaver County, Pennsylvania	2,109	956	126%
(V04) (646GD) Washington County, Pennsylvania	1,893	1,065	133%
(V04) (646GE) Fayette County, Pennsylvania	897	956	92%
(V04) (693) Wilkes-Barre, Pennsylvania	872	1,143	80%
(V04) (693B4) Allentown, Pennsylvania	930	1,129	81%
(V04) (693GA) Sayre, Pennsylvania	775	1,089	64%
(V04) (693GB) Williamsport, Pennsylvania	980	970	88%
(V04) (693GC) Tobyhanna, Pennsylvania	898	1,252	72%
(V04) (693GF) Columbia County, Pennsylvania	1,029	1,024	92%
(V04) (693GG) Northampton County, Pennsylvania	980	1,266	76%
(V04) (693QA) Wayne County, Pennsylvania	627	887	60%
(V05) (512) Baltimore, Maryland	870	1,017	85%
(V05) (512A5) Perry Point, Maryland	902	1,098	85%
(V05) (512GA) Cambridge, Maryland	850	1,162	72%
(V05) (512GC) Glen Burnie, Maryland	999	1,084	92%
(V05) (512GD) Loch Raven, Maryland	930	1,174	82%
(V05) (512GE) Pocomoke City, Maryland	936	1,123	83%
(V05) (512GF) Eastern Baltimore County, Maryland	922	1,082	74%
(V05) (512GG) Fort Meade, Maryland	1,260	981	121%
(V05) (517) Beckley, West Virginia	985	1,040	83%
(V05) (517GB) Greenbrier County, West Virginia	1,151	1,009	96%
(V05) (517QA) Princeton, West Virginia	1,065	982	91%
(V05) (540) Clarksburg, West Virginia (Louis A. Johnson)	1,167	936	106%
(V05) (540GA) Tucker County, West Virginia	891	1,133	79%
(V05) (540GB) Wood County, West Virginia	1,783	1,199	86%

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VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V05) (540GC) Braxton County, West Virginia	935	1,131	83%
(V05) (540GD) Monongalia County, West Virginia	1,018	1,007	101%
(V05) (540HK) Clarksburg, West Virginia - Mobile	396	1,300	31%
(V05) (581) Huntington, West Virginia (Hershel "Woody" Williams)	965	998	89%
(V05) (581GA) Prestonsburg, Kentucky	1,044	795	117%
(V05) (581GB) Charleston, West Virginia	1,169	1,040	90%
(V05) (581GG) Gallipolis, Ohio	761	1,119	71%
(V05) (581GH) Lenore, West Virginia	591	1,137	52%
(V05) (613) Martinsburg, West Virginia	898	1,138	91%
(V05) (613GA) Cumberland, Maryland	992	1,051	84%
(V05) (613GB) Hagerstown, Maryland	1,085	1,097	95%
(V05) (613GC) Stephens City, Virginia	1,162	1,180	98%
(V05) (613GD) Franklin, West Virginia	560	1,370	41%
(V05) (613GE) Petersburg, West Virginia	690	1,194	58%
(V05) (613GF) Harrisonburg, West Virginia	1,019	1,234	83%
(V05) (613GG) Fort Detrick, Maryland	1,063	1,127	93%
(V05) (688) Washington, District of Columbia	976	1,013	98%
(V05) (688GA) Fort Belvoir, Virginia	1,139	942	113%
(V05) (688GB) Southeast Washington, District of Columbia	1,244	962	129%
(V05) (688GD) Charlotte Hall, Maryland	1,396	1,027	124%
(V05) (688GE) Southern Prince Georges County, Maryland	1,113	999	111%
(V05) (688GF) Montgomery County, Maryland	799	1,082	74%
(V05) (688GG) Lexington Park, Maryland	690	996	69%
(V06) (558) Durham, North Carolina	825	1,043	83%
(V06) (558GA) Greenville, North Carolina	872	1,018	83%
(V06) (558GB) Raleigh, North Carolina	767	1,112	75%
(V06) (558GC) Morehead City, North Carolina	919	1,094	85%
(V06) (558GE) Hillandale Road, North Carolina	1,028	1,005	93%

VHA Average Panel Sizes by Facility (As of October 2022)			
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(V06) (558GG) Raleigh-Atlantic Avenue, North Carolina	923	1,076	79%
(V06) (558GH) Clayton-East Raleigh, North Carolina	777	1,015	79%
(V06) (565GA) Jacksonville, North Carolina	1,006	963	87%
(V06) (565GC) Wilmington, North Carolina	1,009	994	91%
(V06) (565GD) Hamlet, North Carolina	1,027	1,092	80%
(V06) (565GE) Robeson County, North Carolina	1,159	990	95%
(V06) (565GF) Goldsboro, North Carolina	886	1,163	78%
(V06) (565GG) Lee County, North Carolina	1,097	1,149	87%
(V06) (565GH) Brunswick County, North Carolina	932	1,135	72%
(V06) (565GL) Cumberland County, North Carolina	1,121	988	102%
(V06) (590) Hampton, West Virginia	1,068	1,010	95%
(V06) (590GB) Virginia Beach, Virginia	1,179	1,036	100%
(V06) (590GC) Albemarle, North Carolina	985	932	85%
(V06) (590GD) Chesapeake, West Virginia	1,055	993	93%
(V06) (590GE) Portsmouth, West Virginia	924	1,043	76%
(V06) (637) Asheville, North Carolina (Charles George)	995	1,125	88%
(V06) (637GA) Franklin, North Carolina	1,022	1,058	90%
(V06) (637GB) Rutherford County, North Carolina	988	1,061	83%
(V06) (637GC) Hickory, North Carolina	1,018	1,020	90%
(V06) (652) Richmond, VA (Hunter Holmes McGuire)	1,139	1,043	100%
(V06) (652GB) Fredericksburg 2, Virginia	1,028	1,069	96%
(V06) (652GC) Henrico County, Virginia	1,077	1,115	98%
(V06) (652GE) Charlottesville, Virginia	878	1,209	70%
(V06) (652GF) Emporia, Virginia	1,019	1,259	81%
(V06) (652GI) Massaponax, Virginia	987	997	81%
(V06) (658) Salem, Virginia	866	935	82%
(V06) (658GA) Tazewell, Virginia	426	890	40%
(V06) (658GB) Danville, Virginia	1,046	921	102%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V06) (658GC) Lynchburg, Virginia	1,018	851	94%
(V06) (658GD) Staunton, Virginia	1,022	870	92%
(V06) (658GE) Wytheville, Virginia	883	1,009	80%
(V06) (659) Salisbury, North Carolina (W.G. (Bill) Hefner Salisbury)	957	1,003	96%
(V06) (659BY) Kernersville, North Carolina	1,143	1,086	101%
(V06) (659BZ) South Charlotte, North Carolina	1,128	1,107	97%
(V06) (659GA) North Charlotte, North Carolina	1,085	1,201	91%
(V07) (508) Atlanta, Georgia	1,208	1,099	109%
(V07) (508GA) Fort McPherson, Georgia	1,259	977	115%
(V07) (508GE) Oakwood, Georgia	1,297	1,174	114%
(V07) (508GF) West Cobb County, Georgia	1,302	1,163	112%
(V07) (508GG) Stockbridge, Georgia	1,206	1,059	112%
(V07) (508GH) Lawrenceville, Georgia	1,179	1,102	113%
(V07) (508GI) Newnan, Georgia	1,473	981	118%
(V07) (508GJ) Blairsville, Georgia	1,118	1,370	82%
(V07) (508GK) Carrollton, Georgia (Trinka Davis Village)	1,671	921	115%
(V07) (508GL) Rome, Georgia	1,159	977	101%
(V07) (508GM) Pickens County, Georgia	1,021	1,070	64%
(V07) (508GN) Covington, Georgia	1,407	1,199	117%
(V07) (508GO) Northeast Cobb County, Georgia	1,369	1,022	121%
(V07) (508GS) Pike County, Georgia	1,093	1,202	76%
(V07) (508QE) Gwinnett County, Georgia	1,210	1,046	110%
(V07) (508QF) Atlanta North Arcadia Avenue, Georgia	1,207	1,073	116%
(V07) (509A0) Augusta Uptown, Georgia	1,323	875	129%
(V07) (509GA) Athens, Georgia	1,216	919	118%
(V07) (509GB) Aiken, South Carolina	1,273	978	112%
(V07) (509QA) Statesboro, Georgia (Ray Hendrix)	1,017	905	97%
(V07) (521GA) Huntsville, Alabama	1,071	1,068	113%
(V07) (521GC) Florence, Alabama	1,098	1,058	89%

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VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V07) (521GD) Rainbow City, Alabama	1,066	1,046	102%
(V07) (521GE) Oxford, Alabama	1,200	1,026	100%
(V07) (521GF) Jasper, Alabama	887	1,249	71%
(V07) (521GG) Bessemer, Alabama	967	1,243	78%
(V07) (521GH) Childersburg, Alabama	1,050	1,185	89%
(V07) (521GI) Guntersville, Alabama	1,090	1,230	89%
(V07) (521GJ) Birmingham 7th Avenue South, AL	1,048	1,131	96%
(V07) (534BY) Savannah, Georgia	1,496	1,092	115%
(V07) (534GB) Myrtle Beach, South Carolina	1,804	1,120	139%
(V07) (534GC) Beaufort, South Carolina	1,899	947	166%
(V07) (534GD) Goose Creek, South Carolina	1,530	1,002	130%
(V07) (534GE) Hinesville, Georgia	1,418	1,141	118%
(V07) (534GF) North Charleston, South Carolina	1,681	1,130	126%
(V07) (544) Columbia, South Carolina (Wm. Jennings Bryan Dorn)	1,209	950	113%
(V07) (544BZ) Greenville, South Carolina	1,299	1,069	111%
(V07) (544GB) Florence, South Carolina	1,079	1,047	93%
(V07) (544GC) Rock Hill, South Carolina	1,133	1,091	95%
(V07) (544GD) Anderson, South Carolina	1,291	1,087	108%
(V07) (544GE) Orangeburg, South Carolina	976	1,058	75%
(V07) (544GF) Sumter, South Carolina	917	1,065	86%
(V07) (544GG) Spartanburg, South Carolina	1,375	1,202	114%
(V07) (557) Dublin, Georgia (Carl Vinson)	882	1,100	83%
(V07) (557GA) Macon, Georgia	1,111	1,067	103%
(V07) (557GB) Albany, Georgia	1,082	915	98%
(V07) (557GC) Milledgeville, Georgia	763	986	67%
(V07) (557GE) Brunswick, Georgia	1,287	1,229	92%
(V07) (557GF) Tifton, Georgia	1,134	1,038	91%
(V07) (557GG) Robins, Georgia	1,094	1,236	86%
(V07) (557HA) Perry, Georgia	1,162	1,177	98%

VHA Average Panel Sizes by Facility (As of October 2022)			
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(V07) (619A4) Tuskegee, Alabama (Central Alabama)	1,004	991	94%
(V07) (619GA) Columbus, Georgia (Robert S. Poydasheff)	911	1,115	82%
(V07) (619GD) Wiregrass, Alabama	1,359	1,201	91%
(V07) (619GE) Monroe County, Alabama	743	800	70%
(V07) (619GF) Central Alabama Montgomery, Alabama	1,397	1,082	116%
(V07) (619GG) Columbus Downtown, Georgia	1,055	1,141	92%
(V07) (619QA) Dothan 2, Alabama	1,439	804	136%
(V07) (619QB) Fort Benning, Georgia	1,102	1,195	92%
(V07) (679) Tuscaloosa, Alabama	798	1,030	81%
(V07) (679GA) Selma, Alabama	768	796	72%
(V08) (516) Bay Pines, Florida (C.W. Bill Young)	1,132	1,084	90%
(V08) (516BZ) Lee County, Florida	1,245	1,057	114%
(V08) (516GA) Sarasota, Florida	1,018	1,092	93%
(V08) (516GB) St. Petersburg, Florida	1,112	1,181	94%
(V08) (516GC) North Pinellas, Florida	1,107	1,232	90%
(V08) (516GD) Bradenton, Florida	1,175	1,070	110%
(V08) (516GE) Port Charlotte, Florida	1,166	1,134	103%
(V08) (516GF) Naples, Florida	1,113	1,078	103%
(V08) (516GH) Sebring, Florida	1,280	1,141	112%
(V08) (546) Miami, Florida (Bruce W. Carter)	762	1,222	60%
(V08) (546BZ) Sunrise, Florida (William "Bill" Kling)	1,133	1,147	93%
(V08) (546GA) Miami Flagler, Florida	274	1,140	24%
(V08) (546GB) Key West, Florida	725	1,065	68%
(V08) (546GC) Homestead, Florida	1,146	1,084	97%
(V08) (546GD) Pembroke Pines, Florida	1,115	1,116	100%
(V08) (546GE) Key Largo, Florida	903	800	85%
(V08) (546GF) Hollywood, Florida	1,115	1,169	83%
(V08) (546GH) Deerfield Beach, Florida	899	1,009	77%
(V08) (548) West Palm Beach, Florida	984	1,087	85%
(V08) (548GA) Fort Pierce, Florida	1,396	985	129%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V08) (548GB) Delray Beach, Florida	1,019	1,104	91%
(V08) (548GC) Stuart, Florida	1,405	838	146%
(V08) (548GD) Boca Raton, Florida	844	892	91%
(V08) (548GE) Vero Beach, Florida	1,136	1,056	99%
(V08) (548GF) Okeechobee, Florida	797	1,044	68%
(V08) (573) Gainesville, Florida (Malcom Randall)	1,061	1,117	91%
(V08) (573A4) Lake City, Florida	972	1,194	77%
(V08) (573BY) Jacksonville 1, Florida	958	1,048	98%
(V08) (573GA) Valdosta, Georgia	1,147	1,035	101%
(V08) (573GD) Ocala, Florida	1,054	1,111	86%
(V08) (573GE) Saint Augustine, Florida (Leo C. Chase Jr.)	876	1,134	88%
(V08) (573GF) Tallahassee, Florida (Sergeant Ernest I. "Boots" Thomas)	1,070	1,075	90%
(V08) (573GI) The Villages, Florida	931	1,153	86%
(V08) (573GJ) St. Marys, Georgia	1,305	924	116%
(V08) (573GK) Marianna, Florida	1,035	1,034	83%
(V08) (573GL) Palatka, Florida	1,093	1,032	93%
(V08) (573GM) Waycross, Georgia	943	1,156	81%
(V08) (573GN) Perry, Florida	789	1,193	66%
(V08) (573GO) Middleburg, Florida	1,023	1,028	103%
(V08) (573QG) Jacksonville Southpoint, Florida	1,130	1,031	111%
(V08) (573QJ) Jacksonville 2, Florida	920	986	100%
(V08) (573QK) Lake City Commerce Drive, Florida	706	1,094	77%
(V08) (672) San Juan, Puerto Rico	1,017	1,130	93%
(V08) (672B0) Ponce, Puerto Rico (Eurípides Rubio)	879	1,168	76%
(V08) (672BZ) Mayaguez, Puerto Rico	1,069	1,191	85%
(V08) (672GA) Saint Croix, Virgin Islands	987	1,221	81%
(V08) (672GB) Saint Thomas, Virgin Islands	747	1,232	61%
(V08) (672GC) Arecibo, Puerto Rico	948	1,155	82%
(V08) (672GD) Ceiba, Puerto Rico	1,329	1,258	78%
(V08) (672GE) Guayama, Puerto Rico	786	1,268	62%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V08) (672QA) Comerio, Puerto Rico	732	1,198	61%
(V08) (672QB) Utuado, Puerto Rico	588	1,255	47%
(V08) (672QC) Vieques, Puerto Rico	690	1,380	50%
(V08) (673) Tampa, FL (James A. Haley)	894	1,664	52%
(V08) (673BZ) New Port Richey, Florida	1,090	1,068	99%
(V08) (673GB) Lakeland, Florida	1,191	1,039	106%
(V08) (673GC) Brooksville, Florida	1,029	1,037	93%
(V08) (673GF) Zephyrhills, Florida	1,021	1,157	88%
(V08) (673GG) South Hillsborough, Florida	1,032	1,183	87%
(V08) (673GH) Lecanto, Florida	968	1,137	86%
(V08) (673QJ) Hidden River, Florida	1,045	1,175	94%
(V08) (675) Orlando, Florida	861	1,066	75%
(V08) (675GA) Viera, Florida	1,112	1,099	99%
(V08) (675GB) Daytona Beach, Florida (William V. Chappell, Jr.)	1,087	1,084	100%
(V08) (675GC) Kissimmee, Florida	1,211	1,048	108%
(V08) (675GD) Deltona, Florida	1,137	1,081	103%
(V08) (675GE) Tavares, Florida	1,068	1,099	97%
(V08) (675GF) Clermont, Florida	1,291	1,032	112%
(V08) (675GG) Lake Baldwin, Florida	1,103	1,104	96%
(V08) (675QG) Palm Bay, Florida	1,126	1,178	94%
(V09) (596) Lexington-Leestown, Kentucky (Franklin R. Sousley Campus)	970	1,092	83%
(V09) (596GA) Somerset, Kentucky	915	1,061	74%
(V09) (596GB) Morehead, Kentucky	1,034	990	91%
(V09) (596GC) Hazard, Kentucky	870	1,074	71%
(V09) (596GD) Berea, Kentucky	931	1,174	79%
(V09) (603GA) Fort Knox, Kentucky	949	947	95%
(V09) (603GB) New Albany, Indiana	1,017	1,108	86%
(V09) (603GC) Greenwood, Kentucky	923	1,054	83%
(V09) (603GD) Stonybrook, Kentucky	1,084	1,175	92%
(V09) (603GE) Newburg, Kentucky	1,039	1,039	92%
(V09) (603GF) Grayson County, Kentucky	897	1,038	79%
(V09) (603GG) Scott County, Indiana	1,203	1,108	95%
(V09) (603GH) Carrollton, Kentucky	984	1,098	74%
(V09) (614) Memphis, Tennessee	972	1,054	84%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V09) (614GA) Tupelo, Mississippi	1,094	1,031	92%
(V09) (614GB) Jonesboro, Arizona	1,104	1,046	88%
(V09) (614GC) Holly Springs, Mississippi	909	971	81%
(V09) (614GD) Savannah, Tennessee	997	1,094	78%
(V09) (614GE) Covington, Tennessee	1,249	1,218	96%
(V09) (614GF) Nonconnah Boulevard, Tennessee	958	1,143	76%
(V09) (614GG) Jackson, Tennessee	980	1,200	78%
(V09) (614GI) Dyersburg, Tennessee	1,105	924	105%
(V09) (614GN) Helena, Arizona	1,247	887	105%
(V09) (621) Mountain Home, Tennessee (James H. Quillen)	1,154	980	101%
(V09) (621BY) Knoxville, Tennessee (William C. Tallent)	1,098	1,072	96%
(V09) (621GA) Rogersville, Tennessee	963	994	84%
(V09) (621GC) Norton, Virginia	1,126	1,149	74%
(V09) (621GG) Morristown, Tennessee	791	941	78%
(V09) (621GI) Sevierville, Tennessee (Dannie A. Carr)	1,042	974	92%
(V09) (621GJ) Bristol, Virginia	914	1,023	77%
(V09) (621GK) Campbell County, Tennessee	970	1,081	78%
(V09) (621GO) Mountain City, Tennessee	993	1,131	88%
(V09) (626) Nashville, Tennessee	772	1,250	54%
(V09) (626A4) Murfreesboro, Tennessee (Alvin C. York)	995	1,130	76%
(V09) (626GA) Dover, Tennessee	579	1,042	47%
(V09) (626GC) Bowling Green, Kentucky	1,408	888	146%
(V09) (626GE) Clarksville, Tennessee	1,057	991	92%
(V09) (626GF) Chattanooga, Tennessee	1,116	1,109	90%
(V09) (626GG) Tullahoma, Tennessee	1,056	1,181	89%
(V09) (626GH) Cookeville, Tennessee	1,177	966	112%
(V09) (626GJ) Hopkinsville, Kentucky	1,547	922	163%
(V09) (626GK) McMinnville, Tennessee	1,339	796	126%
(V09) (626GL) Roane County, Tennessee	1,185	1,013	101%
(V09) (626GM) Columbia, Tennessee	1,524	925	140%
(V09) (626GN) Athens, Tennessee	1,230	1,088	98%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V09) (626GO) International Plaza, Tennessee	1,105	1,069	95%
(V09) (626GP) Gallatin, Tennessee	980	976	83%
(V09) (626QA) Albion Street, Tennessee	1,100	1,126	98%
(V09) (626QB) Charlotte Avenue, Tennessee	1,222	1,000	103%
(V10) (506) Ann Arbor, Michigan (Lieutenant Colonel Charles S. Kettles)	843	1,038	82%
(V10) (506GA) Toledo, Ohio	1,089	1,068	83%
(V10) (506GB) Flint, Michigan	1,001	1,243	81%
(V10) (506GC) Jackson, Michigan	898	1,247	72%
(V10) (506GD) Canton, Michigan	550	1,005	49%
(V10) (506GF) Adrian, Michigan	544	1,134	48%
(V10) (515) Battle Creek, Michigan	1,010	1,039	83%
(V10) (515BY) Wyoming, Michigan	1,228	1,084	95%
(V10) (515GA) Muskegon, Michigan	970	1,010	82%
(V10) (515GB) Lansing, Michigan	1,061	1,061	88%
(V10) (515GC) Benton Harbor, Michigan	978	1,090	75%
(V10) (538) Chillicothe, Ohio	1,003	1,052	84%
(V10) (538GA) Athens, Ohio	1,126	891	95%
(V10) (538GB) Portsmouth, Arizona	1,163	1,092	92%
(V10) (538GC) Marietta, Arizona	1,177	1,135	93%
(V10) (538GD) Lancaster, Ohio	1,012	1,116	83%
(V10) (538GE) Cambridge, Ohio	1,256	1,334	94%
(V10) (538GF) Wilmington, Ohio	1,045	1,248	84%
(V10) (539) Cincinnati, Ohio	897	1,060	77%
(V10) (539GA) Bellevue, Kentucky	749	1,041	63%
(V10) (539GB) Clermont County, Ohio	1,117	1,173	94%
(V10) (539GC) Dearborn, Indiana	1,109	1,252	89%
(V10) (539GD) Florence, Kentucky	1,047	1,118	85%
(V10) (539GE) Hamilton, Ohio	1,191	1,051	103%
(V10) (539GF) Georgetown, Ohio	915	974	84%
(V10) (541) Cleveland, Ohio (Louis Stokes Cleveland)	800	1,035	72%
(V10) (541BY) Canton, Ohio	1,198	966	103%
(V10) (541BZ) Youngstown, Ohio (Carl Nunziato)	1,135	1,074	95%

VHA Average Panel Sizes by Facility (As of October 2022)			
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(V10) (541GB) Lorain, Ohio	1,030	1,178	91%
(V10) (541GC) Sandusky, Ohio	1,097	1,116	94%
(V10) (541GD) Mansfield, Ohio (David F. Winder)	1,092	998	94%
(V10) (541GF) Lake County, Ohio	1,049	1,014	90%
(V10) (541GG) Akron, Ohio	1,044	1,006	94%
(V10) (541GH) East Liverpool, Ohio	1,083	1,045	101%
(V10) (541GI) Warren, Ohio	1,206	944	98%
(V10) (541GJ) New Philadelphia, Ohio	1,145	936	101%
(V10) (541GK) Ravenna, Ohio	1,077	1,045	100%
(V10) (541GL) Parma, Ohio	1,017	910	92%
(V10) (552) Dayton, Ohio	1,092	1,164	84%
(V10) (552GA) Middletown, Ohio	1,123	1,177	89%
(V10) (552GB) Lima, Ohio	1,005	950	89%
(V10) (552GC) Richmond, Indiana	882	998	73%
(V10) (552GD) Springfield, Ohio	897	1,086	75%
(V10) (552GF) Wright-Patterson, Ohio	664	999	66%
(V10) (553) Detroit, Michigan (John D. Dingell)	888	971	97%
(V10) (553GA) Yale, Michigan	1,112	819	100%
(V10) (553GB) Pontiac, Michigan	1,015	946	100%
(V10) (583) Indianapolis, Indiana (Richard L. Roudebush)	669	1,087	79%
(V10) (583GA) Terre Haute, Indiana	1,064	1,052	92%
(V10) (583GB) Bloomington, Indiana	1,092	958	98%
(V10) (583GC) Martinsville, Indiana	618	1,139	75%
(V10) (583GD) Brownsburg, Indiana	981	1,099	80%
(V10) (583GE) Lafayette, Indiana	943	921	87%
(V10) (583GF) Wakeman, Indiana	801	1,047	71%
(V10) (583GG) Shelbyville, Indiana	1,075	1,090	86%
(V10) (610) Marion, Indiana	2,453	925	97%
(V10) (610A4) Fort Wayne, Indiana	1,139	1,140	95%
(V10) (610BY) St. Joseph County, Indiana	993	964	87%
(V10) (610GB) Muncie, Indiana	951	1,039	82%
(V10) (610GD) Hoosier, Indiana	1,357	1,092	109%
(V10) (610GE) Defiance, Ohio	3,253	930	262%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V10) (655) Saginaw, Michigan (Aleda E. Lutz)	979	1,046	85%
(V10) (655GA) Gaylord, Michigan (Navy Corpsman Steve Andrews Health Care)	987	1,090	82%
(V10) (655GB) Traverse City, Michigan (Colonel Demas T. Craw)	1,146	990	94%
(V10) (655GC) Oscoda, Michigan	926	1,094	72%
(V10) (655GD) Alpena, Michigan (Lieutenant Colonel Clement C. Van Wagoner)	1,081	935	87%
(V10) (655GE) Clare, Michigan	1,224	917	100%
(V10) (655GF) Bad Axe, Michigan	1,073	958	84%
(V10) (655GG) Cadillac, Michigan	1,041	1,113	89%
(V10) (655GH) Cheboygan County, Michigan	631	983	58%
(V10) (655GI) Grayling, Michigan	943	848	83%
(V10) (757) Columbus, Ohio (Chalmers P. Wylie)	930	1,028	83%
(V10) (757GA) Zanesville, Ohio	884	1,119	73%
(V10) (757GB) Grove City, Ohio	926	1,170	77%
(V10) (757GC) Marion, Ohio	941	1,149	82%
(V10) (757GD) Newark, Ohio (Daniel L. Kinnard)	950	1,147	82%
(V12) (537) Chicago, Illinois (Jesse Brown)	685	1,063	66%
(V12) (537BY) Crown Point, Indiana (Adam Benjamin Jr.)	907	1,072	83%
(V12) (537GA) Chicago Heights, Illinois	934	1,114	78%
(V12) (537GD) Lakeside, Illinois	92	1,282	4%
(V12) (537HA) Auburn Gresham, Illinois	1,050	1,029	82%
(V12) (550) Danville, Illinois	991	1,120	79%
(V12) (550BY) Peoria, Illinois (Bob Michel)	1,080	1,100	88%
(V12) (550GA) Decatur, Illinois	903	1,014	73%
(V12) (550GD) Springfield, Illinois	1,089	913	101%
(V12) (550GF) Mattoon, Illinois	988	890	83%
(V12) (550GG) Bloomington, Illinois	935	958	81%
(V12) (556) North Chicago, Illinois (Captain James A. Lovell)	753	991	78%

VHA Average Panel Sizes by Facility (As of October 2022)			
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(V12) (556GA) Evanston, Illinois	599	1,098	55%
(V12) (556GC) McHenry, Illinois	1,204	1,065	110%
(V12) (556GD) Kenosha, Wisconsin	898	1,211	74%
(V12) (578) Hines, Illinois (Edward Hines Junior)	680	1,109	64%
(V12) (578GA) Joliet, Illinois	1,084	1,107	91%
(V12) (578GC) Kankakee County, Illinois	654	1,146	58%
(V12) (578GD) Aurora, Illinois	986	1,087	86%
(V12) (578GE) Hoffman Estates, Illinois	1,051	1,184	88%
(V12) (578GF) LaSalle, Illinois	744	1,150	59%
(V12) (578GG) Oak Lawn, Illinois	952	1,051	82%
(V12) (585) Iron Mountain, Michigan (Oscar G. Johnson)	935	892	83%
(V12) (585GA) Hancock, Michigan	1,283	1,190	108%
(V12) (585GB) Rhinelander, Wisconsin	1,114	861	97%
(V12) (585GC) Menominee, Michigan	1,016	1,170	82%
(V12) (585GD) Ironwood, Michigan	1,168	1,247	94%
(V12) (585GF) Manistique, Michigan	1,005	934	81%
(V12) (585GG) Gladstone, Michigan	900	1,057	73%
(V12) (585HA) Marquette, Michigan	965	959	85%
(V12) (585HB) Sault Saint Marie, Michigan	1,053	978	91%
(V12) (607) Madison, WI (William S. Middleton)	520	704	62%
(V12) (607GC) Janesville, Wisconsin	993	921	85%
(V12) (607GD) Baraboo, Wisconsin	1,408	1,016	104%
(V12) (607GE) Beaver Dam, Wisconsin	811	871	72%
(V12) (607GF) Freeport, Illinois	970	1,094	77%
(V12) (607GG) Madison West, Wisconsin	1,014	1,110	86%
(V12) (607HA) Rockford, Illinois	1,011	1,094	81%
(V12) (676) Tomah, Wisconsin	1,148	945	86%
(V12) (676GA) Wausau, Wisconsin	1,037	1,009	85%
(V12) (676GC) La Crosse, Wisconsin	1,249	963	109%
(V12) (676GD) Wisconsin Rapids, Wisconsin	1,358	1,056	113%
(V12) (676GE) Clark County, Wisconsin	1,317	891	111%
(V12) (695) Milwaukee, Wisconsin (Clement J. Zablocki)	791	968	78%

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(V12) (695BY) Appleton, Wisconsin (John H. Bradley)	907	959	76%
(V12) (695GA) Union Grove, Wisconsin	940	1,037	82%
(V12) (695GC) Cleveland, Wisconsin	1,018	953	86%
(V12) (695GD) Green Bay, Wisconsin (Milo C. Huempfner)	846	951	73%
(V15) (589) Kansas City, Missouri	1,089	1,094	91%
(V15) (589A4) Columbia, Missouri (Harry S. Truman)	1,060	1,079	88%
(V15) (589A5) Topeka, Kansas (Colmery-ONeil)	916	1,010	78%
(V15) (589A6) Leavenworth, Kansas (Dwight D. Eisenhower)	988	1,023	84%
(V15) (589A7) Wichita, Kansas (Robert J. Dole)	1,160	1,117	96%
(V15) (589G1) Warrensburg, Missouri	1,007	1,084	79%
(V15) (589G2) Dodge City, Kansas	5,330	1,014	166%
(V15) (589G4) Hays, Kansas	781	1,067	63%
(V15) (589G5) Parsons, Kansas	1,005	1,076	80%
(V15) (589G7) Hutchinson, Kansas	896	887	95%
(V15) (589G8) Jefferson City, Missouri	851	1,173	73%
(V15) (589GB) Belton, Missouri	1,366	1,201	114%
(V15) (589GC) Paola, Kansas	1,451	988	110%
(V15) (589GD) Nevada, Missouri	1,028	894	86%
(V15) (589GE) Kirksville, Missouri	1,239	1,027	104%
(V15) (589GF) Waynesville, Missouri	1,145	1,113	96%
(V15) (589GH) Camdenton, Missouri	746	998	64%
(V15) (589GI) St. Joseph, Missouri	1,290	1,008	100%
(V15) (589GJ) Kansas City Kansas, Kansas	506	1,265	62%
(V15) (589GM) Chanute, Kansas	983	803	92%
(V15) (589GP) Garnett, Kansas	741	808	69%
(V15) (589GR) Junction City, Kansas (Lieutenant General Richard J. Seitz-Based)	998	935	87%
(V15) (589GU) Lawrence, Kansas	951	1,017	79%
(V15) (589GV) Fort Scott, Kansas	759	893	64%
(V15) (589GW) Salina, Kansas	983	912	91%

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(V15) (589GX) Mexico, Missouri	799	1,107	71%
(V15) (589GY) St. James, Missouri	1,097	985	93%
(V15) (589JA) Sedalia, Missouri	904	1,104	69%
(V15) (589JB) Excelsior Springs, Missouri	1,364	1,206	97%
(V15) (589JC) Shawnee, Kansas	808	1,060	76%
(V15) (589JD) Marshfield, Missouri	716	1,129	63%
(V15) (589JE) Platte City, Missouri	1,041	1,127	92%
(V15) (589JF) Honor, Missouri	1,170	1,017	111%
(V15) (589JG) Lenexa, Kansas	1,459	1,058	87%
(V15) (589QD) Wichita, Kansas - Mobile	1,547	840	138%
(V15) (657) St. Louis, Missouri (John J. Cochran)	688	1,121	46%
(V15) (657A0) St. Louis Jefferson Barracks, Missouri	1,074	1,091	87%
(V15) (657A4) Poplar Bluff, Missouri (John J. Pershing)	923	978	77%
(V15) (657A5) Marion, Illinois	1,205	849	106%
(V15) (657GA) St. Clair County, Illinois	1,130	1,044	100%
(V15) (657GB) St. Louis County, Missouri	1,246	997	112%
(V15) (657GD) St. Charles County, Missouri	1,099	1,108	99%
(V15) (657GF) West Plains, Missouri	819	1,152	68%
(V15) (657GG) Paragould, Arizona	710	965	64%
(V15) (657GH) Cape Girardeau, Missouri	958	983	84%
(V15) (657GI) Farmington, Missouri	876	1,078	75%
(V15) (657GJ) Evansville, Indiana	904	1,145	80%
(V15) (657GK) Mount Vernon, Illinois	836	940	71%
(V15) (657GL) Paducah, Kentucky	1,085	961	88%
(V15) (657GM) Effingham, Illinois	784	1,214	65%
(V15) (657GO) Madisonville, Kentucky	976	1,193	82%
(V15) (657GP) Owensboro, Kentucky	959	1,106	79%
(V15) (657GQ) Vincennes, Indiana	792	1,102	72%
(V15) (657GR) Mayfield, Kentucky	825	887	75%
(V15) (657GS) Franklin County, Missouri	1,258	1,019	105%
(V15) (657GT) Carbondale, Illinois	852	1,249	68%
(V15) (657GU) Harrisburg, Illinois	785	1,075	63%
(V15) (657GV) Sikeston, Missouri	773	803	72%

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(V15) (657GW) Pocahontas, Arizona	977	845	87%
(V15) (657GX) Washington Avenue, Missouri	1,012	1,134	92%
(V15) (657GY) Manchester Avenue, Missouri	1,334	1,083	100%
(V15) (657QA) Olive Street, Missouri	968	1,161	83%
(V15) (657QD) Heartland Street, Illinois	870	1,071	74%
(V16) (502) Alexandria, Louisiana	1,042	1,048	88%
(V16) (502GA) Jennings, Louisiana	559	1,251	45%
(V16) (502GB) Lafayette, Louisiana	1,045	1,195	88%
(V16) (502GE) Lake Charles, Louisiana (Douglas Fournet)	951	1,078	77%
(V16) (502GF) Fort Polk, Louisiana	1,059	958	92%
(V16) (502GG) Natchitoches, Louisiana	913	1,184	77%
(V16) (520) Biloxi, Mississippi	1,465	1,014	128%
(V16) (520BZ) Pensacola, Florida	1,221	1,078	114%
(V16) (520GA) Mobile, Alabama	1,272	943	111%
(V16) (520GB) Panama City Beach, Florida	1,163	1,114	104%
(V16) (520GC) Eglin Air Force Base, Florida	1,869	1,168	160%
(V16) (564) Fayetteville, Arizona	996	1,073	88%
(V16) (564BY) Springfield, Missouri (Gene Taylor)	1,127	1,068	89%
(V16) (564GA) Harrison, Arizona	944	1,117	72%
(V16) (564GB) Fort Smith, Arizona	1,093	1,035	94%
(V16) (564GC) Branson, Missouri	959	1,070	75%
(V16) (564GD) Ozark, Arizona	1,449	801	136%
(V16) (564GE) Jay, Oklahoma	854	1,061	70%
(V16) (564GF) Joplin, Missouri	1,189	1,025	101%
(V16) (580) Houston, Texas (Michael E. DeBakey)	1,008	1,091	85%
(V16) (580BY) Beaumont, Texas	1,071	1,191	90%
(V16) (580BZ) Lufkin, Texas (Charles Wilson)	1,211	1,076	95%
(V16) (580GC) Galveston County, Texas	1,009	794	95%
(V16) (580GD) Conroe, Texas	1,544	1,158	111%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V16) (580GE) Katy, Texas	964	1,175	107%
(V16) (580GF) Lake Jackson, Texas	815	1,141	74%
(V16) (580GG) Richmond, Texas	1,139	1,074	98%
(V16) (580GH) Tomball, Texas	1,398	1,085	110%
(V16) (580GJ) Texas City, Texas	1,552	1,098	141%
(V16) (580GK) Kingwood, Texas	1,032	1,150	90%
(V16) (580GL) Sugar Land, Texas	1,173	973	102%
(V16) (586) Jackson, MS (G.V. (Sonny) Montgomery)	1,220	1,057	97%
(V16) (586GA) Kosciusko, MS	1,032	845	92%
(V16) (586GB) Meridian, MS	1,110	925	102%
(V16) (586GC) Greenville, Mississippi	947	754	94%
(V16) (586GD) Hattiesburg, Mississippi	1,139	843	106%
(V16) (586GE) Natchez, Mississippi	949	882	81%
(V16) (586GF) Columbus, Mississippi	1,172	905	97%
(V16) (586GG) McComb, Mississippi	1,086	852	96%
(V16) (598) Little Rock, Arizona (John L. McClellan)	1,061	881	103%
(V16) (598A0) North Little Rock, Arizona (Eugene J. Towbin Healthcare Center)	1,072	1,092	93%
(V16) (598GA) Mountain Home, Arizona	1,091	978	90%
(V16) (598GB) El Dorado, Arizona	1,166	952	107%
(V16) (598GC) Hot Springs, Arizona	987	1,038	80%
(V16) (598GD) Mena, Arizona	763	758	76%
(V16) (598GE) Pine Bluff, Arizona	1,024	987	87%
(V16) (598GF) Searcy, Arizona	958	920	85%
(V16) (598GG) Conway, Arizona	1,063	1,035	89%
(V16) (598GH) Russellville, Arizona	933	1,098	85%
(V16) (629) New Orleans, Louisiana	1,186	1,095	93%
(V16) (629BY) Baton Rouge, Louisiana	1,045	1,109	88%
(V16) (629GA) Houma, Louisiana	1,277	915	114%
(V16) (629GB) Hammond, Louisiana	1,209	1,152	99%
(V16) (629GC) Slidell, Louisiana	984	1,148	84%
(V16) (629GD) St. John, Louisiana	828	1,209	68%
(V16) (629GE) Franklin, Louisiana	1,073	931	86%
(V16) (629GF) Bogalusa, Louisiana	1,020	1,181	86%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V16) (667) Shreveport, Louisiana (Overton Brooks)	1,031	1,084	84%
(V16) (667GA) Texarkana, AR	1,053	1,101	89%
(V16) (667GB) Monroe, Louisiana	883	1,160	86%
(V16) (667GC) Longview, Texas	1,097	1,081	97%
(V17) (504) Amarillo, Texas (Thomas E. Creek)	1,086	1,013	90%
(V17) (504BY) Lubbock, Texas	1,120	1,043	92%
(V17) (504BZ) Clovis, New Mexico	947	817	87%
(V17) (504GA) Childress, Texas	891	936	71%
(V17) (504HB) Dalhart, Texas	453	986	34%
(V17) (519) Big Spring, Texas (George H. OBrien, Jr.)	813	1,072	83%
(V17) (519GA) Permian Basin, Texas (Wilson and Young Medal of Honor)	1,069	1,129	87%
(V17) (519GB) Hobbs, New Mexico	692	904	74%
(V17) (519GD) Fort Stockton, Texas	498	1,010	49%
(V17) (519HC) Abilene, Texas	1,108	1,058	99%
(V17) (519HF) San Angelo, Texas	968	1,180	75%
(V17) (549) Dallas, Texas	1,032	1,199	93%
(V17) (549A4) Bonham, Texas (Sam Rayburn Center)	996	1,115	90%
(V17) (549A5) Garland, Texas	1,114	1,195	93%
(V17) (549BY) Fort Worth, Texas	1,180	1,040	110%
(V17) (549GD) Denton, Texas	1,454	932	135%
(V17) (549GE) Decatur, Texas	1,241	901	116%
(V17) (549GF) Granbury, Texas	1,413	887	137%
(V17) (549GH) Greenville, Texas	1,625	853	139%
(V17) (549GJ) Sherman, Texas	1,001	878	106%
(V17) (549GK) Polk Street, Texas	1,138	1,122	101%
(V17) (549GL) Plano, Texas	1,327	1,149	114%
(V17) (549GM) Grand Prairie, Texas	1,271	1,254	101%
(V17) (549QC) Tyler Broadway, Texas	1,280	1,183	108%
(V17) (671) San Antonio, Texas (Audie L. Murphy)	986	1,040	89%
(V17) (671A4) Kerrville, Texas	1,049	1,126	89%
(V17) (671GB) Victoria, Texas	857	1,000	76%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V17) (671GF) South Bexar County, Texas	931	985	90%
(V17) (671GK) San Antonio Fredericksburg Road, Texas	993	816	105%
(V17) (671GL) New Braunfels, Texas	1,251	839	129%
(V17) (671GN) Seguin, Texas	1,905	793	180%
(V17) (671GO) North Central Federal, Texas	929	1,092	96%
(V17) (671GP) Balcones Heights, Texas	1,085	1,095	99%
(V17) (671GQ) Shavano Park, Texas	1,067	1,055	101%
(V17) (671GR) North Bexar, Texas	811	1,071	81%
(V17) (671GS) Northwest San Antonio, Texas	1,162	1,039	102%
(V17) (674) Temple, Texas (Olin E. Teague Center)	1,174	1,132	79%
(V17) (674A4) Waco, Texas (Doris Miller)	1,128	1,166	91%
(V17) (674BY) Austin, Texas	1,023	1,093	81%
(V17) (674GA) Palestine, Texas	1,008	1,009	82%
(V17) (674GB) Brownwood, Texas	838	1,091	68%
(V17) (674GC) Bryan, Texas	1,027	1,178	87%
(V17) (674GD) Cedar Park, Texas	973	1,088	86%
(V17) (674GF) Temple South General Bruce Drive, Texas	1,016	1,018	88%
(V17) (674HB) LaGrange, Texas	772	1,058	83%
(V17) (740GA) Harlingen Treasure Hills, Texas	1,110	1,113	92%
(V17) (740GB) McAllen, Texas	990	999	90%
(V17) (740GC) Corpus Christi, Texas	1,075	1,072	97%
(V17) (740GD) Laredo, Texas	1,114	1,046	90%
(V17) (756) El Paso, Texas	713	1,025	85%
(V17) (756GA) Las Cruces, New Mexico	1,477	959	120%
(V17) (756GB) El Paso Eastside, Texas	1,139	1,080	94%
(V17) (756GC) El Paso Westside, Texas	1,237	1,104	116%
(V17) (756GD) El Paso Northeast, Texas	1,146	958	92%
(V19) (436) Fort Harrison, Montana	1,050	981	92%
(V19) (436GA) Anaconda, Montana	851	1,030	72%
(V19) (436GB) Great Falls, Montana	1,026	936	86%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V19) (436GC) Missoula, Montana (David J. Thatcher)	1,730	1,201	98%
(V19) (436GD) Bozeman, Montana (Travis W. Atkins)	906	979	82%
(V19) (436GF) Kalispell, Montana	1,006	1,198	90%
(V19) (436GI) Glasgow, Montana	978	1,248	78%
(V19) (436GK) Glendive, Montana	809	1,027	59%
(V19) (436GL) Cut Bank, Montana	1,016	1,026	74%
(V19) (436GM) Lewistown, Montana	1,200	1,024	88%
(V19) (436GN) Billings Spring Creek Lane, MT (Dr. Joseph Medicine Crow)	1,032	1,024	90%
(V19) (436HC) Havre, Montana (Merril Lundman)	873	1,360	64%
(V19) (436QA) Hamilton, Montana	1,228	1,358	90%
(V19) (436QB) Plentywood, Montana	720	1,025	53%
(V19) (436QE) Miles City, Montana	1,215	1,306	93%
(V19) (442) Cheyenne, West Virginia	1,024	1,097	84%
(V19) (442GB) Sidney, Nebraska	1,118	937	90%
(V19) (442GD) Loveland, Colorado	1,020	1,074	88%
(V19) (442GE) Northern Colorado, Colorado	1,070	1,032	95%
(V19) (442HK) Wheatland, West Virginia - Mobile	1,125	1,031	82%
(V19) (442QA) Rawlins, West Virginia	972	937	78%
(V19) (442QB) Torrington, West Virginia - Mobile	1,038	935	83%
(V19) (442QD) Laramie, West Virginia - Mobile	988	846	88%
(V19) (442QE) Sterling, Colorado	1,094	846	97%
(V19) (554) Aurora, Colorado (Rocky Mountain Regional)	837	1,096	88%
(V19) (554GB) Aurora, Colorado	1,200	995	117%
(V19) (554GC) Golden, Colorado	1,206	979	103%
(V19) (554GD) Pueblo, Colorado (PFC James Dunn)	1,189	1,013	98%
(V19) (554GE) Colorado Springs, Colorado (PFC Floyd K. Lindstrom)	1,176	954	110%
(V19) (554GF) Alamosa, Colorado	1,229	842	110%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V19) (554GG) La Junta, Colorado	2,232	1,014	165%
(V19) (554GH) Lamar, Colorado	1,072	1,030	78%
(V19) (554GI) Burlington, Colorado	866	1,192	73%
(V19) (554GK) Union Boulevard, CO Colorado	1,291	1,004	112%
(V19) (554QC) Salida, Colorado	25,667	700	2750%
(V19) (575) Grand Junction, Colorado	924	1,057	74%
(V19) (575GA) Montrose, Colorado	1,102	1,161	95%
(V19) (575GB) Craig, Colorado (Major William Edward Adams)	1,106	1,308	85%
(V19) (575QA) Glenwood Springs, Colorado	1,386	1,298	107%
(V19) (575QB) Moab, Utah	1,075	1,365	79%
(V19) (575QC) Grand Junction, Colorado - Mobile	745	1,280	58%
(V19) (623) Muskogee, Oklahoma (Jack C. Montgomery)	950	1,116	81%
(V19) (623BY) Tulsa, Oklahoma (Ernest Childers)	1,014	1,217	84%
(V19) (623GA) McAlester, Oklahoma	853	981	73%
(V19) (623GB) Vinita, Oklahoma	742	1,107	60%
(V19) (623GC) McCurtain County, Oklahoma	967	1,189	81%
(V19) (635) Oklahoma City, Oklahoma	1,067	1,080	94%
(V19) (635GA) Lawton, Oklahoma	1,183	1,037	98%
(V19) (635GB) Wichita Falls, Texas	1,048	998	112%
(V19) (635GC) Blackwell, Oklahoma	1,196	1,363	88%
(V19) (635GD) Ada, Oklahoma	1,138	773	119%
(V19) (635GE) Stillwater, Oklahoma	1,037	983	92%
(V19) (635GF) Altus, Oklahoma	1,130	1,236	91%
(V19) (635GG) Enid, Oklahoma	769	933	71%
(V19) (635GH) Clinton, Oklahoma	597	939	56%
(V19) (635GI) Norman, Oklahoma	1,108	1,161	95%
(V19) (635GJ) Yukon, Oklahoma	1,129	1,115	101%
(V19) (635HB) Ardmore, Oklahoma	1,113	799	105%
(V19) (635QA) North May, Oklahoma	1,195	1,134	105%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V19) (635QB) South Oklahoma City, Oklahoma	1,124	1,073	97%
(V19) (635QE) Tinker, Oklahoma	819	1,004	82%
(V19) (660) Salt Lake City, Utah (George E. Wahlen)	561	962	56%
(V19) (660GA) Pocatello, Idaho	814	920	68%
(V19) (660GB) Ogden, Utah	1,192	907	103%
(V19) (660GD) Roosevelt, Utah	925	1,010	70%
(V19) (660GE) Orem, Utah	869	942	79%
(V19) (660GG) St. George, Utah	1,086	935	104%
(V19) (660GJ) South Jordan, Utah	875	936	76%
(V19) (660GK) Elko, Nevada	893	844	79%
(V19) (660QA) Idaho Falls, Idaho	891	820	87%
(V19) (660QB) Price, Utah	660	1,073	61%
(V19) (660QD) Cache Valley, Utah	1,416	932	114%
(V19) (666) Sheridan, Wyoming	840	1,168	72%
(V19) (666GB) Casper, Wyoming	969	983	82%
(V19) (666GC) Riverton, Wyoming	794	920	75%
(V19) (666GD) Cody, Wyoming	3,443	1,000	258%
(V19) (666GE) Gillette, Wyoming	890	1,142	78%
(V19) (666GF) Rock Springs, Wyoming	919	839	82%
(V19) (666QA) Afton, Wyoming	800	1,069	75%
(V19) (666QB) Evanston, Wyoming	790	914	75%
(V19) (666QC) Worland, Wyoming	1,207	1,240	97%
(V20) (463) Anchorage, Alaska	934	1,104	75%
(V20) (463GA) Fairbanks, Alaska	888	903	79%
(V20) (463GB) Soldotna, Alaska	904	1,046	74%
(V20) (463GC) Mat-Su, Alaska	1,107	1,080	89%
(V20) (463GD) Homer, Alaska	755	1,183	61%
(V20) (463GE) Juneau, Alaska	701	846	62%
(V20) (531) Boise, Idaho	899	959	74%
(V20) (531GE) Twin Falls, Idaho	903	832	86%
(V20) (531GG) Caldwell, Idaho	1,200	970	103%
(V20) (531GH) Eastern Oregon, OR	1,051	888	89%
(V20) (531GI) Mountain Home, Idaho	976	798	88%
(V20) (531GJ) Salmon, Idaho	944	845	84%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V20) (648) Portland, Oregon	1,299	829	99%
(V20) (648A4) Portland Vancouver, Washington	1,191	1,059	104%
(V20) (648GA) Bend, Oregon (Robert D. Maxwell)	1,210	985	101%
(V20) (648GB) Salem, Oregon	919	960	77%
(V20) (648GD) North Coast, Oregon	720	913	67%
(V20) (648GE) Fairview, Oregon	1,058	983	89%
(V20) (648GF) Hillsboro, Oregon	938	1,090	80%
(V20) (648GG) West Linn, Oregon	1,011	1,146	86%
(V20) (648GH) Newport, Oregon	1,141	905	94%
(V20) (648GJ) The Dalles, Oregon (Loren R. Kaufman)	1,000	889	81%
(V20) (653) Roseburg, Oregon	868	973	70%
(V20) (653BY) Eugene, Oregon	993	1,090	83%
(V20) (653GA) North Bend, Oregon	999	1,037	82%
(V20) (653GB) Brookings, Oregon	775	892	65%
(V20) (663) Seattle, Washington	951	1,018	80%
(V20) (663A4) American Lake, Washington	944	959	90%
(V20) (663GB) Silverdale, Washington	906	1,011	77%
(V20) (663GC) Mount Vernon, Washington	1,170	959	106%
(V20) (663GE) North Olympic Peninsula, Washington	798	943	91%
(V20) (663GH) Edmonds, Washington	1,024	1,029	88%
(V20) (663GI) Olympia, Washington	1,039	901	94%
(V20) (663GJ) Puyallup, Washington	1,303	946	79%
(V20) (663GK) Everett, Washington	823	1,106	74%
(V20) (668) Spokane, Washington (Mann-Grandstaff)	987	1,036	83%
(V20) (668GA) Wenatchee, Washington	992	1,247	79%
(V20) (668GB) Coeur d Alene, Idaho	978	998	84%
(V20) (668GC) East Front Avenue, Washington	897	1,340	67%
(V20) (668HK) Spokane, Washington - Mobile	267	763	26%
(V20) (668QB) Libby, Montana	911	845	84%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V20) (668QD) Sandpoint, Idaho	1,494	1,302	115%
(V20) (687) Walla Walla, Washington (Jonathan M. Wainwright)	1,067	1,138	82%
(V20) (687GA) Richland, Washington	1,005	1,065	86%
(V20) (687GB) Lewiston, Idaho	1,096	889	92%
(V20) (687GC) La Grande, Oregon	598	940	48%
(V20) (687HA) Yakima, Washington	911	1,013	82%
(V20) (692) White City, Oregon	888	921	75%
(V20) (692GA) Klamath Falls, Oregon	917	1,016	75%
(V20) (692GB) Grants Pass, Oregon	965	952	84%
(V21) (459) Honolulu, Hawaii (Spark M. Matsunaga)	1,058	1,098	96%
(V21) (459GA) Maui, Hawaii	770	1,111	70%
(V21) (459GB) Hilo, Hawaii	938	1,107	85%
(V21) (459GC) Kailua-Kona, Hawaii	536	1,086	50%
(V21) (459GD) Lihue, Hawaii	969	1,234	76%
(V21) (459GE) Guam, Guåhan	718	1,156	68%
(V21) (459GF) American Samoa, American Samoa (Faleomavaega Eni Faauaa Hunkin)	524	1,072	49%
(V21) (459GG) Leeward Oahu, Hawaii	897	1,049	82%
(V21) (459GH) Saipan, Northern Marina Islands	1,620	995	163%
(V21) (459QA) Lanai, Hawaii	2,700	1,000	270%
(V21) (459QB) Molokai, Hawaii	233	1,016	23%
(V21) (459QC) Windward, Hawaii	896	1,154	77%
(V21) (570) Fresno, California	877	1,227	71%
(V21) (570GA) Merced, California	1,564	1,171	98%
(V21) (570GB) Tulare, California	1,038	1,129	84%
(V21) (570GC) Oakhurst, California	827	1,130	63%
(V21) (593) North Las Vegas, Nevada	1,167	942	106%
(V21) (593GC) Pahrump, Nevada	997	969	84%
(V21) (593GD) Northwest Las Vegas, Nevada	1,243	1,005	109%
(V21) (593GE) Southeast Las Vegas, Nevada	1,150	1,058	97%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V21) (593GF) Southwest Las Vegas, Nevada	1,232	1,059	105%
(V21) (593GG) Northeast Las Vegas, Nevada	1,062	1,038	89%
(V21) (593GH) Laughlin, Nevada (Master Chief Petty Officer Jesse Dean)	1,263	889	107%
(V21) (612A4) Sacramento, California	795	1,098	84%
(V21) (612B4) Redding, California	1,184	1,115	100%
(V21) (612GD) Fairfield, California	1,045	1,031	93%
(V21) (612GE) Mare Island, California	925	1,144	84%
(V21) (612GF) Martinez, California	907	1,083	83%
(V21) (612GG) Chico, California	990	1,108	85%
(V21) (612GH) McClellan Park, California	1,066	1,125	95%
(V21) (612GI) Yuba City, California	844	975	78%
(V21) (612GJ) Yreka, California	993	1,251	79%
(V21) (612GK) Sierra Foothills, California	1,234	1,266	97%
(V21) (612QE) Stockton, California	868	1,095	79%
(V21) (640) Palo Alto, California	599	1,230	64%
(V21) (640A4) Livermore, California	872	1,063	83%
(V21) (640BY) San Jose, California	483	1,124	76%
(V21) (640GA) Capitola, California	1,213	798	114%
(V21) (640GB) Sonora, California	900	1,048	75%
(V21) (640GC) Fremont, California	970	1,172	83%
(V21) (640HB) Modesto, California	1,072	1,038	103%
(V21) (640HC) Monterey, California (Major General William H. Gourley)	903	1,087	90%
(V21) (654) Reno, NV (Ioannis A. Lougaris)	1,072	1,262	84%
(V21) (654GB) Carson Valley, Nevada	722	1,196	75%
(V21) (654GC) Lahontan Valley, Nevada	792	1,019	71%
(V21) (654GD) Diamond View, California	1,087	1,305	83%
(V21) (654GE) Reno East, Nevada	973	1,025	85%
(V21) (654GF) North Reno, Nevada	886	1,143	52%
(V21) (654QC) Winnemucca, Nevada	1,088	1,244	87%
(V21) (662) San Francisco, California	646	944	63%
(V21) (662GA) Santa Rosa, California	779	972	72%
(V21) (662GC) Eureka, California	760	884	65%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V21) (662GD) Ukiah, California	703	991	65%
(V21) (662GE) San Bruno, California	894	1,083	77%
(V21) (662GF) San Francisco Downtown, California	484	978	44%
(V21) (662GG) Clearlake, California	645	694	77%
(V21) (662GH) Oakland, California	763	1,059	72%
(V22) (501) Albuquerque, NM (Raymond G. Murphy)	995	1,027	79%
(V22) (501G2) Las Vegas, New Mexico	817	1,071	76%
(V22) (501GA) Artesia, New Mexico	963	882	95%
(V22) (501GB) Farmington, New Mexico	772	965	67%
(V22) (501GC) Silver City, New Mexico	975	859	85%
(V22) (501GD) Gallup, New Mexico	935	887	81%
(V22) (501GE) Espanola, NM New Mexico	742	1,252	59%
(V22) (501GH) Truth or Consequences, NM New Mexico	587	934	54%
(V22) (501GI) Alamogordo, New Mexico	1,119	875	109%
(V22) (501GJ) Durango, Colorado	1,107	1,065	91%
(V22) (501GK) Santa Fe, New Mexico	1,353	1,062	115%
(V22) (501GM) Northwest Metro, New Mexico	1,135	1,101	93%
(V22) (501GN) Taos, New Mexico	687	843	70%
(V22) (501HB) Raton, New Mexico	919	801	86%
(V22) (600) Long Beach, California (Tibor Rubin)	989	969	89%
(V22) (600GA) Placentia, California	1,022	1,013	95%
(V22) (600GB) Santa Ana, California	1,085	1,015	97%
(V22) (600GC) Cabrillo, California	531	760	52%
(V22) (600GD) Santa Fe Springs, California	1,064	922	95%
(V22) (600GE) Laguna Hills, California	1,427	988	124%
(V22) (600GF) Gardena, California	1,159	875	111%
(V22) (605) Loma Linda, California (Jerry L. Pettis)	667	760	66%
(V22) (605BZ) Loma Linda Redlands, California	1,076	1,073	98%
(V22) (605GA) Victorville, California	1,462	1,077	127%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V22) (605GB) Murrieta, California	1,318	996	116%
(V22) (605GC) Palm Desert, Arizona	2,063	1,164	145%
(V22) (605GD) Corona, California	1,262	989	114%
(V22) (605GE) Rancho Cucamonga, California	1,390	1,181	127%
(V22) (644BY) Southeast Gilbert, Arizona (Staff Sergeant Alexander W. Conrad Health Care)	1,123	1,068	100%
(V22) (644GA) Northwest Surprise, Arizona	1,078	983	102%
(V22) (644GB) Show Low, Arizona	999	1,074	80%
(V22) (644GC) Southwest Phoenix, Arizona	1,002	959	86%
(V22) (644GD) Payson, Arizona	1,238	1,087	109%
(V22) (644GF) Globe, Arizona	1,021	891	86%
(V22) (644GG) Northeast Phoenix, Arizona	1,427	1,095	130%
(V22) (644GI) Phoenix 32nd Street, Arizona	1,124	1,148	92%
(V22) (649) Prescott, Arizona (Bob Stump)	954	1,065	81%
(V22) (649GA) Kingman, Arizona	4,137	924	126%
(V22) (649GB) Flagstaff, Arizona	1,185	1,068	92%
(V22) (649GC) Lake Havasu City, Arizona	1,168	1,073	91%
(V22) (649GD) Anthem, Arizona	899	963	79%
(V22) (649GE) Cottonwood, Arizona	894	1,070	76%
(V22) (649QA) Chinle, Arizona	2,093	1,010	155%
(V22) (649QB) Holbrook, Arizona	788	1,364	58%
(V22) (649QD) Page, Arizona	612	1,368	45%
(V22) (649QF) Tuba City, Arizona	554	1,369	40%
(V22) (649QG) Polacca, Arizona	150	1,142	13%
(V22) (649QH) Kayenta, Arizona	907	840	81%
(V22) (664) San Diego, California (Jennifer Moreno)	978	995	98%
(V22) (664BY) Kearny Mesa, California	1,157	1,003	105%
(V22) (664GA) Imperial Valley, California	1,220	973	109%
(V22) (664GB) Oceanside, California	1,134	1,081	105%
(V22) (664GC) Chula Vista, California	1,028	1,061	90%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V22) (664GD) Escondido, California	1,185	814	119%
(V22) (664GF) Sorrento Valley, California	1,281	1,096	106%
(V22) (678) Tucson, Arizona	1,061	1,048	91%
(V22) (678GA) Sierra Vista, Arizona	873	895	89%
(V22) (678GB) Yuma, Arizona	1,146	967	101%
(V22) (678GC) Casa Grande, Arizona	1,080	977	89%
(V22) (678GD) Safford, Arizona	876	1,191	74%
(V22) (678GE) Green Valley, Arizona	1,027	1,144	79%
(V22) (678GF) Northwest Tucson, Arizona	1,060	1,211	81%
(V22) (678GG) Southeast Tucson, Arizona	1,059	1,129	91%
(V22) (691) West Los Angeles, California	631	926	62%
(V22) (691A4) Sepulveda, California	757	879	75%
(V22) (691GB) Santa Barbara, California	918	987	82%
(V22) (691GD) Bakersfield, California	937	998	87%
(V22) (691GE) Los Angeles, California	869	1,098	71%
(V22) (691GF) East Los Angeles, California	855	1,101	80%
(V22) (691GG) Antelope Valley, California	1,390	768	136%
(V22) (691GK) San Luis Obispo, California	947	1,076	82%
(V22) (691GL) Santa Maria, California	873	971	82%
(V22) (691GM) Oxnard, California	1,183	1,001	113%
(V22) (691GP) San Gabriel Valley, California	1,170	968	119%
(V23) (437) Fargo, North Dakota	1,091	1,064	89%
(V23) (437GA) Grafton, North Dakota	1,310	939	105%
(V23) (437GB) Bismarck, North Dakota	1,126	1,088	89%
(V23) (437GC) Fergus Falls, Minnesota	819	1,021	70%
(V23) (437GD) Minot, North Dakota	1,137	1,030	90%
(V23) (437GE) Bemidji, North Dakota	1,227	1,153	95%
(V23) (437GF) Williston, North Dakota	2,038	779	196%
(V23) (437GI) Grand Forks, North Dakota	1,111	1,045	95%
(V23) (437GJ) Dickinson, North Dakota	942	1,153	82%
(V23) (437GK) Jamestown, North Dakota	869	1,250	70%
(V23) (437GL) Devils Lake, North Dakota	1,464	1,024	107%
(V23) (438) Sioux Falls, South Dakota (Royal C. Johnson)	1,007	921	94%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V23) (438GA) Spirit Lake, Iowa	1,294	1,153	95%
(V23) (438GC) Sioux City, South Dakota	1,467	1,066	115%
(V23) (438GD) Aberdeen, South Dakota	1,085	846	96%
(V23) (438GE) Wagner, South Dakota	693	850	61%
(V23) (438GF) Watertown, South Dakota	1,083	1,129	82%
(V23) (568) Fort Meade, South Dakota	962	1,094	74%
(V23) (568A4) Hot Springs, South Dakota	841	1,066	68%
(V23) (568GA) Rapid City, South Dakota	1,146	1,040	93%
(V23) (568GB) Pierre, South Dakota	886	1,026	58%
(V23) (568HA) Newcastle, Wyoming	1,173	930	95%
(V23) (568HB) Gordon, Nebraska	640	760	63%
(V23) (568HF) Pine Ridge, South Dakota	880	970	68%
(V23) (568HH) Scottsbluff, Nebraska	673	859	73%
(V23) (568HP) Winner, South Dakota	913	1,081	66%
(V23) (618) Minneapolis, Minnesota	1,109	960	104%
(V23) (618BY) Twin Ports, Wisconsin	1,735	1,199	118%
(V23) (618GA) St. James, Minnesota	1,251	936	100%
(V23) (618GB) Hibbing, Minnesota	1,225	948	107%
(V23) (618GD) Maplewood, Minnesota	1,174	1,159	101%
(V23) (618GE) Chippewa Valley, Wisconsin	1,373	1,083	110%
(V23) (618GG) Rochester, Minnesota	1,273	1,062	107%
(V23) (618GH) Hayward, Wisconsin	1,088	932	103%
(V23) (618GI) Northwest Metro, Minnesota	1,442	1,141	128%
(V23) (618GJ) Shakopee, Minnesota	3,668	1,088	112%
(V23) (618GK) Albert Lea, Minnesota	1,198	1,058	97%
(V23) (618GM) Rice Lake, Wisconsin	1,609	1,041	132%
(V23) (618GN) Mankato, Minnesota (Lyle C. Pearson)	1,199	1,066	95%
(V23) (618QB) Ely, Minnesota	778	1,253	62%
(V23) (636) Omaha, Nebraska	980	1,076	82%
(V23) (636A4) Grand Island, Nebraska	1,016	944	83%
(V23) (636A5) Lincoln, Nebraska	940	985	83%
(V23) (636A6) Des Moines, Iowa	1,147	1,110	94%
(V23) (636A8) Iowa City, Iowa	754	1,152	55%
(V23) (636GA) Norfolk, Nebraska	939	1,085	77%

VHA Average Panel Sizes by Facility (As of October 2022)			
VHA Facility	PCP Panel Size Average	PCP Capacity Average	% Panel Fullness (All Assignments/ Team Modeled Capacity)
(V23) (636GB) North Platte, Nebraska	1,116	1,129	96%
(V23) (636GC) Mason City, Iowa	812	1,054	70%
(V23) (636GD) Marshalltown, Iowa	766	1,096	61%
(V23) (636GF) Quad Cities, Iowa	1,147	1,087	88%
(V23) (636GG) Quincy, Illinois	991	962	85%
(V23) (636GH) Waterloo, Iowa	959	1,074	82%
(V23) (636GI) Galesburg, Illinois (Lane A. Evans)	1,020	1,102	79%
(V23) (636GJ) Dubuque, Iowa	1,145	1,176	91%
(V23) (636GK) Fort Dodge, Iowa	909	1,061	78%
(V23) (636GL) Bellevue, Nebraska	888	1,021	78%
(V23) (636GM) Carroll, Iowa	1,029	1,099	80%
(V23) (636GN) Cedar Rapids, Iowa	1,177	1,166	95%
(V23) (636GP) Shenandoah, Iowa	910	1,120	72%
(V23) (636GQ) Holdrege, Nebraska	935	849	83%
(V23) (636GR) Knoxville, Iowa	703	1,252	56%
(V23) (636GS) Ottumwa, Iowa	1,036	1,113	81%
(V23) (636GT) Sterling, Illinois	1,234	1,111	97%
(V23) (636GU) Decorah, Iowa	904	895	76%
(V23) (636GW) Coralville, Iowa	950	1,064	77%
(V23) (636GY) Burlington, Iowa	1,021	892	86%
(V23) (656) St. Cloud, Minnesota	1,208	1,004	100%
(V23) (656GA) Brainerd, Minnesota	1,402	1,112	125%
(V23) (656GB) Montevideo, Minnesota	1,079	1,013	87%
(V23) (656GC) Alexandria, Minnesota (Max J. Beilke)	1,404	988	124%
Grand Total	**1,090**	**1,049**	**90%**

Appendix G: Physical Plant Space by Facility

Column	Definition
Total Adjusted Inventory	Current Space Per Capital Asset Inventory (CAI) Database - Disposals/Lease Terminations (as of FY 2015 President's Budget)
Total Planned New	New Space to be Added Via in Process Projects and Leases (as of FY 2015 President's Budget)
Total Projected Inventory	Total Adjusted Inventory + Total Planned New
Total Projected 2023 Need	Space Needed Based on the 2023 Projected Workload Projections
Space Gap	Total Projected 2023 Need – Total Projected Inventory
Space Gap as % of Need	Space Gap ÷ Total Projected 2023 Need

All data is represented in square feet and is as of October 2022

Station Number	Station Name	FY 2022 Total Projected Inventory	Total Projected 2030 Sq Ft Need	FY 2030 Space Gap	FY 2030 Space Gap
VHA Total		**181,305,032**	**244,667,535**	**63,362,503**	**35%**
VISN 1		8,410,466	11,014,578	2,604,112	31%
402	Togus	862,388	1,185,629	323,241	37%
405	White River Junction	577,967	704,788	126,821	22%
518	Bedford	1,123,437	1,254,432	130,995	12%
523	Boston HS, Jamaica Plain	1,039,660	1,613,546	573,886	55%
608	Manchester	435,723	708,988	273,265	63%
631	VA Central Western Mass HCS	684,704	620,411	-64,293	-9%
650	Providence	746,184	1,191,901	445,717	60%
689	VACHS, West Haven	1,232,051	1,500,997	268,946	22%
523A4	BHS, West Roxbury	371,206	742,463	371,257	100%
523A5	BHS, Brockton	915,942	1,028,402	112,460	12%
689A4	VACHS, Newington	421,204	463,022	41,818	10%
VISN 2		13,608,665	14,999,127	1,390,462	10%
526	Bronx	1,120,242	1,566,852	446,610	40%
528	Buffalo	1,172,677	1,233,391	60,714	5%
561	East Orange	1,075,764	1,321,092	245,328	23%

Station Number	Station Name	FY 2022 Total Projected Inventory	Total Projected 2030 Sq Ft Need	FY 2030 Space Gap	FY 2030 Space Gap
620	Montrose	793,650	892,801	99,151	12%
630	New York	1,161,481	982,297	-179,184	-15%
632	Northport	1,251,889	1,412,234	160,345	13%
528A4	Batavia	302,844	347,582	44,738	15%
528A5	Canandaigua	1,065,580	846,670	-218,910	-21%
528A6	Bath	504,702	773,490	268,788	53%
528A7	Syracuse	999,866	1,291,761	291,895	29%
528A8	Albany	963,500	1,073,461	109,961	11%
561A4	Lyons	1,044,464	1,224,410	179,946	17%
620A4	Castle Point	537,776	565,882	28,106	5%
630A4	Brooklyn	980,478	753,406	-227,072	-23%
630A5	St. Albans	633,752	713,797	80,045	13%
VISN 4		7,903,483	10,490,133	2,586,650	33%
460	Wilmington	599,850	785,627	185,777	31%
503	Altoona	496,019	558,259	62,240	13%
529	Butler	440,756	629,859	189,103	43%
542	Coatesville, PA	939,831	957,849	18,018	2%
562	Erie	415,235	514,955	99,720	24%
595	Lebanon	1,057,418	1,404,728	347,310	33%
642	Philadelphia	1,237,499	1,979,968	742,469	60%
646	Pittsburgh, University Drive	1,175,609	1,679,763	504,154	43%
693	Wilkes Barre	889,824	1,089,594	199,770	22%
646A4	Pittsburgh, HJ Heinz Division	651,442	889,532	238,090	37%
VISN 5		7,165,081	9,487,313	2,322,232	32%
512	Baltimore	1,294,134	1,981,153	687,019	53%
517	Beckley	405,889	434,548	28,659	7%
540	Clarksburg	487,639	734,827	247,188	51%
581	Huntington	761,003	872,527	111,524	15%
613	Martinsburg	1,380,806	1,807,175	426,369	31%
688	Washington, DC	1,322,744	2,182,971	860,227	65%
512A5	Perry Point	1,361,154	1,102,803	-258,351	-19%
512GD	Baltimore, Loch Raven	151,712	371,309	219,597	145%
VISN 6		10,006,937	14,467,365	4,460,428	45%
558	Durham	1,427,974	2,387,087	959,113	67%
565	Fayetteville	1,199,749	1,749,650	549,901	46%

Station Number	Station Name	FY 2022 Total Projected Inventory	Total Projected 2030 Sq Ft Need	FY 2030 Space Gap	FY 2030 Space Gap
590	Hampton	1,410,501	2,001,064	590,563	42%
637	Asheville	837,307	1,441,003	603,696	72%
652	Richmond	1,903,474	2,925,184	1,021,710	54%
658	Salem	1,297,238	1,458,647	161,409	12%
659	Salisbury	1,930,694	2,504,731	574,037	30%
VISN 7		10,988,033	16,565,577	5,577,545	51%
508	Atlanta (Decatur)	1,917,083	3,539,539	1,622,456	85%
509	Augusta, Downtown	762,131	1,342,665	580,534	76%
521	Birmingham	1,295,240	1,852,687	557,447	43%
534	Charleston	974,276	2,498,777	1,524,501	156%
544	Columbia, South Carolina	1,626,294	2,607,503	981,209	60%
557	Dublin	984,951	1,295,932	310,981	32%
619	CAVHCS, Montgomery	555,671	548,288	-7,383	-1%
679	Tuscaloosa	1,129,247	1,113,561	-15,686	-1%
509A0	Augusta, Uptown	1,012,953	975,417	-37,536	-4%
619A4	CAVHCS, Tuskegee	730,187	791,209	61,022	8%
VISN 8		13,650,719	21,995,314	8,344,595	61%
516	Bay Pines	1,818,688	3,336,590	1,517,902	83%
546	Miami	1,293,478	2,273,633	980,155	76%
548	West Palm Beach	1,046,947	2,091,540	1,044,593	100%
573	Gainesville	2,930,596	4,513,595	1,582,999	54%
672	San Juan	1,840,072	1,738,305	-101,767	-6%
673	Tampa	2,708,367	4,005,506	1,297,139	48%
675	Orlando	2,012,571	4,036,145	2,023,574	101%
VISN 9		8,027,646	10,675,792	2,648,146	33%
596	Lexington, Leestown	1,191,989	1,408,430	216,441	18%
603	Louisville	1,232,928	1,389,476	156,548	13%
614	Memphis	1,368,779	1,667,946	299,167	22%
621	Mountain Home	2,041,059	2,800,264	759,205	37%
626	Nashville	1,076,353	1,638,769	562,416	52%
626A4	Murfreesboro	1,116,538	1,770,906	654,368	59%
VISN 10		14,276,749	19,253,534	4,976,785	35%

Station Number	Station Name	FY 2022 Total Projected Inventory	Total Projected 2030 Sq Ft Need	FY 2030 Space Gap	FY 2030 Space Gap
506	Ann Arbor	1,407,513	1,778,840	371,327	26%
515	Battle Creek	1,295,666	1,386,163	90,497	7%
538	Chillicothe	989,567	1,133,824	144,257	15%
539	Cincinnati	1,225,261	1,709,606	484,345	40%
541	Cleveland, Wade Park	1,942,326	3,895,104	1,952,778	101%
552	Dayton	1,679,846	1,986,592	306,746	18%
553	Detroit	1,361,005	1,415,051	54,046	4%
583	Indianapolis	1,901,965	2,491,782	589,817	31%
610	NIHCS, Marion	1,001,462	1,011,554	10,092	1%
655	Saginaw	547,469	863,316	315,847	58%
757	Columbus VAACC	555,904	1,098,179	542,275	98%
610A4	NIHCS, Fort Wayne	368,765	483,524	114,759	31%
VISN 12		10,058,757	12,635,433	2,576,676	26%
537	Chicago	1,194,495	1,705,302	510,807	43%
550	Danville	918,306	1,220,840	302,534	33%
556	North Chicago	1,512,996	1,138,728	-374,268	-25%
578	Hines	2,164,471	3,144,897	980,426	45%
585	Iron Mountain	400,604	445,870	45,266	11%
607	Madison	906,352	1,214,481	308,129	34%
676	Tomah	883,730	944,776	61,046	7%
695	Milwaukee	2,077,803	2,820,539	742,736	36%
VISN 15		8,245,237	9,161,908	916,671	11%
589	Kansas City	997,554	1,296,345	298,791	30%
657	St Louis	1,067,473	1,354,887	287,414	27%
589A4	Columbia	896,314	1,103,246	206,932	23%
589A5	Topeka	940,014	859,883	-80,131	-9%
589A6	Leavenworth	1,333,407	1,472,424	139,017	10%
589A7	Wichita	628,482	866,824	238,342	38%
657A0	St Louis, Jefferson Barracks	1,330,192	849,476	-480,716	-36%
657A4	Poplar Bluff	338,221	470,698	132,477	39%
657A5	Marion	713,580	888,126	174,546	24%
VISN 16		11,940,493	14,641,074	2,700,581	23%
502	Alexandria	804,255	877,609	73,354	9%
520	Biloxi	1,522,130	1,957,701	435,571	29%
564	Fayetteville AR	733,056	1,167,473	434,417	59%

Station Number	Station Name	FY 2022 Total Projected Inventory	Total Projected 2030 Sq Ft Need	FY 2030 Space Gap	FY 2030 Space Gap
580	Houston Texas	2,325,618	4,118,216	1,792,598	77%
586	Jackson	977,660	1,142,540	164,880	17%
598	Little Rock	2,449,776	2,877,599	427,823	17%
629	New Orleans	2,370,469	1,550,897	-819,572	-35%
667	Shreveport	757,529	949,039	191,510	25%
VISN 17		10,628,816	15,352,134	4,723,318	44%
504	Amarillo	715,730	769,126	53,396	7%
519	Big Spring	438,825	381,169	-57,656	-13%
549	Dallas	3,063,880	4,349,069	1,285,189	42%
671	San Antonio	1,922,852	3,421,138	1,498,286	78%
674	Temple	1,872,702	3,007,755	1,135,053	61%
740	Texas Valley Coastal Bend HCS	455,135	713,421	258,286	57%
756	El Paso	484,694	678,435	193,741	40%
549A4	Bonham	419,095	651,963	232,868	56%
671A4	Kerrville	368,141	450,947	82,806	22%
674A4	Waco	887,762	929,110	41,348	5%
VISN 19		6,830,970	9,874,434	3,043,464	45%
436	Fort Harrison	702,949	962,492	259,543	37%
442	Cheyenne	447,166	664,139	216,973	49%
554	Denver	1,618,978	2,667,345	1,048,367	65%
575	Grand Junction	366,388	480,112	113,724	31%
623	Muskogee	933,341	944,836	11,495	1%
635	Oklahoma City	1,149,268	1,756,091	606,823	53%
660	Salt Lake City	946,089	1,758,724	812,635	86%
666	Sheridan	666,791	640,696	-26,095	-4%
VISN 20		7,472,652	9,933,474	2,460,822	33%
463	Anchorage	349,569	434,768	85,199	24%
531	Boise	585,119	1,064,738	479,619	82%
648	Portland	1,724,421	2,548,021	823,600	48%
653	Roseburg	655,687	766,022	110,335	17%
663	Seattle	1,628,155	2,324,852	696,697	43%
668	Spokane	464,540	865,462	400,922	86%
687	Walla Walla	436,425	395,414	-41,011	-9%
692	White City	871,624	527,597	-344,027	-39%
663A4	American Lake	757,112	1,006,600	249,488	33%
VISN 21		9,672,972	12,902,578	3,229,606	33%
459	Honolulu	566,376	949,496	383,120	68%
570	Fresno	564,982	1,004,196	439,214	78%

Station Number	Station Name	FY 2022 Total Projected Inventory	Total Projected 2030 Sq Ft Need	FY 2030 Space Gap	FY 2030 Space Gap
593	Las Vegas	1,306,843	2,055,062	748,219	57%
612	NCHCS, Martinez	1,455,122	2,393,585	938,463	64%
640	Palo Alto	3,675,378	3,421,328	-254,050	-7%
654	Reno	811,743	1,052,106	240,363	30%
662	San Francisco	1,292,528	2,026,805	734,277	57%
VISN 22		13,148,490	19,829,586	6,681,096	51%
501	Albuquerque	1,317,799	1,705,893	388,094	29%
600	Long Beach	1,735,113	2,807,340	1,072,227	62%
605	Loma Linda	1,330,326	2,332,899	1,002,573	75%
644	Phoenix	1,498,574	2,877,958	1,379,384	92%
649	Prescott	726,269	801,754	75,485	10%
664	San Diego	1,508,557	2,832,507	1,323,950	88%
678	Tucson	1,238,057	1,960,008	721,951	58%
691	Los Angeles	2,924,840	3,535,060	610,220	21%
691A4	Sepulveda	868,955	976,167	107,212	12%
VISN 23		9,268,867	11,388,180	2,119,313	23%
437	Fargo	666,525	767,075	100,550	15%
438	Sioux Falls	672,039	770,173	98,134	15%
568	Black Hills, Fort Meade	1,307,935	1,267,498	-40,437	-3%
618	Minneapolis	2,152,380	2,947,760	795,380	37%
636	Omaha	1,448,595	1,651,593	202,998	14%
656	St. Cloud	1,059,661	1,625,752	566,091	53%
636A6	Des Moines	915,760	1,070,528	154,768	17%
636A8	Iowa City	1,045,972	1,287,801	241,829	23%

Appendix H and I: Wait Time Data by VISN and Facility
(November 2022)

Document has been included in a separate file.

Appendix J: Temporary Employees by Facility

Facility	All Others	NTE APPT	Research	Student	Temporary Employees
VISN 1	363	563	164	1	1091
HCS Boston, Massachusetts (Jamaica Plain) (523)	103	318	103	1	525
HCS Central Western Massachusetts (631)	15	9	-	-	24
HCS Connecticut (West Haven) (689)	65	53	24	-	142
HCS Maine - Togus (Augusta, Maine) (402)	22	20	-	-	42
VAMC Bedford, Massachusetts (518)	70	71	19	-	160
VAMC Manchester, New Hampshire (608)	21		-	-	21
VAMC Providence, Rhode Island (650)	29	70	13	-	112
VAMC White River Junction, Vermont (405)	38	21	5	-	64
VISN 2	495	221	21	1	738
HCS Hudson Valley, New York (620)	20	4	-	-	24
HCS New Jersey (East Orange) (561)	54	35	1	-	90
HCS NY Harbor, New York (630)	103	22	1	-	126
HCS Western New York (Buffalo) (528)	52	21	1	1	75
VAMC Albany, New York (528 D)	14	19	2	-	35
VAMC Bath, New York (528 N)	23	48	-	-	71
VAMC Bronx, New York (526)	128	62	14	-	204
VAMC Northport, New York (632)	29	4	2	-	35
VAMC Syracuse, New York (528 E)	72	6	-	-	78
VISN 4	252	184	43	7	486
HCS Pittsburgh, Pennsylvania (646)	49	78	26	-	153
VAMC Altoona, Pennsylvania (503)	13	-	-	1	14
VAMC Butler, Pennsylvania (529)	11	1	-	1	13
VAMC Coatesville, Pennsylvania (542)	23	7	-	1	31
VAMC Erie, Pennsylvania (562)	8	4	-	-	12
VAMC Lebanon, Pennsylvania (595)	14	5	-	-	19
VAMC Philadelphia, Pennsylvania (642)	46	73	17	3	139
VAMC Wilkes-Barre, Pennsylvania (693)	10	1	-	-	11
VAMC Wilmington, Delaware (460)	75	15	-	-	90
VISN 5	193	89	22	2	306
HCS Maryland (Baltimore) (512)	60	30	21	-	111
VAMC Beckley, West Virginia (517)	16	1	-	-	17
VAMC Clarksburg, West Virginia WV (540)	35	41	-	-	76
VAMC Huntington, West Virginia (581)	22	3	-	-	25

Facility	All Others	NTE APPT	Research	Student	Temporary Employees
VAMC Martinsburg, West Virginia (613)	19	1	-	-	20
VAMC Washington, District of Columbia (688)	39	13	1	2	55
VISN 6	511	237	48	1	797
HCS Central Virginia (Richmond) (652)	109	9	13	-	131
VAMC Asheville, North Carolina (637)	23	5	-	-	28
VAMC Durham, North Carolina (558)	173	124	33	-	330
VAMC Fayetteville, North Carolina (565)	13	37	-	1	51
VAMC Hampton, Virginia (590)	57	17	-	-	74
VAMC Salem, Virginia (658)	46	27	-	-	73
VAMC Salisbury, North Carolina (659)	90	14	2	-	106
VISN 7	418	336	56	18	828
HCS Central Alabama (Montgomery) (619)	27	8	-	-	35
VAMC Atlanta, Georgia (Decatur) (508)	210	64	31	4	309
VAMC Augusta, Georgia (509)	13	12	2	-	27
VAMC Birmingham, Alabama (521)	97	44	6	12	159
VAMC Charleston, South Carolina (534)	21	107	12	-	140
VAMC Columbia, South Carolina (544)	22	4	5	-	31
VAMC Dublin, Georgia (557)	13	40	-	-	53
VAMC Tuscaloosa, Alabama (679)	15	57	-	2	74
VISN 8	1287	436	71	18	1812
HCS Miami, Florida (546)	74	115	8	-	197
HCS North Florida-South Georgia (Gainesville, Florida) (573)	247	68	35	-	350
HCS San Juan, Puerto Rico (672)	283	64	-	-	347
VAMC Bay Pines, Florida (516)	84	4	4	-	92
VAMC Orlando, Florida (675)	338	89	-	16	443
VAMC Tampa, Florida (673)	178	85	24	2	289
VAMC West Palm Beach, Florida (548)	81	11	-	-	92
VISN 9	181	104	43	3	331
HCS TN Valley (Nashville) (626)	57	29	28	-	114
VAMC Lexington, Kentucky (596)	16	9	5	2	32
VAMC Louisville, Kentucky (603)	14	6	2	-	22
VAMC Memphis, Tennessee (614)	59	51	4	1	115
VAMC Mountain Home, Tennessee (621)	35	7	4	-	46
VISN 10	499	246	135	23	903
ACC Columbus, Ohio (757)	9	2	-	-	11

Facility	All Others	NTE APPT	Research	Student	Temporary Employees
HCS Northern Indiana (Ft. Wayne) (610)	12	19	-	1	32
VAMC Ann Arbor, Michigan (506)	161	111	9	-	281
VAMC Battle Creek, Michigan (515)	46	3	-	-	49
VAMC Chillicothe, Ohio (538)	5	2	-	-	7
VAMC Cincinnati, Ohio (539)	51	9	9	-	69
VAMC Cleveland, Ohio (541)	85	43	60	2	190
VAMC Dayton, Ohio (552)	29	4	-	2	35
VAMC Detroit, Michigan (553)	42	6	9	-	57
VAMC Indianapolis, Indiana (583)	41	34	48	11	134
VAMC Saginaw, Michigan (655)	15	12	-	7	34
VISN 12	332	238	34	14	618
FHCC Captain James A. Lovell (N Chicago, Illinois) (556)	30	11	-	-	41
VAMC Chicago, Illinois (537)	80	37	3	-	120
VAMC Danville, Illinois (550)	11	13	-	1	25
VAMC Hines, Illinois (578)	52	116	15	-	183
VAMC Iron Mountain, Michigan (585)	15	4	-	12	31
VAMC Madison, Wisconsin (607)	55	39	5	-	99
VAMC Milwaukee, Wisconsin (695)	82	9	11	1	103
VAMC Tomah, WI (676)	7	9	-	-	16
VISN 15	176	82	7	17	282
HCS Eastern Kansas (589 EA)	20	-	-	-	20
HCS St. Louis, Missouri (657)	43	8	5	17	73
VAMC Columbia, Missouri (589 CA)	21	31	2	-	54
VAMC Kansas City, Missouri (589)	47	22	-	-	69
VAMC Marion, Illinois (657 MA)	24	2	-	-	26
VAMC Poplar Bluff, Missouri (657 PA)	4	4	-	-	8
VAMC Wichita, Kansas (589 WA)	16	13	-	-	29
VISN 16	466	351	40	-	857
HCS Central Arkansas (Little Rock) (598)	66	69	18	-	153
HCS Gulf Coast Veterans (Biloxi, Mississippi) (520)	26	41	-	-	67
HCS of the Ozarks, Fayetteville, Arizona (564)	10	4	-	-	14
HCS Southeast Louisiana (New Orleans) (629)	83	49	10	-	142
VAMC Alexandria, Louisan (502)	28	14	-	-	42
VAMC Houston, Texas (580)	125	104	10	-	239

Facility	All Others	NTE APPT	Research	Student	Temporary Employees
VAMC Jackson, Mississippi (586)	74	36	-	-	110
VAMC Shreveport, Louisiana (667)	53	33	2	-	88
VISN 17	312	318	6	-	636
HCS Amarillo, Texas (504)	31	53	-	-	84
HCS Central Texas (Temple) (674)	41	40	1	-	82
HCS El Paso, Texas (756)	6	4	-	-	10
HCS North Texas (Dallas) (549)	131	142	2	-	275
HCS South Texas (San Antonio) (671)	72	55	3	-	130
HCS Texas Valley Coastal Bend (Harlingen) (740)	12	2	-	-	14
HCS West Texas HCS (Big Spring) (519)	14	9	-	-	23
VISN 19	380	192	86		658
HCS Eastern Colorado (Denver) (554)	122	77	36	-	235
HCS Montana (Fort Harrison) (436)	15	6	-	-	21
HCS Oklahoma City, Oklahoma (635)	116	8	4	-	128
HCS Salt Lake City, Utah (660)	27	75	45	-	147
VAMC Cheyenne, Wyoming (442)	6	8	-	-	14
VAMC Grand Junction, Colorado (575)	24	-	-	-	24
VAMC Muskogee, Oklahoma (623)	59	12	1	-	72
VAMC Sheridan, Wyoming (666)	11	6	-	-	17
VISN 20	223	372	92	1	688
HCS Alaska (Anchorage) (463)	15	5	-	-	20
HCS Portland, Oregon (648)	31	133	61	-	225
HCS Puget Sound, Washington (663)	93	198	30	-	321
HCS Roseburg, Oregon (653)	30	19	-	-	49
SORCC White City, Oregon (692)	23	9	-	1	33
VAMC Boise, Idaho (531)	7	1	1	-	9
VAMC Spokane, Washington (668)	16	2	-	-	18
VAMC Walla Walla, Washington (687)	5	2	-	-	7
VISN 21	654	415	47	22	1138
HCS Central California (Fresno) (570)	29	31	-	-	60
HCS Northern California (Mather) (612)	64	25	11	3	103
HCS Pacific Islands (Honolulu, HI) (459)	17	10	-	-	27
HCS Palo Alto, California (640)	320	176	21	16	533
HCS San Francisco, California (662)	132	64	15	1	212
HCS Sierra Nevada (Reno) (654)	37	3	-	2	42
HCS Southern Nevada (N Vegas) (593)	54	105	-	-	159
OPC Manila, Philippines (358)	1	-	-	-	1

Facility	All Others	NTE APPT	Research	Student	Temporary Employees
VISN 22	697	309	131	4	1141
HCS Greater Los Angeles, California (691)	116	98	75	-	289
HCS Loma Linda, California (605)	100	22	4	-	126
HCS Long Beach, California (600)	259	33	5	1	298
HCS New Mexico (Albuquerque) (501)	27	16	4	-	47
HCS Northern Arizona (Prescott) (649)	5	-	-	-	5
HCS Phoenix, Arizona (644)	74	20	5	-	99
HCS San Diego, California (664)	69	93	35	3	200
HCS Southern Arizona (Tucson) (678)	44	22	3	-	69
VISN 23	308	203	56	2	569
HCS Black Hills, South Dakota (568)	6	2	-	-	8
HCS Central Iowa (Des Moines) (636 D)	8	19	-	-	27
HCS Fargo, North Dakota (437)	23	5	-	-	28
HCS Iowa City, Iowa (636 I)	138	68	10	1	217
HCS Minneapolis, Minnesota (618)	65	84	37	-	186
HCS Nebraska-Western Iowa (Omaha, Nebraska) (636)	43	18	9	-	70
HCS Sioux Falls, South Dakota (438)	12	3	-	-	15
HCS St. Cloud, Minnesota (656)	11	3	-	1	15
				Total	**10,140**

Appendix K: List of Acting Leaders

VISN	Position	Facility
1	Associate Medical Center Director	VAMC Manchester, New Hampshire
1	Chief of Staff	VAMC Manchester, New Hampshire
2	Assoc Med Center Director	HCS Hudson Valley, New York
2	Assistant Medical Center Director	HCS Hudson Valley, New York
2	Associate Medical Center Director	VAMC Albany, New York
2	Chief of Staff	VAMC Bronx, New York
4	Chief of Staff	VAMC Butler, Pennsylvania
4	Medical Center Director	VAMC Coatesville, Pennsylvania
4	Associate Medical Center Director	VAMC Coatesville, Pennsylvania
4	Associate Medical Center Director	VAMC Philadelphia, Pennsylvania
4	Assistant Medical Center Director	VAMC Philadelphia, Pennsylvania
5	Quality Management Officer	VISN 5 Linthicum, Maryland
5	Medical Center Director	HCS Maryland (Baltimore)
5	Associate Medical Center Director	HCS Maryland (Baltimore)
5	Associate Med Center Director	VAMC Martinsburg, WV
6	Deputy Network Director	VISN 6 Durham, North Carolina
6	Associate Medical Center Director	VAMC Asheville, North Carolina
6	Associate Medical Center Director	VAMC Durham, North Carolina
6	Assistant Medical Center Director	VAMC Durham, North Carolina
6	Medical Center Director	VAMC Hampton, Virginia
6	Chief of Staff	VAMC Hampton, Virginia
6	Chief of Staff	VAMC Salisbury, North Carolina
7	Network Director	VISN 7 Atlanta, Georgia
7	Quality Mgt Officer	VISN 7 Atlanta, Georgia
7	Associate Director for Patient Care Services	HCS Central AL (Montgomery)
7	Associate Medical Center Director	VAMC Atlanta, Georgia (Decatur)
7	Assistant Medical Center Director	VAMC Atlanta, Georgia (Decatur)
7	Associate Director Patient Care Services	VAMC Augusta, Georgia
7	Chief of Staff	VAMC Charleston, South Carolina
7	Associate Medical Center Director	VAMC Dublin, Georgia
7	Associate Med Center Director	VAMC Tuscaloosa, Alabama
8	Associate Director for Patient Care Services	HCS Miami, Florida
8	Chief of Staff	HCS San Juan, Puerto Rico
8	Associate Director for Patient Care Services	VAMC Bay Pines, Florida
8	Associate Medical Center Director	VAMC Orlando, Florida

VISN	Position	Facility
8	Medical Center Director	VAMC Tampa, Florida
8	Deputy Medical Center Director	VAMC Tampa, Florida
8	Associate Medical Center Director	VAMC Tampa, Florida
8	Medical Center Director	VAMC West Palm Beach, Florida
8	Assistant Med Center Director	VAMC West Palm Beach, Florida
9	Deputy Med Center Director	HCS Tennessee Valley (Nashville)
9	Associate Medical Center Director	HCS Tennessee Valley (Nashville)
12	Associate Dir for Patient Care Services	FHCC Captain James A. Lovell (N Chicago, Illinois)
12	Asst Med Center Director	VAMC Chicago, Illinois
12	Associate Medical Center Director	VAMC Danville, Illinois
12	Assoc Dir for Patient Care Services	VAMC Danville, Illinois
12	Associate Medical Center Director	VAMC Hines, Illinois
12	Med Center Director	VAMC Tomah, Wisconsin
15	Chief Medical Officer	VISN 15 Kansas City, Missouri
15	Associate Medical Center Director	HCS St. Louis, Missouri
15	Associate Medical Center Director	VAMC Columbia, Missouri
15	Associate Medical Center Director	VAMC Columbia, Missouri
15	Medical Center Director	VAMC Poplar Bluff, Missouri
15	Associate Medical Center Director	VAMC Poplar Bluff, Missouri
15	Chief of Staff	VAMC Poplar Bluff, Missouri
16	Chief of Staff	VAMC Houston, Texas
16	Assistant Medical Center Director	VAMC Shreveport, Louisiana
19	Associate Director for Patient Care Services	HCS Eastern Colorado (Denver)
20	Medical Center Director	HCS Alaska (Anchorage)
21	Chief of Staff	HCS Pacific Islands (Honolulu, Hawaii)
22	Quality Management Officer	VISN 22 Long Beach, California
22	Executive Director	HCS Greater Los Angeles, California
22	Associate Medical Center Director	HCS Long Beach, California
23	Chief of Staff	HCS Iowa City, Iowa

Appendix L: VHA Directive 0320

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 0320
Transmittal Sheet
July 6, 2020

VHA COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive updates policy for the VHA Comprehensive Emergency Management Program (CEMP) and describes responsibilities for implementing the CEMP at VHA Central Office, Veterans Integrated Service Network (VISN) and Department of Veterans Affairs (VA) medical facilities.

2. SUMMARY OF MAJOR CHANGES: This revised VHA directive serves as an umbrella directive for the other VHA 0320-series (emergency management) directives that provide program-specific policy and responsibilities. This revised VHA directive:

a. Focuses the VHA CEMP on providing health security for VA patients, military personnel, first responders and the public during emergencies, as appropriate.

b. Adds health security as an outcome of the CEMP (paragraph 4).

c. Incorporates major national security, health and emergency management policy and doctrinal guidance.

d. Adds additional responsibilities for the Director, VHA Office of Emergency Management (OEM) (paragraph 5.e.)

3. RELATED ISSUES: VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, dated April 6, 2017; VHA Directive 0320.05, Medical Emergency Radiological Response Team Program, dated August 12, 2019; VHA Directive 0320.06, First Receivers Decontamination Program, dated October 27, 2016; VHA Directive 0320.07, Dual Use Vehicle (DUV) Program, dated June 18, 2018; VHA Directive 0320.09, Resilient High Frequency Radio Network, dated September 1, 2017; VHA Directive 0320.10, Inspection of VA All-Hazard Emergency Caches by the VHA Office of Emergency Management, dated July 26, 2017; VHA Directive 1154, Mobile Medical Unit (MMU) Program Management, dated July 26, 2017; VHA Handbook 0320.03, Disaster Emergency Medical Personnel System (DEMPS) Program and Database, dated March 26, 2008; VHA Handbook 0320.04, Department of Veterans Affairs and Department of Defense Contingency Plan, dated March 13, 2014.

4. RESPONSIBLE OFFICE: The VHA Office of Emergency Management (OEM, 10NA1) is responsible for the contents of this directive. Questions may be referred to 304-264-4800.

5. RESCISSION: VHA Directive 0320, Comprehensive Emergency Management Program, dated April 12, 2013, is rescinded.

T-1

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of July 2025. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY THE DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Renee Oshinski
Assistant Under Secretary for Health
for Operations

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publication Distribution List on July 8, 2020.

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VHA COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM

VHA COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy and responsibilities for VHA's Comprehensive Emergency Management Program (CEMP) ensuring health security of Veterans from the impacts of emergencies and disasters. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 1784, 1785, 8111A, 8117 and 8153; and 42 U.S.C. § 300hh – 300hh–31 and § 5121-5208.

2. BACKGROUND

a. In 1999, VHA adopted Comprehensive Emergency Management (CEM) which had been the Federal Emergency Management Agency's (FEMA) overall policy context since 1980.

b. VHA retains the CEM concept and incorporates the following national policy and doctrinal guidance into the CEMP:

(1) After the terrorist attacks of September 11, 2001, the Department of Veterans Affairs (VA) Emergency Preparedness Act identified requirements for the readiness of VA medical facilities, security, tracking of pharmaceuticals, mental health counseling and training.

(2) The Department of Homeland Security (DHS) established national preparedness policy to provide an overall structure for the coordination and implementation of all-hazards preparedness in the United States. The National Preparedness System (NPS) includes a national preparedness goal and process, mission areas and core capabilities.

(3) DHS also created the National Incident Management System (NIMS) from its wildland firefighting roots and required its use by Federal departments and agencies and State, Local, Tribal and Territorial (SLTT) agencies so that a single domestic emergency management system existed.

(4) The Pandemic and All-Hazards Preparedness Act (PAHPA), and subsequent reauthorizations, has guided the major programs of Department of Health and Human Services (HHS), Assistant Secretary for Preparedness and Response (ASPR), including the National Health Security Strategy (NHSS), a strategic framework for health and medical service delivery in emergencies and disasters.

c. CEMP includes reduction or elimination of the impact from potential hazards (mitigation); building the capacity and capability of the organization to manage the impacts (preparedness); acting to stop on-going negative effects (response); and, working to restore essential functions and returning the organization to a new normal (recovery). VHA implements CEMP through an integrated emergency management process that includes:

(1) An assessment of the status of the current program through an audit and the establishment of goals and priorities.

(2) An appraisal of hazards and their primary and secondary effects.

(3) Mitigation activities designed to reduce the effects of those hazards.

(4) The development of capabilities (staff education, planning, training, exercises, purchase of equipment/supplies).

(5) Emergency operations.

(6) Identification of shortfalls in capability (evaluation activities including, after-action critiques from exercises or actual events providing the feedback loop to unmet preparedness issues).

(7) A multi-year development plan to guide the overall mitigation and preparedness activities.

d. Resiliency is an outcome of a CEMP and is defined as the ability to maintain mission critical business operations and regular health care services, ensuring health security despite the effects of a disaster or emergency.

e. Health security is achieved through actions in support of three primary objectives:

(1) Preparing, mobilizing and coordinating the Whole-of-Government to bring the full spectrum of Federal medical and public health capabilities to support SLTT authorities in the event of a public health emergency, disaster or attack;

(2) Protecting the Nation from the health effects of emerging and pandemic infectious diseases and chemical, biological, radiological and nuclear threats; and

(3) Leveraging the capabilities of the private sector.

3. DEFINITIONS

a. **Continuity.** Continuity is the ability to provide uninterrupted services and support, while maintaining organizational viability, before, during and after an event that disrupts normal operations.

b. **Emergency.** An emergency is a hazard impact causing adverse physical, social, psychological, economic or political effects requiring immediate actions to maintain or increase capacity and capability (call-back procedures, mutual aid), and commonly requires change from routine management methods to an incident command process to achieve the expected outcome. Synonymous with incident.

c. **Emergency Management Capabilities Assessment Program.** Emergency Management Capabilities Assessment Programs (EMCAP) are surveys to assess the status of all VA medical facility CEMP Programs.

d. **Emergency Management Coordination Cell.** VHA's Emergency Management Coordination Cell (EMCC) serves as the central point of communication and coordination for the Under Secretary for Health in planning for, responding to and recovering from significant events that require national level direction/support or supporting Federal interagency requests for assistance.

e. **Emergency Management Performance Improvement Funds.** For the purposes of this directive, Emergency Management Performance Improvement (EMPI) Funds are funds provided through the VHA Office of Emergency Management (OEM) to support VA medical facility projects that enhance local emergency management program goals.

f. **Emergency Operations Plan.** An Emergency Operations Plan (EOP) provides the structure and processes that the organization utilizes to respond to and initially recover from an event. The EOP is implemented through the Incident Command System.

g. **Emergency Relocation Group.** The Emergency Relocation Group (ERG) consists of staff assigned to continue performance of essential functions at an alternate location should their primary operating facility or facilities be impacted or incapacitated by an emergency.

h. **Essential Functions.** Essential functions are those functions an organization must continue through emergencies. The identification and prioritization of essential functions is the foundation of continuity planning and establishes the parameters that drive an organization's continuity planning and preparedness efforts.

i. **Hazard.** A hazard is a potential or actual force, physical condition or agent with the ability to cause human injury, illness or death and significant damage to property, the environment, critical infrastructure, agriculture and business operations and other types of harm or loss.

j. **Health Care Coalition.** A health care coalition is a functional entity of health care organizations and related organizations that work together to prevent, protect, militate against, respond to and recover from an incident.

k. **Incident Command System.** The Incident Command System (ICS) is a component of NIMS which provides a standardized organizational structure with common terminology to enable effective and efficient domestic incident management.

l. **Incident Management Team.** An incident management team (IMT) is an organization based on ICS that is focused on the resolution of the emergency or management of the exercise or designated special event.

m. **Mission Essential Functions.** Mission Essential Functions (MEF) are the essential functions directly related to accomplishing an organization's mission as set forth in statutes or executive charters.

n. **National Disaster Medical System.** The National Disaster Medical System (NDMS) is a federally coordinated health care system and partnership of HHS, DHS, the Department of Defense (DoD) and VA.

o. **Primary Mission Essential Function.** Primary Mission Essential Function (PMEF) are those MEFs that must be continuously performed to support or provide for the uninterrupted performance of National Essential Functions.

p. **Public Health Emergency Medical Countermeasures Enterprise Strategy.** The Public Health Emergency Medical Countermeasure Enterprise (PHEMCE) Strategy includes "medical countermeasures" (pharmaceutical interventions such as vaccines, antimicrobials and antitoxins) and non-pharmaceutical interventions (diagnostics, ventilators, personal protective equipment and patient decontamination) that may be used to prevent, mitigate or treat the adverse health effects of an intentional, accidental or naturally occurring chemical, biological, radiological or nuclear threat. See https://www.phe.gov/Preparedness/mcm/phemce/Pages/about.aspx.

q. **Vulnerable Patients.** Vulnerable patients are patients enrolled in Home-based Primary Care (HBPC), home oxygen, homeless, spinal cord/vent, nursing home, high-risk mental health, dialysis, chemotherapy and infusion services and tier 1 telehealth programs.

4. POLICY

It is VHA policy to provide health security for Veterans, military personnel, first responders and the public during emergencies, as appropriate.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Designating VHA OEM as the program office responsible for the overall coordination of emergency management within VHA.

(2) Determining resources to be shared and establishing crisis standards of care for VHA during emergencies, in consultation with VA leadership, the Assistant Secretary for Preparedness and Response, Department of Health and Human Services, the Assistant Secretary of Defense for Health Affairs, Department of Defense and other officials. ***NOTE:*** *The responsibility to set controls on what resources are shared with other Federal agencies and with SLTT entities during emergencies and establish crisis standards of care is a discretionary act.*

(3) Serving as a member of the NDMS Senior Policy Group (SPG).

(4) Serving as co-chairperson of the Health Executive Committee (HEC) with the Assistant Secretary of Defense for Health Affairs.

(5) Serving as a member of the Department of Health and Human Service PHEMCE.

(6) Ensuring the timely research, development, regulation, procurement, stockpiling, maintenance, deployment and utilization of priority emergency medical countermeasures.

(7) Serving as a member of the VA Secretary's ERG to support the PMEF of VA. ***NOTE:*** *For more information see: https://www.va.gov/VHAEMERGENCYMANAGEMENT/CEMP/CEMP_COOP.asp*.

(8) Ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health.** The Deputy Under Secretary for Health is responsible for:

(1) Ensuring directors of VHA program offices actively support requests for assistance communicated through the EMCC.

(2) Serving as a member of the VA Secretary's ERG to support the PMEF of VA.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Serving in the ICS Agency Executive role for the VHA EMCC, providing command and control to the Veterans Integrated Service Networks (VISNs) for the continuous and safe operation of all VA medical facilities during emergencies.

(2) Providing oversight of VISNs to assure compliance with this directive, relevant standards and applicable regulations.

(3) Providing available support to DoD for medical care of military personnel as defined under the VA-DoD Memorandum of Understanding and VA-DoD Contingency Hospital System Plan (see VHA Handbook 0320.04, Department of Veterans Affairs and Department of Defense Contingency Plan, dated May 31, 2014).

(4) Serving as a member of the VA Secretary's ERG to support the PMEF of VA.

(5) Communicating the contents of this directive to each VISN.

(6) Providing assistance to VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

d. **Deputy Assistant Under Secretary for Health for Operations.** The Deputy Assistant Under Secretary for Health for Operations is responsible for:

(1) Providing oversight for the entire VHA OEM organization.

(2) Serving as a member of the VA Secretary's ERG to support the PMEF of VA.

e. **Director, VHA Office of Emergency Management.** The Director, VHA OEM is responsible for:

(1) Establishing CEMP requirements for program offices, VISNs and VA medical facilities.

(2) Engaging stakeholders to establish the strategic direction for VHA CEMP. ***NOTE:*** *Stakeholders refers to both internal VHA organizations and intergovernmental bodies such as HHS and DoD.*

(3) Ensuring VHA OEM provides situational awareness information needed by VHA leadership to support the requirements identified by VISNs during emergencies. Such information is obtained through open source information products developed by the VHA Watch Office and reports from VISNs and VA medical facilities.

(4) Overseeing the Medical Emergency Radiological Response Team (MERRT) (see VHA Directive 0320.05, Medical Emergency Radiological Response Team Program, dated August 12, 2019).

(5) Directing the Disaster Emergency Medical Personnel System (DEMPS) (see VHA Handbook 0320.03, Disaster Emergency Medical Personnel Management (DEMPS), dated March 26, 2008).

(6) Coordinating the deployments of personnel, mobile assets and other logistical support to meet requirements from VISNs and other Federal agencies during emergencies, special events and exercises.

(7) Providing technical assistance and available funding to VA medical facilities for emergency management capability development, assessment and performance improvement. ***NOTE:*** *The VHA OEM Director approves distribution of EMPI funds requested by VISNs and VA medical facilities. VA medical facility requests are additionally reviewed and approved by their respective VISN office.*

(8) Ensuring the development, testing and maintenance of VHA continuity procedures.

(9) Managing a comprehensive CEMP education, training and exercise program.

(10) Providing technical assistance and available funding to VA medical facilities for the development and maintenance of first receivers decontamination and all-hazards response teams.

(11) Providing staff to advise and help coordinate readiness and patient movement operations at VA medical facilities designated as NDMS Federal Coordinating Centers (FCCs), Primary Receiving Centers (PRCs) and Secondary Support Centers (SSCs) for the VA-DoD Contingency Hospital System.

(12) Collaborating with the VA Emergency Management Evaluation Center (VEMEC) on research that contributes to the health security for Veterans.

(13) Providing subject matter expertise to advise VA medical facilities on development of plans for mobilization and use of the VA All Hazards Emergency Caches (AHEC).

(14) Maintaining information systems (e.g., Performance Improvement Management System (PIMS)) that support the VHA CEMP.

(15) Providing planning, resource coordination, expertise and emergency management staff to support the emergency management requirements of VA special events and National Special Security Events (NSSEs).

(16) Establishing policy and guidance for compliance with NIMS.

(17) Maintaining an inventory of VHA OEM vehicles, equipment and supplies that can be deployed to support intra-/inter-agency requirements during emergencies.

(18) Overseeing the operations of the VHA Watch Office.

(19) Ensuring VHA OEM compliance with all VA CEMP requirements.

(20) Reviewing and certifying VA medical facility EOPs and supporting documents.

f. **VHA Program Office Director.** The Directors of VHA program offices with assigned emergency management responsibilities will ensure compliance with all CEMP requirements.

g. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Assigning staff with existing emergency management duties to coordinate VISN and VA medical facility emergency management activities in collaboration with VHA OEM staff.

(2) Providing guidance and coordination to VA medical facility Directors during emergencies.

(3) Proactively identifying vulnerabilities to infrastructure, security and health care operations through annual Hazards Vulnerability Analyses (HVA), program reviews and implementing improvement projects. (See VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, dated April 6, 2017.)

(4) Enhancing partnerships with SLTT health and emergency management authorities.

(5) Coordinating a VISN-wide effort to organize, train and equip staff to support internal or external requirements during emergencies. (See VHA Handbook 0320.03.)

(6) Ensuring the reporting of emergencies.

(7) Maintaining the capability to coordinate VISN-wide response to and recovery from emergencies.

(8) Ensuring VISN office and VISN-wide compliance with the VHA CEMP requirements by reviewing EMCAP reports prepared by OEM. ***NOTE:*** *Compliance entails the development and execution of an Improvement Plan.* (See VHA Directive 0320.01.)

(9) Ensuring VA medical facilities provide outreach to vulnerable patients during emergencies.

(10) Approving EMPI funds requested by VA medical facilities within their VISN.

h. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Assigning staff emergency management duties to coordinate the VA medical facility CEMP in collaboration with the VISN and VHA OEM staff.

(2) Enhancing and maintaining partnerships with health care coalitions and community response partners.

(3) Providing reports on the status of the VA medical facility's CEMP through PIMS.

(4) Ensuring VA medical facility compliance with VHA CEMP requirements.

(5) Providing guidance regarding policy and direction to the VA medical facility emergency management team.

(6) Applying criteria to make decisions regarding the curtailment of services, closure of facilities, use of alternate care sites, application of crisis standards of care and evacuation of facilities.

(7) Rendering the determination to provide emergency medical services to non-VA beneficiaries as a humanitarian service during local emergencies, on a cost reimbursable basis.

(8) Furnishing hospital care and medical services to individuals responding to, involved in or otherwise affected by disasters and emergencies that have been declared by the President under the Stafford Act (42 U.S.C. § 5121 et seq.), or during activation of the NDMS based on VA medical facility capabilities.

(9) Delivering care to active-duty Service members during war and immediately following a war or national emergency based on VA medical facility capabilities.

(10) Distributing medical countermeasures to Veterans, employees (including contractors), family members and others on VA property during a disaster or emergency declared under the Public Health Service Act (P.L. 78-410) or the Stafford Act.

(11) Sharing health care resources with other health care providers, entities or individuals subject to a sharing agreement within statutory limitations and availability of resources.

(12) Utilizing Government-owned or leased vehicles to transport employees to and from the VA medical facility and nearest adequate public transportation, or, if such public transportation is either unavailable or not feasible to use, to and from the VA medical facility and their home, on a cost reimbursable basis with VA Secretary approval. (See VA Directive 0637, VA Vehicle Fleet Management Program, dated May 10, 2013.)

(13) Providing situation reports to the VISN Office including any unmet requirements.

(14) Organizing, training and equipping VA medical facility staff to respond to internal or external requirements during emergencies.

(15) Providing training to resident medical staff and health care personnel on public health emergencies.

(16) Based on the mission of the VA medical facility, overseeing patient reception planning and operations under VA/DoD sharing authorities and the NDMS.

(17) Maintaining a health care continuity capability that is fully integrated into the VA medical facility's EOP.

(18) Conducting a VA medical facility after-action review process following an emergency and participating in other after-action review processes to identify corrective or preventive actions to be added to the VA medical facility's improvement plan.

(19) Appointing primary and secondary DEMPS Coordinators.

(20) Ensuring the use and maintenance of a mass notification system.

(21) Ensuring outreach is provided to vulnerable patients during emergencies.

(22) Ensuring that VA medical facility-specific profile information is provided in PIMS.

(23) Authorizing VA medical facility requests for EMPI funds.

(24) Ensuring that the VA medical facility provide bed reports quarterly for VA-DoD Contingency Hospital System.

(25) Ensuring that the VA medical facility report Dual Use Vehicle (DUV) readiness.

(26) Ensuring that the VA medical facility report on the status of their First Receivers Decontamination Program annually.

(27) Ensuring that the VA medical facility file Issue Briefs or Heads Up messages when emergencies occur.

6. REPORTS

PIMS is used to manage the records of VA medical facility emergency management programs, such as Emergency Management Capability Assessment Program (EMCAP) reports, self-assessments and the status of requests for EMPI funds. Situation reporting during emergencies will occur through normal administrative channels, unless otherwise directed by VHA OEM.

7. TRAINING

There are no formal training requirements associated with this directive. Other 0320-series VHA directives identify specific training recommendations and requirements.

8. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

9. REFERENCES

a. P.L. 78-410

b. 38 U.S.C. § 1784, 1785, 8111A, 8117 and 8153.

c. 42 U.S.C. § 300hh-300hh-31, and § 5151-5208.

d. 45 C.F.R. Part 160, 164 Subparts A and C.

e. Executive Order (EO)12657, Federal Emergency Management Agency Assistance in Emergency Preparedness Planning at Commercial Nuclear Power Plants.

f. Presidential Policy Directive (PPD)-8, National Preparedness.

g. Presidential Policy Directive (PPD)-21, Critical Infrastructure Protection and Resilience.

h. Presidential Policy Directive (PPD)-22, National Special Security Events.

i. Presidential Policy Directive (PPD)-40, Continuity of Operations.

j. Homeland Security Presidential Directive (HSPD)-5, Management of Domestic Incidents.

k. Homeland Security Presidential Directive (HSPD)-10, Biodefense for the 21st Century.

l. Homeland Security Presidential Directive (HSPD)-18, Medical Countermeasures against Weapons of Mass Destruction.

m. Homeland Security Presidential Directive (HSPD)-20, Federal Continuity Program.

n. Homeland Security Presidential Directive (HSPD) -21, Public Health and Medical Preparedness.

o. VA Directive 0320, VA Comprehensive Emergency Management Program, dated August 13, 2012.

p. VA Directive 0321, Serious Incident Reports, dated June 6, 2012.

q. VA Directive 0322, VA Integrated Operations Center (VA IOC), dated April 29, 2010.

r. VA Directive 0324, Test, Training, Exercise, and Evaluation Program, dated April 5, 2012.

s. VA Directive 0637, VA Vehicle Fleet Management Program, dated May 10, 2013.

t. VA Directive 5011/2, Hours of Duty and Leave, dated June 16, 2004.

u. VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, dated April 6, 2017.

v. VHA Directive 0320.05, Medical Emergency Radiological Response Team Program, dated August 12, 2019.

w. VHA Handbook 0320.03, Disaster Emergency Medical Personnel Management (DEMPS), dated March 26, 2008.

x. VHA Handbook 0320.04, Department of Veterans Affairs and Department of Defense Contingency Plan, dated March 13, 2014

y. VHA Emergency Management Capability Assessment Program Guide.

z. VHA Emergency Management Program Guide.

aa. VHA Emergency Management Program Guidebook.

bb. VHA Physical Security and Design Manual: http://vaww.ceosh.med.va.gov/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

cc. VA Financial Policy Vol. XIII Chapter 6, Accounting During Declared Emergencies: https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIIIChapter06.pdf.

dd. Department of Health and Human Services, National Disaster Framework.

ee. Department of Health and Human Services, National Health Security Strategy.

ff. Department of Health and Human Services, National Homeland Security Strategy.

gg. Department of Health and Human Services, National Infrastructure Protection Plan.

hh. Department of Health and Human Services, National Response Framework.

ii. Centers for Medicare and Medicaid Services, Emergency Preparedness Rule (See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule).

jj. The Joint Commission, Emergency Management Standards: http://vaww.ceosh.med.va.gov/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

kk. Commission on the Accreditation of Rehabilitation Facilities, Health and Safety: http://vaww.ceosh.med.va.gov/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

ll. National Fire Protection Association (NFPA), NFPA 99 – Health Care Facilities Code, Chapter 12, Emergency Management: http://vaww.ceosh.med.va.gov/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

mm. National Fire Protection Association (NFPA), NPFA 1600 – Standard on Continuity, Emergency, and Crisis Management.

nn. Institute of Medicine, Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. March 21, 2012.

Appendix M: VHA Directive 0320.01

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 0320.01
Transmittal Sheet
April 6, 2017

VETERANS HEALTH ADMINISTRATION COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM (CEMP) PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes implementation procedures for the Comprehensive Emergency Management Program (CEMP). It supports VHA Directive 0320 by articulating the overall roles and responsibilities of officials, key staff and all employees in emergency management at the VA Medical Center (VAMC), Veterans Integrated Service Network (VISN) and VHA Central Office (VHACO) levels. Other 0320-series VHA Handbooks provide additional detail on the roles and responsibilities for specific program areas.

2. SUMMARY OF CONTENTS: This VHA directive contains procedures for carrying out the VHA CEMP whose purpose is to ensure the continuity of medical and hospital services to Veterans, and during disasters and emergencies, to military personnel, responders and civilians, as appropriate.

3. RELATED ISSUES: VHA Directive 0320 and VHA 0320-series Handbooks.

4. RESPONSIBLE OFFICE: The VHA Office of Emergency Management (VHA OEM - 10NA1) is responsible for the contents of this VHA directive. Address questions to the Director, OEM at 304-264-4826.

5. RESCISSIONS: VHA Handbook 0320.2, dated June 12, 2000, is rescinded.

6. RECERTIFICATION: This VHA directive is due to be recertified on or before the last working day of April 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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

DISTRIBUTION: Emailed to the VHA Publications Distribution List on April 11, 2017.

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VETERANS HEALTH ADMINISTRATION COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM (CEMP) PROCEDURES

VETERANS HEALTH ADMINISTRATION COMPREHENSIVE EMERGENCY MANAGEMENT PROGRAM (CEMP) PROCEDURES

1. PURPOSE

The purpose of this Veterans Health Administration (VHA) directive is to clarify roles and responsibilities for the implementation of the VHA Comprehensive Emergency Management Program (VHA CEMP). The purpose of the VHA CEMP is to ensure the continuity of medical and hospital services for Veterans, and during a disaster or emergency, to civilians, as appropriate. **AUTHORITY:** The VHA CEMP is based upon the following public laws, regulations, executive orders, VA and VHA Directives and Handbooks:

a. Title 38, United States Code (USC), Sections 1784, Humanitarian Assistance; 1785, Care and Services during Certain Disasters; 8110, Operation of Medical Facilities; 8111A, Furnishing of Health Care to Members of the Armed Forces (P.L. 97-174); 8117, Emergency Preparedness (P.L. 107-287); and, 8153, Sharing of Health Care Resources.

b. Title 42, USC, Sections 5121-5208 – Disaster Relief (specifically, 5192 - Federal Emergency Assistance (P.L. 100-707)); and, Section 201-300mm61 – Public Health Service (specifically, 300hh-300hh31 – National All-Hazards Preparedness for Public Health Emergencies (P.L. 107-188)).

c. Homeland Security Presidential Directive 5, Management of Domestic Incidents.

d. Presidential Policy Directive 8, National Preparedness.

e. Homeland Security Presidential Directive 20, Federal Continuity Program.

f. Presidential Policy Directive 40, National Continuity Policy.

g. Department of Veterans Affairs (VA) Directives 0320-0324 and 5011.

h. VHA Directive 0320.

2. BACKGROUND

The outcome of an effective CEMP is increased resilience, ensuring the continuity of health care service delivery, and access to care. The following objectives support this outcome:

a. Identify the impacts on health care and other essential services from potential hazards, threats, incidents and events.

b. Focus mitigation activities on decreasing the vulnerabilities from such hazards,

threats, incidents and events, as well as increasing the resilience of systems and resources that support essential services.

c. Demonstrate the requisite levels of readiness and competence at VAMC, VISN, and VHACO levels through on-going, all-hazards preparedness activities.

d. Minimize the impact of incidents and events on people, health care and other services, vital records, property, and the environment by facilitating effective and efficient response activities.

e. Restore access to and the delivery of health care services.

f. Monitor program performance and establish processes for continuous improvement.

g. Evaluate compliance with applicable standards.

3. POLICY

The VHA CEMP includes all activities assigned to VHA through the authorities listed in Section 1. Responsibilities assigned to VAMC leadership and staff in this document include the VAMC and its Community Based Outpatient Clinics (CBOCs), satellite clinics, mobile clinics, home care programs, telehealth sites and business occupancy sites for administrative functions, and tenant organizations.

4. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Ensuring the coordination of VA and VHA program offices whose responsibilities include activities which fall within the scope of the VHA CEMP.

(2) Ensuring VHA programs and construction designs and specifications comply with CEMP requirements.

(3) Ensuring a contingency capacity to assist the Department of Defense (DoD) in time of war or national emergency to care for the casualties of such war or national emergency is maintained.

(4) Providing health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency as part of the National Disaster Medical System (NDMS), as directed.

(5) Supporting the Department of Health and Human Services (HHS), to furnish available VHA hospital care and medical services to individuals responding to, involved in, or otherwise affected by incidents and events, as directed.

(6) Supporting, in cooperation with HHS, the development of state and local plans for the provision of disaster medical services, as well as the development of national plans to mobilize the health care industry during national security emergencies.

(7) Ensuring, in cooperation with VA, the development and maintenance of a continuity of government/operations program across VHA.

(8) Serving as, or designating, the VHA Agency Executive for each operational period during incidents and events.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible for:

(1) Ensuring that clinical policy and technical expertise is coordinated and integrated within the VHA incident management process.

(2) Serving as the VHA Agency Executive in the absence of the Under Secretary for Health during emergencies and disasters.

c. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Designating VHA OEM as the Program Office for the VHA CEMP.

(2) Providing adequate resources to implement the VHA CEMP.

(3) Ensuring compliance with VHA CEMP policies and procedures.

(4) Ensuring OEM, VISNs and VAMCs use the National Incident Management System (NIMS) Incident Command System (ICS) to manage all incidents and events.

d. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for:

(1) Ensuring relevant program office participation in support of the Emergency Management Coordination Cell (EMCC).

(2) Providing appropriate subject matter expertise to address unique incident and event-related policy requirements, as required.

e. **Assistant Deputy Under Secretary for Health, Administrative Operations.** The Assistant Deputy Under Secretary for Health, Administrative Operations is responsible for:

(1) Overseeing the VHA OEM.

(2) Ensuring the support and integration of all relevant VHA expertise in the EMCC during incidents or events, disasters, emergencies, exercises, or other contingencies.

(3) Providing appropriate subject matter expertise to address unique incident-related policy requirements, as required.

f. **VHA Central Office Senior Officer.** Each VHA Central Office Senior Officer is responsible for:

(1) Ensuring portions of the VHA Emergency Operations Plan (EOP) relevant to their areas of responsibility are kept current, and personnel are knowledgeable of their roles and responsibilities through participation in training and exercises, and implementation during emergencies.

(2) Identifying program offices and personnel with technical expertise relevant to issues particular to policy being considered by the EMCC.

h. **VHA Emergency Management Coordination Cell.** The Emergency Management Coordination Cell (EMCC) serves as the central point of communication and coordination for the Under Secretary of Health in planning for, responding to, and recovering from significant incidents/events that require national level direction/support or supporting federal interagency requests for assistance. The EMCC provides VHA incident action planning and operational situation reporting, as well as coordination of VHA logistical, administrative, and financial support for VHA and other VA administrations as needed during incidents and events. The EMCC also serves as the focal point for synthesis of public health, medical, and special needs information related to the emergency, disaster, or contingency on behalf of the VHA

i. **Director, Office of Emergency Management.** The Director, VHA Office of Emergency Management (VHA OEM) is responsible for:

(1) Focusing the VHA CEMP on increasing the resiliency of VHA infrastructure and supporting systems to ensure continuity of health care and other essential services to Veterans, military personnel, responders and the public during emergencies, as appropriate.

(2) Establishing VHA CEMP performance standards for line officials and those in related program offices under the Under Secretary for Health's supervision;

(3) Leading and overseeing the activities of the VHA OEM.

(4) Creating automated systems for data collection, analysis, reporting and operations.

(5) Establishing an evidence-based system for the development, implementation, evaluation and improvement of the VHA CEMP.

(6) Promoting unity of effort between VISN, VAMC and VHA OEM emergency management staff through quarterly system-wide coordination calls.

(7) Approving the distribution of performance improvement funds for VISNs and VAMCs.

(8) Assisting and advising the Assistant Deputy Under Secretary for Health/Administrative Operations on VHA policies and programs related to enhancing the resiliency and continuity of health care and other services.

(9) Developing periodic and annual reports to VHA leadership.

(10) Establishing and maintaining a deployable personnel system.

(11) Serving as the Under Secretary for Health's liaison to the VA Integrated Operations Center (VAIOC).

(12) Implementing the VA-DoD Contingency Hospital System and VA support of DoD during war and national security emergencies, and providing a liaison to the United States Transportation Command.

(13) Implementing the VHA EOP during emergencies and disasters that affect or involve VHA Central Office, VISNs or VAMCs.

(14) Ensuring the use of NIMS ICS within VHA OEM to manage all incidents and events.

(15) Leading the development of a VHA-wide system of emergency response resources, including maintaining an inventory of these assets.

(16) Coordinating VHA support of the national planning frameworks and other Federal emergency plans and activities.

(17) Providing technical assistance and support to VHA entities not directly associated with VISN and/or VAMC CEMPs (e.g., Consolidated Mail-Out Pharmacies, Call Centers), as appropriate.

(18) Assigning OEM staff to support the readiness of VAMCs designated as NDMS FCCs.

(19) Providing liaisons to the HHS Secretary's Operations Center (SOC); to field-based HHS Incident Response Coordination Teams (IRCT); and/or, to the Department of Homeland Security (DHS) Joint Field Office (JFO).

(20) Providing VHA Watch Officers to serve as the VHA conduit for the VAIOC, working with VHA Network Support Office to process all Requests for Information (RFIs), Requests for Assistance (RFAs) and situational awareness products regarding current events that may have significance to VHA.

(21) Serving as the VHA EMCC Director during incidents and events, as directed.

j. **OEM Regional Emergency Manager.** The OEM Regional Emergency Manager (REM) is responsible for:

(1) Leading and supervising the OEM regional staff in the development, implementation, evaluation and improvement of the VHA CEMP in assigned VISNs.

(2) Serving as the primary OEM liaison to the VISN Office leadership in assigned areas on issues related to VISN CEMP status, performance and customer satisfaction, including facilitating periodic meetings with VISN Office leadership for planning, consultation and evaluation.

(3) Using applicable reporting systems to review data on the assigned VISN CEMP status, performance and customer satisfaction.

(4) Gathering and analyzing data and creating reports that describe the status and performance of VISN CEMPs to assist with improving performance and customer satisfaction.

(5) Participating on the OEM senior management committee in reviewing and analyzing data related to the VISN CEMPs and making recommendations to the VHA OEM Director for changes in policies and procedures, funding levels and program activities in order to enhance VHA OEM support to VISN CEMPs.

(6) Providing liaison to the HHS, Federal Emergency Management Agency (FEMA), and other Federal agencies for regional planning, response and recovery support.

(7) Providing management, guidance and response planning for the VHA OEM disaster support cadres to ensure the readiness of OEM staff for the support of VHA or other Federal agency requirements.

(8) Serving as the VHA Agency Representative to the FEMA Regional Response Coordination Center (RRCC), and the VA Agency Representative to the HHS SOC, and other roles as required.

k. **OEM Area Emergency Manager**. OEM Area Emergency Managers (AEMs) are responsible for:

(1) If designated as the VISN Liaison AEM, supporting the REM in providing liaison to the VISN Office leadership in assigned areas.

(2) Supporting the VHA CEMP in assigned areas under the supervision of the REM.

(3) Providing technical assistance and support to VISN and VAMC emergency management programs.

(4) Providing technical assistance and support to VHA entities not directly associated with VISN and/or VAMC CEMPs (e.g., Consolidated Mail-Out Pharmacies, Call Centers), as assigned.

(5) In coordination with designated VAMCs, support the VA~DoD Contingency Hospital System and NDMS, as appropriate.

(6) Using designated automated systems to review data on VISN and/or VAMC CEMP status, performance and customer satisfaction in order to assist with VHA CEMP improvement activities.

(7) Providing liaison to State and local government agencies and other organizations and programs designed to enhance mitigation, preparedness, response, recovery and resilience of public health and medical service delivery during disasters and emergencies to ensure linkage to VHA facilities and VISNs.

(8) Participating on incident management teams to support VHA Central Office, VISNs, VAMCs, and other Federal agencies.

(9) Conducting annual inspections of the VHA all hazards caches.

(10) Participating in assessments of VISN and VAMC CEMPs; providing technical assistance on performance improvement activities; making recommendations for performance improvement funding requests; and, monitoring the results of these activities, in partnership with VAMC and VISN Emergency Managers.

(11) Participating in and providing assistance with implementation of training and exercises to increase VHA OEM, VISN and VAMC staff proficiencies in carrying out response and recovery roles.

(12) Serving as the VHA Agency Representative to State and/or local EOCs, and/or in an appropriate ICS role during emergencies and disasters that affect or involve the VISN Office or VAMC, or other positions as required.

l. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for:

(1) Ensuring the VISN Office and VISN-wide CEMP meets VHA CEMP requirements.

(2) Establishing a VISN-wide Emergency Management Committee (EMC) by charter.

(3) Supporting a contingency capacity to assist the DoD in time of war or national emergency to care for the casualties of such war or national emergency, as appropriate.

(4) Supporting health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims in cases of humanitarian assistance, as appropriate, and during a public health emergency as part of the NDMS Federal Coordinating Center (FCC), as designated.

(5) Supporting an annual schedule of training and exercises.

(6) With input from the VA medical facilities, establishing an evidence-based system for the development, implementation, evaluation and improvement of the VISN-wide CEMP.

(7) Promoting unity of effort between VISN, VA medical facility and OEM emergency management staff, including periodic meetings with the OEM Regional Emergency Manager (REM), OEM VISN Liaison Area Emergency Manager (AEM) and/or VHA OEM leadership to discuss the VISN-wide CEMP.

(8) Requiring the use of designated automated systems for inputting data from assessments, exercises, incidents and events that reflect the status and performance of VAMC and the VISN CEMPs.

(9) Ensuring a cadre of staff and other resources to support incident management requirements, including maintaining an inventory of these assets.

(10) Ensure the rollup of facility annual business process analyses and business impact analyses for continuity of operations planning.

(11) Ensuring the VISN Office and facilities use NIMS ICS to manage incidents and events.

(12) Designating staff to serve on the VISN Office incident management team.

(13) Activating the VISN EOP to ensure VISN Office continuity and/or VISN-wide coordination during incidents and events that affect medical and hospital service delivery within the VISN, as needed, in coordination with facilities, other VISNs and OEM.

(14) Managing, controlling, communicating, and coordinating among facilities within the VISN and with the Network support team and VHA OEM during emergencies.

(15) Supporting the priorities set by VAMC Directors for the restoration of any degraded VHA medical or hospital services resulting from disasters and emergencies.

(16) Ensuring emergency situation and resource status information involving the VISN is reported.

(17) Serving as, or designating, the VISN Agency Executive for each operational period during emergencies and disasters.

m. **VISN Emergency Manager.** The VISN Emergency Manager (VISN EM) is responsible for:

(1) Developing, implementing, evaluating and improving the VISN Office CEMP to ensure it meets VHA CEMP requirements and provides for effective response and recovery activities.

(2) Ensuring the coordination of the VISN-wide CEMP in collaboration with VHA OEM.

(3) Establishing and regularly testing VISN-wide plans and procedures for the continuity and restoration of health and medical services.

(4) Providing leadership, support and/or consultation to the VISN EMC and working groups, as designated by VISN leadership.

(5) Using designated automated systems for inputting data from assessments, exercises, incidents and events that reflect the status and performance of the VISN CEMP.

(6) Managing requests for performance improvement funds, and providing quarterly reports on the implementation of EMPI grant monies, from VA medical facilities and the VISN Office through the OEM as instructed.

(7) Developing deployable emergency response staff and resources within the VISN, including maintaining an inventory of these assets.

(8) Developing an annual training plan for VISN Office staff and directing the training and exercising of those staff to perform NIMS ICS and continuity roles during emergency operations.

(9) Participating in VHA CEMP training, professional development, working groups and other activities.

(10) Serving in a NIMS ICS role during incidents and events that affect or involve the VISN.

n. **VISN Emergency Management Committee.** The VISN Emergency Management Committees (VISN EMC) is responsible for:

(1) Establishing goals and providing governance and policy direction for the VISN-wide CEMP the scope of which includes the VISN Office and all VA medical facilities in the VISN. The VISN EMC shall be established by charter and a member of leadership appointed as Chair. The VISN EMC shall include VISN Office and facility leadership, key clinical and non-clinical managers, and AEMs; meet at least quarterly; coordinate and collaborate with other relevant committees; and, document that process.

(2) Monitoring the status and performance of the VISN-wide CEMP, including conducting an annual review of the VISN Office EOP, Continuity of Operations Plan (COOP), and Hazards Vulnerability Analysis (HVA); reviewing the results of VISN EMCAP assessments, exercises, incidents and events; approving recommendations and funding requests for improvement activities; establishing an annual work plan to carry out improvement activities and training and exercises; and, tracking of action items to completion.

(3) At least annually conducting a review of the collective VISN-wide strengths, weaknesses, priorities and requirements for improvement that is documented in writing and sent to VISN leadership for review and approval.

o. **VA Medical Center Director.** The VA Medical Center (VAMC) Director is responsible for:

(1) Ensuring the VAMC CEMP meets VHA CEMP requirements.

(2) Establishing a VAMC EMC, and providing feedback to the VISN EMC.

(3) Maintaining a contingency capacity to assist the DoD in time of war or national emergency to care for the casualties of such war or national emergency, as appropriate.

(4) Providing health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims in cases of humanitarian assistance, as appropriate, and during a public health emergency as part of Presidentially-declared disasters under the Stafford Act that may involve the NDMS FCC, as designated.

(5) Serving as the NDMS FCC Director, as appropriate, and designating appropriate staff to coordinate with and designate a backup to the AEM as FCC Coordinator.

(6) Supporting an annual schedule of training and exercises.

(7) Conducting annual business process analyses and business impact analyses for continuity of operations planning.

(8) Establishing an evidence-based system for the development, implementation, evaluation and improvement of the VAMC CEMP.

~~(9)~~ Ensuring a cadre of staff and other resources to support incident management requirements, including maintaining an inventory of these assets.

(10) Ensuring the use of designated automated systems for inputting data from assessments, exercises, incidents and events; monitoring and reporting the status and performance of the VAMC CEMP.

(11) Approving the facility's requests for performance improvement funds, and ensuring these funds are used as planned.

(12) Ensuring the facility's use of NIMS ICS to manage all incidents and events.

(13) Maintaining the capability to decontaminate persons presenting to the facility for treatment.

(14) Ensuring that plans and processes are in place and evaluated annually for the use of the VA all-hazards cache and other medical-related stockpiles for the treatment

of Veterans, staff and the public in emergencies.

(15) Ensuring information on emergency management is accessible to all Veterans within the catchment area, their family members and/or caregivers.

(16) Designating staff to serve on the VAMC incident management team.

(17) Implementing the VAMC EOP during incidents and events that affect or involve the facility, in coordination with the local community, other facilities, the VISN Office, and VHA OEM.

(18) Providing situation and resource status during emergencies involving the VAMC and its facilities.

(19) Serving as, or designating, the VAMC Agency Executive for each operational period during emergencies and disasters.

(20) Ensuring all Community Based Outpatient Clinics (CBOCs) and satellite operations not located on the facility campus participate in the VAMC CEMP, including identifying an emergency management lead at each site to maintain and implement emergency procedures, in conjunction with the VAMC EMC.

p. **VAMC Emergency Manager.** The VAMC Emergency Manager (VAMC EM) is responsible for:

(1) Developing, implementing, maintaining, evaluating and improving the VAMC CEMP and ensuring it meets VHA, accreditation, and other regulatory requirements, including providing technical assistance and support to satellite offices and to the CBOC emergency response leads.

(2) Providing leadership, support and consultation to the VAMC EMC and working groups, as designated by facility leadership.

(3) Conducting an annual program evaluation to determine the status and performance of the VAMC CEMP for the purposes of improvement.

(4) Using designated automated systems for inputting data from assessments, exercises, incidents and events; monitoring and reporting the status and performance of the VAMC CEMP.

(5) With assistance from the AEM, as needed, developing facility requests for performance improvement funds, overseeing the management of grant monies through completion, and providing quarterly updates to VISN EMC regarding same.

(6) Leading the development of a cadre of staff and other resources to support incident management requirements, including maintaining an inventory of these assets.

(7) Training and exercising staff designated to perform NIMS ICS roles during facility

emergency operations, to increase staff proficiencies.

(8) Participating in VHA CEMP training, professional development, working groups and other activities.

(9) Developing an annual training and exercise program.

(10) Collecting situation and resource status involving the VAMC and/or its subordinate medical facilities.

(11) Serving in a NIMS ICS role during emergencies and disasters that affect or involve the VAMC.

q. **VA Medical Center Emergency Management Committee.** The VA Medical Center Emergency Management Committees (VAMC EMC) is responsible for:

(1) Establishing goals and providing governance and policy direction for the VAMC CEMP (including all associated facilities such as CBOC). The VAMC EMC shall be established by charter and a member of leadership appointed as Chair. Membership must include leadership, key clinical and non-clinical operating unit managers and AEMs; must meet at least quarterly; coordinate and collaborate with other relevant committees; and, document the process.

(2) Monitoring the status and performance of the VAMC CEMP, including conducting an annual review of the VAMC EOP, COOP plan and HVA; the results of assessments, exercises, incidents and events; reviewing; and, approving recommendations from staff for improvement activities; establishing a work plan to carry out those improvement activities and training and exercises; seeking the input from VAMC senior leadership; reviewing and recommending approval of funding requests for improvement activities; and tracking of action items to completion.

(3) Annually conducting a comprehensive review of the CEMP to include: Objectives, scope, and update of the EOP; required annual training and exercise and accomplishments; emergency equipment, resources, and supplies inventory; EM budget requirements and expenditures; and priorities and requirements for program improvement. This review is documented in writing and is reviewed by the EMC and approved by the executive leadership team.

(4) Establishing and regularly testing plans and procedures for the continuity and restoration of health and medical services; and, providing that annual report to the VISN EMC and other data, as requested.

r. **Community-Based Outpatient Clinic Manager.** The Community-Based Outpatient Clinic (CBOC) Manager is responsible for participation in the affiliated VAMC EMC; disseminate and facilitate emergency management procedures and training at the CBOC; and, provide leadership to response efforts.

s. **VHA Key Operating Unit Managers.** VHA Key Operating Unit Managers, e.g.,

Departments, Services, Service Lines, Product Lines and so forth, with responsibilities in the EOP are responsible for:

(1) Ensuring participation in the development, maintenance and practice of Service-specific procedures to support resiliency, continuity and emergency operations.

(2) Providing and participating in training and exercises on emergency and continuity procedures and/or assigned staff.

t. **VHA Supervisors.** All VHA Supervisors are responsible for:

(1) Ensuring all employees have access to and understand the relevant emergency and continuity procedures for their place of work.

(2) Providing and participating in training and exercises on emergency and continuity procedures to staff and conducting testing to ensure proficiency.

u. **All VHA Employees.** All VHA employees are responsible for:

(1) Demonstrating proficiency through performance of relevant emergency and continuity procedures and the ability to explain to others what steps to take should an emergency occur.

(2) Participating in training and exercises on emergency procedures, as appropriate.

(3) Taking appropriate steps to ensure personal and family preparedness for emergency situations occurring in their home communities.

(4) Completing registration and data update of all supervised employees in VA-approved personnel accountability and notifications systems, as appropriate.

5. STANDARDS

Generally-accepted industry standards applicable to emergency management and business continuity define the scope and direction of the VHA CEMP. These include, but are not limited to:

a. Applicable Federal laws and regulations.

b. Applicable VA and VHA Directives and Handbooks.

c. Applicable VHA-accepted accreditation standards.

d. Emergency management standards certified by the American National Standards Institute (ANSI).

e. International Organization for Standardization (ISO) standards.

6. ACRONYMS

AEM	Area Emergency Manager
ANSI	American National Standards Institute
CBOC	Community-based Outpatient Clinic
CEMP	Comprehensive Emergency Management Program
COOP	Continuity of Operations Plan
DHS	Department of Homeland Security
DoD	Department of Defense
EMC	Emergency Management Committee
EMCC	Emergency Management Coordination Cell
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
FEMA	Federal Emergency Management Agency
FCC	Federal Coordinating Center
HHS	Department of Health and Human Services
HVA	Hazards Vulnerability Analysis
ICS	Incident Command System
IRCT	Incident Response Coordination Team (HHS)
ISO	International Organization for Standardization
JFO	Joint Field Office
MEF	Mission Essential Function
NDMS	National Disaster Medical System
NFPA	National Fire Protection Association
NIMS	National Incident Management System
PMEF	Primary Mission Essential Function

REM	Regional Emergency Manager
RFA	Request for Assistance
RFI	Request for Information
RRCC	Regional Response Coordination Center
SOC	Secretary's Operations Center (HHS)
VA/DoD	Department of Veterans Affairs/Department of Defense
VAIOC	VA Integrated Operations Center
VAMC	VA Medical Center
VAMC EM	VA Medical Center Emergency Manager
VAMC EMC	VA Medical Center Emergency Management Committee
VHA CO	Veterans Health Administration Central Office
VHA OEM	Veterans Health Administration Office of Emergency Management
VISN	Veterans Integrated Service Network
VISN EM	Veterans Integrated Service Network Emergency Manager
VISN EMC	Veterans Integrated Service Network Emergency Management Committee

7. REFERENCES

a. Department of Homeland Security (DHS), National Incident Management System (NIMS).

b. DHS, Federal Continuity Directives 1 and 2.

c. DHS, National Response Framework.

d. DHS, National Disaster Recovery Framework.

e. DHS, National Infrastructure Protection Plan.

f. DHS, Homeland Security Exercise and Evaluation Program (HSEEP).

g. DHS, National Preparedness System.

h. DHS, Ready.gov.

i. Department of Health and Human Services (HHS), Assistant Secretary for Preparedness and Response (ASPR), Healthcare Preparedness Capabilities, National Guidance for Healthcare System Preparedness.

j. HHS, ASPR, National Health Security Strategy Implementation Plan.

k. HHS, Medical Surge Capacity and Capability Handbook.

l. HHS, National Disaster Medical System (NDMS), Federal Coordinating Center (FCC) Guide.

m. HHS, Health Insurance Portability and Accountability Act (HIPAA) Waivers.

n. HHS, Emergency Medical Treatment and Active Labor Act (EMTALA) Waivers.

o. The Joint Commission, National Fire Protection Association (NFPA), and other regulatory and accrediting requirements.

p. International Organization for Standardization 9001, Quality Management System.

q. International Organization for Standardization 22301, Societal Security: Business Continuity Management Systems.

Appendix N: VHA Directive 0320.02

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Transmittal Sheet
VHA DIRECTIVE 0320.02
January 22, 2020

VETERANS HEALTH ADMINISTRATION HEALTH CARE CONTINUITY PROGRAM

1. REASON FOR ISSUE: This new Veterans Health Administration (VHA) directive establishes policy and responsibilities for ensuring continuity of essential health care functions and services during emergencies.

2. SUMMARY OF CONTENT: This directive provides policy and responsibilities for VHA program offices, Veterans Integrated Service Network offices, and VA medical facilities for continuity of access to, and the delivery of, health care services during emergencies.

3. RELATED ISSUE. VHA Directive 0320, Comprehensive Emergency Management Program (CEMP), dated April 12, 2013; VHA Directive 0320.01, CEMP Procedures, dated April 6, 2017.

4. RESPONSIBLE OFFICE: The Office of Emergency Management (OEM) (10NA1) is responsible for the contents in this Directive. Questions may be referred to the Director, OEM at [redacted] or [redacted]@va.gov.

5. RESCISSIONS: None.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day January 31, 2025. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY DIRECTION OF THE EXECUTIVE IN CHARGE:

/s/ Renee Oshinski
Deputy Under Secretary for Health for
Operations and Management

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publication Distribution List on January 23, 2020.

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VETERANS HEALTH ADMINISTRATION HEALTH CARE CONTINUITY PROGRAM

VETERANS HEALTH ADMINISTRATION HEALTH CARE CONTINUITY PROGRAM

1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy and responsibilities for the continuity of essential health care functions and services during emergencies. **AUTHORITY:** Title 38, United States Code (U.S.C.) 1784, 1785, 7301(b), 8117, 8153; 42 U.S.C. 300hh through 300hh31, 5192.

2. BACKGROUND

a. Disaster resilience is the ability to prepare and plan for, absorb, recover from, and more successfully adapt to adverse impacts of disasters. The Department of Homeland Security (DHS) is responsible for providing disaster resilience leadership by establishing government-wide policies and programs for coordinating disaster response among federal agencies, state, local, tribal, and territorial (SLTT) governments, private and non-profit organizations, and the public.

b. VHA applies DHS Continuity of Operations (COOP) and the National Preparedness System (NPS) policies. Current hospital accreditation standards also contain many of the COOP and NPS components related to health care.

c. One of the applicable federal statutes that governs VHA's emergency response is the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) (P. L. 93-288) as amended provides the statutory framework that governs the authority of the President and the Federal Emergency Management Agency (FEMA) to provide assistance to a State in response to an emergency or disaster.

3. DEFINITIONS

a. **Continuity.** Continuity is the ability to provide uninterrupted services and support, while maintaining organizational viability, before, during, and after an event that disrupts normal operations.

b. **Critical Infrastructure.** Critical Infrastructure is assets, systems, and networks, whether physical or virtual, so vital that their incapacitation or destruction would have a debilitating effect on safety, security, public health and/or the economy.

c. **Emergency.** An emergency is a hazard impact causing adverse physical, social, psychological, economic, or political effects requiring immediate actions to maintain or increase capacity and capability (call-back procedures, mutual aid, etc.), and commonly requires change from routine management methods to an incident command process to achieve the expected outcome. ***NOTE:*** *Synonymous with incident.*

d. **Emergency Management Coordination Cell.** VHA's Emergency Management Coordination Cell (EMCC) serves as the central point of communication and coordination for the Under Secretary for Health in planning for, responding to, and

recovering from significant incidents/events that require national level direction/support, or support to other federal agency requests for assistance.

e. **Emergency Operations Plan.** An Emergency Operations Plan (EOP) provides the structure and processes that the organization utilizes to respond to and initially recover from an incident/event. The EOP is implemented through the Incident Command System (ICS).

f. **Essential Functions.** Essential functions are those functions an organization must continue through emergencies. The identification and prioritization of essential functions is the foundation of continuity planning and establishes the parameters that drive an organization's continuity planning and preparedness efforts.

g. **Essential Records.** Essential records are those an organization needs to meet operational responsibilities during emergencies (emergency operating records) or to protect the legal and financial rights of the government and those affected by government activities (legal and financial rights records).

h. **Event.** An event is a planned non-emergency activity within a community that brings together a large number of people. Emphasis is not placed on the total number of people attending but rather the impact on the community's ability to respond to a large-scale emergency or disaster or the exceptional demands that the activity places on response services.

i. **Government Emergency Telecommunications System.** The Government Emergency Telecommunications System (GETS) supports national leadership; federal, state, local, tribal and territorial governments; first responders; and other authorized national security and emergency preparedness users. It is intended to be used in an emergency or crisis when the landline network is congested and the probability of completing a normal call is reduced.

j. **Incident Command System (ICS).** The Incident Command System (ICS) is a component of the National Incident Management System (NIMS) which provides a standardized organizational structure with common terminology to enable effective and efficient domestic incident management.

k. **Recovery/Reconstitution.** The recovery phase often overlaps with the response phase. Recovery and reconstitution include such actions as restoring essential functions and services, reestablishing disrupted critical infrastructure, accounting for the welfare of patients and employees, and providing support for those displaced by the disaster. Some of these activities may last for weeks, months or even years depending on the severity of the emergency.

l. **Resiliency.** Resiliency is the ability to maintain operational continuity or the ability to maintain mission critical business operations and regular health care services despite the effects of a hazard impact.

m. **Telework.** Telework is a work flexibility arrangement under which an employee performs the duties and responsibilities of his/her position and other authorized activities, from an approved worksite other than the location from which the employee would otherwise work.

n. **Wireless Priority Service.** Wireless Priority Service (WPS) supports national leadership; federal, state, local, tribal and territorial governments; and other authorized national security and emergency preparedness users. It is intended to be used in an emergency when the wireless network is congested and the probability of completing a normal call is reduced.

4. POLICY

It is VHA policy to ensure access to and delivery of health care services during emergencies, including the capability to respond to the needs of individuals and SLTT governments.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Providing leadership and policy to ensure continuity of health care in all Veterans Affairs (VA) medical facilities and all medical services to Veterans and other victims, as appropriate, through the EMCC.

(2) Coordinating policy for resource sharing with the Secretary of VA, the Assistant Secretary for Preparedness and Response (ASPR) in the Department of Health and Human Services (HHS), and other federal agencies.

(3) Establishing health care continuity priorities and policy for resource sharing in support of SLTT other federal agency requirements during emergencies.

(4) Establishing crisis standards of care for VHA in coordination with other federal and state agencies and adjudicating requests for scarce resources within VHA. ***NOTE:*** *For more information on crisis standards of care, see:* https://www.ncbi.nlm.nih.gov/books/NBK32748/.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible for:

(1) Ensuring directors of all VHA program offices are aware of their responsibilities for ensuring continuity of health care operations throughout the VHA enterprise.

(2) Ensuring directors of VHA program offices actively support requests for assistance communicated through the EMCC.

c. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Ensuring Veterans Integrated Service Network (VISN) Directors have the necessary resources to implement the responsibilities in this directive.

(2) Providing guidance, subject matter expertise and resource support to VISN Directors during emergencies that impact continuity of health care operations.

(3) Identifying resource requirements for the EMCC, as communicated by VISN Directors, for national-level support during emergencies that affect continuity of care.

d. **Assistant Deputy Under Secretary for Health for Administrative Operations.** The Assistant Deputy Under Secretary for Health for Administrative Operations is responsible for ensuring the development, and maintenance of VHA's continuity of health care operations program, and the program's compliance with regulatory and accreditation requirements.

e. **Director, Office of Emergency Management.** The Director, VHA Office of Emergency Management (OEM) is responsible for:

(1) Providing training, guidance and technical assistance to VISN Offices and VA medical facilities for the development, testing and improvement of health care continuity program.

(2) Maintaining procedures to ensure the ability to support resource requirements during incidents.

(3) Focusing OEM efforts on increasing the resiliency of the VHA health care system through the management of a mobile asset program.

(4) Conducting assessments of VA medical facility continuity of health care operations procedures and providing support for program improvement.

(5) Collaborating with officials from the HHS ASPR Hospital Preparedness Program, the Healthcare and Public Health Critical Infrastructure Protection Partnership, and other Federal and SLTT agencies to ensure awareness of VHA capabilities and requirements.

(6) Supporting VISNs, VA medical facilities, other Federal and SLTT agencies in response to a Public Health Emergency and/or a Stafford Act declaration for continuity of health care operations.

(7) Ensuring the regular testing of GETS/WPS capabilities.

(8) Upon recognition of a threat or incident and in consultation with the Assistant Deputy Under Secretary for Health for Administrative Operations, activating the EMCC.

f. **VHA Program Office Directors.** Directors of VHA program offices assigned to support the EMCC are responsible for:

(1) Developing and maintaining continuity of health care operations plans and ensuring all staff members are familiar with and understand their roles in VHA's health care resiliency.

(2) Ensuring key staff members maintain a telework capability.

(3) Maintaining essential records.

(4) Ensuring all staff members review the Occupant Emergency Plans (OEP) on a regular basis.

(5) Coordinating national-level support to VISNs affected by an incident by providing technical assistance through the EMCC, as designated or requested by the Principal Deputy Under Secretary for Health.

g. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring the VISN Office has developed and tested COOP procedures.

(2) Ensuring VA medical facilities incorporate COOP requirements that apply to health care operations in the development, testing, exercising, and maintenance of their EOPs.

(3) Coordinating with affected VA medical facilities within the VISN to determine resource requirements for ensuring continuity of health care operations.

(4) Identifying resource requirements for national-level support and communicating them to the VHA EMCC.

h. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Maintaining a health care continuity plan and incorporating applicable federal requirements in the development, testing and maintenance of the facility's EOP.

(2) Developing and coordinating the EOP and COOP plan, through the facility's Emergency Management Committee (EMC). ***NOTE:*** *For more information on the VA medical facility EMC, please see VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, dated April 6, 2017.*

(3) Developing, publishing, and communicating criteria for the suspension of service delivery and the closure of VA medical facilities during emergencies.

(4) Developing and implementing procedures for scarce resource allocation and crisis standards of care. ***NOTE:*** *When questions of uncertainty or conflict over values exist, contact the National Center for Ethics in Health Care (10E1E) at* [redacted]*@va.gov as a resource.*

(5) Developing criteria and procedures for shelter-in-place and the evacuation of patients.

(6) Developing reporting procedures for determining the status, safety, and accountability of employees and patients during incidents.

(7) Developing and implementing procedures to ensure rapid communication with patients and employees during emergencies through social media, phone, web, print, radio and television.

(8) Developing procedures for providing health care services in alternate locations.

(9) Coordinating with the VA Office of Information and Technology (VA OI&T) staff regarding computer applications that support essential health care services.

(10) Upon recognition of a threat or actual emergency that could impact health care continuity, implementing procedures to optimize access to and delivery of health care services.

i. **VA Medical Facility Operating Unit Managers.** VA medical facility operating unit managers, e.g., Departments, Services, Service Lines, and Product Lines, with responsibilities in the EOP are responsible for:

(1) Ensuring participation in the development, maintenance and exercise of service-specific procedures to support resiliency, continuity and emergency operations.

(2) Participating in training and exercises on emergency and continuity procedures.

j. **VA Medical Facility Supervisors.** VA medical facility supervisors are responsible for:

(1) Ensuring all employees have access to and understand the relevant emergency and continuity procedures for their place of work.

(2) Ensuring staff participation in exercises related to continuity of health care operations.

(3) Providing information and encouragement to staff to engage in personal and family preparedness, including development of a family disaster plan, the preparation of home emergency supplies and a kit for their vehicles.

6. TRAINING

a. There are no required trainings associated with this directive.

b. There are several recommended courses available. These are identified in the Program Guide associated with the directive. ***NOTE:*** *The associated Program Guide can be accessed at*

https://vaww.vha.vaco.portal.va.gov/sites/DUSHOM/10NA/VHAOEM/TEST%20OEM%20Staff%20Actions/Forms/AllItems.aspx?RootFolder=%2Fsites%2FDUSHOM%2F10NA%2FVHAOEM%2FTEST%20OEM%20Staff%20Actions%2FDirectives%2FHealth%20Care%20Continuuity&FolderCTID=0x012000F389FB5C7E63A44A84A9F55B4D3898C9&View=%7B9770C08E%2DFC0B%2D41E8%2D9F0B%2D799391676716%7D. This is an internal VA website that is not available to the public.

7. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA records control schedule 10-1. Any questions regarding any aspect of records management should be directed to the facility records manager or records liaison.

8. REFERENCES

a. 38 U.S.C. 7301(b), 1784, 1785, 8110, 8111A, 8117, and 8153.

b. 42 U.S.C. 5121 – 5208, 201 – 300mm61.

c. VHA Directive 0320, Comprehensive Emergency Management Program, 2013.

d. VHA Directive 0320.01, VHA Comprehensive Emergency Management Program Procedures, 2017.

Appendix O: Losses by Clinical Practice Area

Breakdown of Loss Categories of Losses (FY 2019 - FY 2020)					
Clinical Practice Area (Occupation)	All Other Losses	Quits	Removals	Retirements	Total
0060 Chaplain	11	38	9	76	134
0101 Social Science	18	132	18	127	295
0102 Social Science Aid and Technician	15	111	37	80	243
0180 Psychology	109	420	18	245	792
0181 Psychology Aid and Technician	18	104	12	38	172
0184 Sociology	0	0	0	0	0
0185 Social Work	41	1,095	112	683	1,931
0186 Social Services Aid and Assistant	3	51	20	24	98
0187 Social Services	1	13	3	8	25
0188 Recreation Specialist	0	1	0	1	2
0189 Recreation Aid and Assistant	3	21	4	13	41
0199 Social Science Student Trainee	2	0	0	0	2
0440 Genetics	0	0	0	1	1
0601 General Health Science	109	662	86	363	1,220
0602 Medical Officer	145	2,302	160	1,645	4,252
0603 Physician's Assistant	20	179	14	137	350
0604 Chiropractor	0	0	0	0	0
0605 Nurse Anesthetist	0	70	7	68	145
0610 Nurse	180	5,281	469	4,753	10,683
0620 Practical Nurse	39	1,531	263	1,043	2,876
0621 Nursing Assistant	55	1,456	618	561	2,690
0625 Autopsy Assistant	0	0	0	0	0
0630 Dietitian and Nutritionist	28	172	12	130	342
0631 Occupational Therapist	10	84	6	73	173
0633 Physical Therapist	46	77	2	55	180
0636 Rehabilitation Therapy Assistant	5	63	6	39	113
0637 Manual Arts Therapist	0	0	0	0	0
0638 Recreation/Creative Arts Therapist	2	40	8	58	108
0639 Educational Therapist	0	0	0	0	0
0640 Health Aid and Technician	53	837	179	488	1,557

Breakdown of Loss Categories of Losses (FY 2019 - FY 2020)					
Clinical Practice Area (Occupation)	**All Other Losses**	**Quits**	**Removals**	**Retirements**	**Total**
0642 Nuclear Medicine Technician	0	0	0	2	2
0644 Medical Technologist	19	392	36	343	790
0645 Medical Technician	8	320	71	85	484
0646 Pathology Technician	0	41	4	20	65
0647 Diagnostic Radiologic Technologist	11	263	43	184	501
0648 Therapeutic Radiologic Technologist	1	26	2	15	44
0649 Medical Instrument Technician	13	248	42	199	502
0651 Respiratory Therapist	0	4	0	6	10
0660 Pharmacist	35	292	43	327	697
0661 Pharmacy Technician	32	381	67	213	693
0662 Optometrist	15	51	12	29	107
0665 Speech Pathology and Audiology	42	80	7	64	193
0667 Orthotist and Prosthetist	3	19	4	23	49
0668 Podiatrist	7	20	11	30	68
0680 Dental Officer	2	69	9	86	166
0681 Dental Assistant	6	130	21	83	240
0682 Dental Hygiene	0	33	11	30	74
0683 Dental Laboratory Aid and Technician	0	19	2	32	53
0699 Medical and Health Student Trainee	61	60	6	0	127
1301 General Physical Science	0	0	0	0	0
1306 Health Physics	0	9	3	9	21
1310 Physics	0	1	0	0	1
1311 Physical Science Technician	0	0	0	3	3
1320 Chemistry	2	2	0	7	11
1715 Vocational Rehabilitation	1	47	10	73	131
Total Health Care Provider Losses	**1,171**	**17,243**	**2,466**	**12,569**	**33,449**

Appendix P: Loss Rates by Clinical Practice Area

Occupation	Losses FY 2019	Average Onboard FY 2019	Loss Rate FY 2019	Losses FY 2020	Average Onboard FY 2020	Loss Rate FY 2020
0060 Chaplain	85	657.2	12.9%	49	643.7	7.6%
0101 Social Science	154	1,792.2	8.6%	141	1,876.3	7.5%
0102 Social Science Aid and Technician	138	1,315.7	10.5%	105	1,298.9	8.1%
0180 Psychology	439	5,971.9	7.4%	353	6,105	5.8%
0181 Psychology Aid and Technician	89	483.3	18.4%	83	476.8	17.4%
0184 Sociology	-	2	-	-	2	-
0185 Social Work	1,053	14,918.3	7.1%	878	15,684	5.6%
0186 Social Services Aid and Assistant	48	349.5	13.7%	50	369.3	13.5%
0187 Social Services	17	167.8	10.1%	8	170.1	4.7%
0188 Recreation Specialist	1	22	4.6%	1	24.2	4.1%
0189 Recreation Aid and Assistant	18	153.6	11.7%	23	164.3	14%
0199 Social Science Student Trainee	2	1.3	150%	-	1	-
0440 Genetics	-	4.8	-	1	4.4	22.6%
0601 General Health Science	629	7,210.5	8.7%	591	7,481	7.9%
0602 Medical Officer	2,286	26,393.9	8.7%	1,966	26,831.9	7.3%
0603 Physician's Assistant	185	2,399.1	7.7%	165	2,484.6	6.6%
0604 Chiropractor	-	-	-	-	-	-
0605 Nurse Anesthetist	76	1,035.2	7.3%	69	1,061.7	6.5%
0610 Nurse	5,440	71,827.3	7.6%	5,243	74,655.8	7%
0620 Practical Nurse	1,513	15,091	10%	1,363	15,447.6	8.8%
0621 Nursing Assistant	1,405	13,258.2	10.6%	1,285	13,741.3	9.4%
0625 Autopsy Assistant	-	-	-	-	1	-
0630 Dietitian and Nutritionist	205	2,342.3	8.8%	137	2,385.2	5.7%
0631 Occupational Therapist	98	1,377.8	7.1%	75	1,423.1	5.3%
0633 Physical Therapist	106	2,314.1	4.6%	74	2,420.5	3.1%
0636 Rehabilitation Therapy Assistant	67	787.6	8.5%	46	830.5	5.5%

Occupation	Losses FY 2019	Average Onboard FY 2019	Loss Rate FY 2019	Losses FY 2020	Average Onboard FY 2020	Loss Rate FY 2020
0637 Manual Arts Therapist	-	-	-	-	-	-
0638 Recreation/Creative Arts Therapist	58	943.6	6.2%	50	974.7	5.1%
0639 Educational Therapist	-	-	-	-	-	-
0640 Health Aid and Technician	756	7,677.3	9.9%	801	8,081.4	9.9%
0642 Nuclear Medicine Technician	2	4.3	46.2%	-	1.4	-
0644 Medical Technologist	419	4,536.2	9.2%	371	4,596.3	8.1%
0645 Medical Technician	245	1,721.6	14.2%	239	1,742.4	13.7%
0646 Pathology Technician	45	275.4	16.3%	20	274.3	7.3%
0647 Diagnostic Radiologic Technologist	290	4,215.8	6.9%	211	4,326.6	4.9%
0648 Therapeutic Radiologic Technologist	22	295.2	7.5%	22	295.7	7.4%
0649 Medical Instrument Technician	274	3,432.8	8%	228	3,540.3	6.4%
0651 Respiratory Therapist	8	19.3	41.4%	2	13.1	15.3%
0660 Pharmacist	394	8,739.1	4.5%	303	9,121.3	3.3%
0661 Pharmacy Technician	365	4,549.6	8%	328	4,656	7%
0662 Optometrist	71	976.1	7.3%	36	978	3.7%
0665 Speech Pathology and Audiology	116	1,863.8	6.2%	77	1,898.5	4.1%
0667 Orthotist and Prosthetist	30	335.4	8.9%	19	343.8	5.5%
0668 Podiatrist	47	599.2	7.8%	21	594.9	3.5%
0680 Dental Officer	81	1,204.3	6.7%	85	1,243.5	6.8%
0681 Dental Assistant	121	1,703.5	7.1%	119	1,715.3	6.9%
0682 Dental Hygiene	39	430.8	9.1%	35	457.8	7.7%
0683 Dental Laboratory Aid and Technician	26	307.8	8.5%	27	298	9.1%
0699 Medical and Health Student Trainee	88	115.9	75.9%	39	77.6	50.3%
1301 General Physical Science	-	3.6	-	-	4.6	-

Occupation	Losses FY 2019	Average Onboard FY 2019	Loss Rate FY 2019	Losses FY 2020	Average Onboard FY 2020	Loss Rate FY 2020
1306 Health Physics	10	82.6	12.1%	11	87.3	12.6%
1310 Physics	1	7.8	12.8%	-	9	-
1311 Physical Science Technician	2	10.2	19.7%	1	6.5	15.4%
1320 Chemistry	6	50.7	11.8%	5	46.5	10.8%
1715 Vocational Rehabilitation	66	842.3	7.8%	65	823.6	7.9%