Physician assistants working in the Department of Veterans Affairs

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Near the end of the last century, the Veterans Health Administration (VHA) in the Department of Veterans Affairs (VA) initiated a medical workforce re-engineering effort to improve its quality of care.1,2 The VHA is vertically integrated and comprehensive.3 Admired for its ability to deliver services in both urban and rural areas, it has also been a leader in advance medical record integration technology and safety.4 Additionally, the VHA is a major employer of physician assistants (PAs).

The VHA is notable for its commitment to primary care, and this specialty serves as the entry point for beneficiaries to access the health system. It is also a model of a managed health system that relies heavily on electronic record access to all aspects of care. Because of a commitment to improve all aspects of care to veterans, the VHA boosts its efforts to improve quality through performance measurement.5 However, an increasing transition of active duty military members to VA status and new policies on beneficiary enrollment over the past decade have created backlogs in access to medical care and processing claims.6 Furthermore, the VA takes care of a different population than the civilian sector; predominantly male, elderly, vulnerable, and burdened with significant chronic diseases. The profile of this beneficiary structure produces large differences in patterns of practice within the VA, and as a result, more care is inpatient-based and specialist-oriented with higher per capita expenditures than in private practices. These veterans, many with service-connected disabilities and without any other means of medical care, consume resources at different rates than a non-VA population. Nonetheless, the VA is challenged to make systematic improvements while at the same time implementing economy of scale measures of cost-effectiveness. Because the VA is vertically organized with most of the care produced under one roof, it serves as a model institution to study optimal delivery of health care services.

Since the late 1990s, the VHA has increasingly turned to PAs to improve access and maintain continuity of care. Employment criteria include graduation from an accredited PA program and a passing score on the PA National Certification Examination (VA policy). Each of the 153 VA medical centers or the more than 900 community-based outpatient centers employs providers according to its need. As a result, the utilization of PAs is irregular across the nation. Some locations have no PAs, and other regions make very high use of PAs.

Administration is hierarchical; each medical officer (MO) and PA reports to the service chief. The service chief reports to the medical director of the facility. A director of PA services reports to the chief patient care services officer. In turn, a VHA physician assistant field advisory committee advises the PA director on policy matters.

PAs employed in federal institutions often bypass state control of provider services. For example, state PA practice laws tend to have little bearing on whether a VA facility permits PAs to perform medical or surgical procedures. PAs practice under federal authority, and states do not have jurisdiction over federal health care facilities. If the facility approves a scope of practice that includes performing medical or surgical procedures. PAs practice under federal authority, and states do not have jurisdiction over federal health care facilities. If the facility approves a scope of practice that includes performing medical or surgical procedures.

ABSTRACT

There is broad consensus among medical workforce analysts that the demand for physician assistants (PAs), physicians, nurses, allied health, and other medical providers has substantially increased since the late 1990s. While researchers tend to examine the deployment of various providers in private medical offices, they often overlook federally-employed PAs. Since the late 1980s, the Department of Veterans Affairs (VA) has been a major employer of PAs. The demand for services is projected to increase by 30% over the next decade as the VA undergoes expansion.

We examined the characteristics of PAs in the Veterans Health Administration (VHA), the medical arm of the VA. In 2010, 1,878 PAs were employed in 153 VA medical centers and many of the more than 900 community-based outpatient clinics. The majority work full time, and 49% are female. VHA PAs are distributed broadly across medical services (38%), surgery (47%), mental health (11%), and other services (4%). Thirty-one percent of PAs have prior military experience. The average years of VHA PA employment is 10.5, and the average age of a VHA PA is 49 years (range 23-74 years); one-third (34%) are within 5 years of retirement eligibility. Annual attrition for PAs is 9%, consistent with doctors, nurses, and pharmacists in the VHA. Projected demand for PA services in the VHA is expected to grow to 2,550 by 2018. Strategies are under way to improve the PA workforce in the VA.
colonoscopy (or any other procedure), it can be granted by that facility under federal law.

The VA also supports PA education. For example, a VA Medical Center in Durham, North Carolina, has provided clinical education sites dating back to the first PA students at Duke University in the 1960s. The St. Louis University PA program was partially funded by the VA in 1971. In 1972, the VA standardized the role of PAs, defined the areas of the hospital in which PAs could be utilized, and specified the type and level of tasks assigned to them.

Implementing and using team delivered care has been a major goal of the VHA, and PAs are part of this effort. In one study of 32 VHA medical centers, 84% of operating room (OR) and 75% of intensive care units had implemented team concepts to improve care. As a result, efficiency improvements were reported by 94% of OR implementation teams. Almost all facilities (97%) reported a success story or avoiding an undesirable event.7

A major goal of the VA is to enlarge the medical workforce to meet the needs of an increasing enrollment of veteran beneficiaries. One of the VHA’s stated goals is to grow PA services to 2,550 by 2018. Increased recruitment is part of a larger goal to expand the size and capacity of the VA. This expansion will necessitate an increase in the number of doctors, nurses, and other personnel during the same time period. This investment in human resources requires more information to be made available both internally and in the public domain.

We undertook an organizational examination of PAs in the VA because their role in the federal workforce has been described only broadly.4 There is growing interest in understanding the PA workforce and the extent it is used in this institution. Our aim was to establish historical data for medical workforce planning purposes and to contribute to the growing body of literature on the US medical system of care.

METHODS
A descriptive study of PAs in the VHA was undertaken using existing administrative files from the VA Central Office. One author (DW) is the manager of PA medical workforce data and advisor to the under secretary for health. Administrative files were probed for pertinent information on employment trends, gender, age, role, and pay. The data were aggregated, descriptive statistics were used, and no individual employee was identifiable in the analysis. The study was approved by the VA Central Office.

RESULTS
As of 2010, the VHA was composed of 1,878 PAs; 49% were female. The mean age was 49 years (median 54 years; range 24-74 years) (Figure 1). During the period 1992 to 2009, the cadre of PAs in the VA grew by 55% (on average, an additional 45 PAs were added each year) (Figure 2). The percentage of PAs in the VHA workforce who will be of retirement age or older (65 years or older) within the next 5 years is 16.24%; 35% of PAs in the VHA are older than 55 years. The turnover rate from 2000 to 2009 is shown in Figure 3.

The national VA system is composed of 21 integrated service networks (VISNs), and the deployment of PAs is spread over these VISNs. The ratio of medical officers to PAs and nurse practitioners (NPs) differs widely depending on the VISN. In 2010, the ratio of PA/NP to MO was 3:7, with approximately 1.5 times as many NPs as PAs (Figure 4). Overall PAs were grouped broadly under medical services (38%), surgery (47%), mental health (11%), and other services (4%, including anesthesia/pain clinic, radiology, rehabilitation, and administration).

The wage for VHA-employed PAs is structured through the General Schedule (GS) system of the US Office of Personnel Management and is the pay structure for most federal workers. PA salary ranges from GS-9 to GS-13 (92% of PAs are GS-12 or GS-13). Most pay is assigned a locality adjustment for cost of living differences across the country (www.opm.gov/oca/10tables). In 2010, a GS-13 who had topped out in pay scale steps earned an annual salary

FIGURE 1. PAs in the VA by age and gender, 2010
of around $110,000. The benefit structure in the federal compensation system is about 25% on top of the wage and includes 4 weeks vacation, holidays, health insurance, and education. Once a PA is a government employee, transfers are possible both within a VA health facility and across the nation (including other federal services) depending on need and supply.

Approximately 50 PA programs used the VA System for clinical rotation. More than 250 PA students rotated through VHA facilities in 2010, and 58 qualified for a stipend. Institutional agreements are usually on the local level, and arrangements of PA students who are provided clinical sites for training may exceed this estimate.

All new employees are surveyed for their reasons for joining the VA. In 2009 and 2010, 48 respondents cited the benefit structure and loan repayment as the two leading reasons for accepting employment within the VA as a PA.

**DISCUSSION**

Since 1967, the VHA has been an employer of PAs (personal communication Vic Germino, PA, July 2010); a trend to employ more has been under way since 1992. As of 2010, 1,872 PAs were working in most of the 153 VA medical centers and 976 community-based outpatient clinics. The majority work full time, and half are female. These VHA PAs are distributed broadly across medicine and surgery, and their diverse roles are known only broadly. Less than 1% of PAs are in senior administrative roles. This distribution among the rank and file of clinical PAs is analogous to the military in the late 1900s, when there was a dearth of senior officers in PA ranks. Only when PAs began moving into senior command levels did policy improvements in the utilization and career focus of PAs in uniform change. We suggest that similar senior administrative VA positions need to be filled by PAs who can provide a representative voice in organizational change and policy decisions.

An important observation about the PA in the VA is the age distribution. The average age of a VHA PA is 49 years, but the age curve shows that more than half are older than 50 years. Furthermore, about one-third of PAs (34%) are within 5 years of retirement eligibility. The average years of VHA PA employment is 10.5, and the annual attrition rate of PAs is 9% (consistent with doctors, nurses, and pharmacists in the VHA). These observations suggest that the pool of older, more experienced PAs are eligible to depart in large numbers over the next few years, producing recruitment and retention challenges ahead. Not only does the VA want to expand its corps of PAs (along with all other clinicians), but it will need to replace at least 100 PAs a year to stay even and more than 200 PAs per annum to reach full complement by decade’s end. Retention and recruitment are significant issues for the VHA, as competition from the private sector vies for scarce human resources in health. Pay disparity leads this list of challenges because compensation tends to be high on the priorities list of graduates wishing to pay off loans acquired in training. In addition, older males with decades of procedural experience are being replaced with younger females with newer knowledge of medicine and technology. Such generational changes also present challenges for managers.

Strategies to help cope with challenges for recruitment and retention are being developed. Policy makers are proposing new initiatives that will permit those in government service to have their accrued education costs repaid if they extend their federal career for a period of time. Contracting with retirees to return as part-time clinicians is an option in some locations. Increasing the PA student’s experience in VA settings may provide the needed contact for recruitment. Developing postgraduate traineeships for physician assistants may be another option.

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**FIGURE 2.** Employment of PAs in the VHA, 1992-2009

**FIGURE 3.** Turnover rate for PAs in the VHA, 2000-2009
LIMITATIONS
Medical workforce research relies on surveys such as censuses or secondary data such as administrative files. Both have their advantages and limitations. Administrative data capture all workers employed but sacrifice candid responses that help shape attitudes, roles, and relationships. Research on public organizations reveals a substantial and growing body of empirical evidence relevant to many international issues in political economy and organization theory, such as the privatization of public services. However, certain assumptions are made that may mislead goals. While the institutional data we obtained have a great deal of integrity due to accurate compensation and benefit structure, the data do not capture the role delineation of PAs employed in federal service. As a result of policy, specifics had to be set aside to avoid identifying characteristics such as age and gender co-variables or PA density in certain VISNs. Also missing are qualitative studies needed to probe the organizational issues concerned with job satisfaction in the VA and how federally employed PAs compare to those in the private sector.

CONCLUSION
The re-engineering of the VHA that began in the 1990s has resulted in an unprecedented enrollment of American veterans. Along with this came a broad mix of providers: one that mirrors the diversity of medical care clinicians in American society. Included in this mix are PAs, many of whom are veterans themselves. Several principles adopted by the VA in its quality-improvement projects include an emphasis on the use of PAs to expand services to veterans. This integration of provider services, designed to achieve high-quality, effective, and timely care, has been embodied by the architects of VA service change and delivery.

Our findings suggest that initiatives based on principles that improve the quality of care in the VA are being carried out with PA involvement on many levels. This trend in task transfer and integrated skill mix using PAs in the VA is consistent with the changing pace of health care in America. However, the VHA may be challenged by social changes where demand for PAs is high and compensation is increasing in the private sector. On top of this is an impending loss of human intellectual capital over the next few years. Improving the representation of PAs with managerial skills in the hierarchy of the VHA is a critical piece needed to achieve a dynamic, integrated health care system that is highly prized by social system advocates.

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REFERENCES