HUMAN RESOURCES CHALLENGES WITH THE VETERANS HEALTH ADMINISTRATION

HEARING

BEFORE THE

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HUMAN RESOURCES CHALLENGES WITH THE VETERANS HEALTH ADMINISTRATION

THURSDAY, MAY 22, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Hare, and Miller.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. The hearing will come to order, and I will ask the first panel to come forward.

I would like to thank everyone for coming today.

The Veterans Health Administration's (VHA's) mission is to provide patient-centered healthcare that is comparable to or better than care available in the non-U.S. Department of Veterans Affairs (VA) sector. To do this, VHA must have a viable healthcare workforce that is competent, well-trained and happy.

Over the past 5 years, the VA has built a reputation of delivering healthcare efficiently and effectively. VA has been touted as the "best care anywhere," and the Department has been recognized on numerous occasions for healthcare quality and patient satisfaction.

However, in order to carry that banner forward, careful planning and efficient processes must be put into the system to ensure continued success.

We know that VA's workforce is aging, with an average age of 48.6 years. We know that at the end of 2012 a significant percentage of the employees will be eligible to retire.

This Subcommittee has held many hearings that have examined the appropriateness and quality of care and treatment that veterans receive within the healthcare system. This hearing today will focus on the human resource challenges that VHA must address in order to ensure that there will not be a gap in expertise and quality of care provided to our veterans.

The Subcommittee realizes that this is a complex issue, but we also recognize that it is an important one that deserves serious thought and consideration as well.

I would like to recognize Mr. Miller for any opening statement that he might have.

[The prepared statement of Chairman Michaud appears on p. 33.]

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. I do appreciate you holding this hearing today to examine all those challenges the VA faces in regards to keeping the high-quality healthcare workers that are currently in the system. They are on the frontline of the healthcare issue every single day.

Our servicemembers who have honorably served our country deserve high-quality healthcare, and we must do what we can to keep those professionals retained and recruit them as well. One of the most pressing problems we face as a Nation is a marked shortage in virtually all areas of the healthcare worker industry, including nurses, physicians, physicians' assistants, psychologists, pharmacists, and physical and occupational therapists.

The VA system has been recognized for the significant benefit of its use of electronic medical records and focus on preventative care. To make sure that our veterans continue to receive the best care, it is critical that we see the VA as a workplace of choice. So I appreciate you putting this hearing together to focus and see what we can do better.

I yield back the balance of my time.

[The prepared statement of Congressman Miller appears on p. 33.]

Mr. MICHAUD. Thank you.

Mr. Hare.

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Mr. Chairman. I want to thank you and Ranking Member Miller for holding this hearing today.

The Veterans Health Administration is one of the most impressive healthcare delivery systems in the entire world, and that is in large part due to the dedicated medical professionals who make up the system. From doctors to nurses to technicians to psychologists, these are the men and women who are on the ground every day taking care of our Nation's veterans.

The veterans population will undergo significant changes over the next two decades. And as such, the leadership at the VHA will have to be prepared to handle these challenges.

One of the biggest challenges is the recruitment and retention of highly qualified medical personnel at a time when the overall health industry is facing massive shortages. The VA must be able to compete with the private sector for medical staff. And we must ensure that, as the VHA continues forward, that they have the tools and the funds necessary to guarantee adequate numbers of staff in order to continue the care of our veterans.

Once again, Mr. Chairman, I want to thank you for holding the hearing today. I look forward to hearing from our panels. And thank you very much, Mr. Chairman. I yield back.

Mr. MICHAUD. Thank you very much, Mr. Hare.

Our first panel includes David Cox, a Registered Nurse (RN) who is the National Secretary-Treasurer for American Federation of Government Employees (AFGE) of the AFL-CIO.

I want to welcome you, David, here this morning.

And Dr. Randy Phelps, who is the Deputy Executive Director of the American Psychological Association (APA); and Angela Mund,

who is a CRNA, the Clinical Director for Minneapolis VA Medical Center, who is here on behalf of the American Association of Nurse Anesthetists (AANA); and then Jay Wommack, President of Vertical Alliance Group, Inc.

So I want to welcome our four panelists this morning and am looking forward to hearing your testimony.

We will start off with Mr. Cox.

STATEMENTS OF J. DAVID COX, RN, NATIONAL SECRETARY-TREASURER, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO; RANDY PHELPS, PH.D., DEPUTY EXECUTIVE DIRECTOR FOR PROFESSIONAL PRACTICE, AMERICAN PSYCHOLOGICAL ASSOCIATION; ANGELA MUND, CRNA, MS, CLINICAL DIRECTOR, UNIVERSITY OF MINNESOTA NURSE ANESTHESIA AREA OF STUDY, MINNEAPOLIS VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ON BEHALF OF AMERICAN ASSOCIATION OF NURSE ANESTHETISTS; AND JAY W. WOMMACK, FOUNDER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VERTICAL ALLIANCE GROUP, INC., TEXARKANA, TX

STATEMENT OF J. DAVID COX

Mr. COX. Chairman Michaud and Ranking Member Miller and distinguished Members of the Subcommittee—it seems like I am getting off to a bad start here. I am tying my tongue up this morning. I have never been first on a panel; maybe that is what it is. Thank you for the opportunity to testify today. AFGE greatly appreciates the Subcommittee's continued attention to the impact of VA healthcare workforce problems on patient care.

Veterans want to get their care from the VA because VA healthcare professionals are extremely dedicated to their patients and committed to the mission of the VA. In the eighties, labor management collaboration helped transform the VA into a healthcare leader in best practices, patient safety and healthcare information technology.

AFGE believes the greatest human resources challenge facing VHA today is the continuing erosion of title 38 collective bargaining rights, as I will discuss shortly. First, I would like to address several other human resources issues of concern to AFGE.

The hybrid title 38 process, which covers psychologists, social workers, pharmacists and licensed practical nurses (LPNs), among others, has become severely backlogged. It is also troubling that VHA employees lose their veterans' preference when they are converted to title 38 from title 5.

Therefore, AFGE urges this Subcommittee to reject proposals to add more positions to title 38 and instead conduct a pilot project using a streamlined title 5 hiring process to compare the two systems. We would be pleased to work with you to develop this pilot project and believe it can provide valuable lessons for other Federal employers.

AFGE also urges the Subcommittee to conduct oversight into the many implementation problems surrounding the 2004 physician pay law, such as secretive process for setting market pay and use

of improper performance measures. Since Congress is still waiting for the VA's long-overdue report on how well the pay law is working and whether it is has reduced the VA's reliance on costly contract physicians, we urge the Subcommittee to conduct its own study on this important law instead.

Nurse alternative work schedules provide full-time pay for working 3 12-hour days per week or 9 months per year. These schedules are very popular in the private sector and could be a valuable VHA recruitment and retention tool. Unfortunately, VHA refuses to offer this schedule option to its nurses, even though they were given this authority by Congress 4 years ago. AFGE recommends that Congress amend the law to require the VA to offer alternate work schedules based on a fixed formula that aligns facilities with their local labor markets.

Turning to title 38 collective bargaining rights, we are very grateful to Chairman Michaud and Subcommittee Members Berkley, Brown and Doyle for cosponsoring H.R. 4089. This bill is an essential enforcement tool for past and future VHA recruitment and retention legislation.

In 1991, Congress provided RNs, physicians and other pure title 38 providers with rights to challenge improper personnel policies through grievances, arbitrations and the court. Providers lost these rights because the VA began using an arbitrary interpretation of the three exceptions in section 7422 of title 38: professional conduct and competency, peer review, and compensation.

Management's section 7422 policy directly contradicts Congressional intent, as is evident by the plain language of the law and the legislative history. Management's section 7422 policy is also inconsistent with its own position that it took in 1996 with a labor management agreement to allow grievances over indirect patient care matters, scheduling, and rights to pay survey data.

The VA contends that amending section 7422 will allow labor to disrupt patient care. But management's rights to determine the agency's mission under title 5 already protect against that. And the VA cannot point to a single case where a grievance involved a challenge to medical procedures. VHA employees who have full grievance rights, such as LPNs, psychologists, and pharmacists, never use these rights to disrupt patient care.

The VA also contends that current law gives title 38 providers fair process for deciding when a grievance can be filed, pointing to a review by the Under Secretary for Health. We asked, fair to whom? In the past 3 years, 100 percent of these decisions have been in favor of management. Shouldn't VA healthcare dollars be spent on caring for veterans, not looking for ways to block legitimate concerns of hard-working, dedicated nurses and physicians?

Thank you, Mr. Chairman. I would be glad to entertain any questions from the Committee.

[The prepared statement of Mr. Cox appears on p. 34.]

Mr. MICHAUD. Thank you very much.

Doctor.

STATEMENT OF RANDY PHELPS, PH.D.

Dr. PHELPS. Thank you, Mr. Chairman, Ranking Member Miller and distinguished Members of the Subcommittee. I am Dr. Randy

Phelps, Deputy Executive Director for Professional Practice of the American Psychological Association.

We are the largest association of psychologists, with approximately 90,000 full doctoral psychology members and another 50,000 graduate students in the pipeline. Our folks are engaged in the study, research and practice of psychology.

I am currently a licensed clinical psychologist but formerly a practitioner myself, a clinical researcher and educator. And for the last 15 years, I have been on the APA Executive Staff and have served as APA's liaison to Professional Psychology in the Department of Veterans Affairs.

We really appreciate the opportunity to testify today about human resources challenges within VHA.

I should note at the outset that VHA is the workplace of choice for many of our members. There are over 2,400 psychologists working nationwide in the system. And, in fact, VA is the largest single employer of psychologists in this country.

Professional psychology was born as a result of the needs of returning soldiers from previous wars, particularly World War II. So we owe a great debt to the brave men and women who have served this country.

I will shorten the remarks, obviously, for the oral testimony. There is a considerable amount of detail in the written testimony.

But psychologists are very actively involved, particularly in the mental health side, of treatment of veterans in VA. The architects of the two evidence-based practice treatments for post traumatic stress disorder (PTSD) are psychologists. Psychologists are serving a very critical role in understanding diagnosis and treatment of traumatic brain injury (TBI), which is the other signature wound of the war, alongside nursing, neurologists and other folks.

Recruitment of psychologists in the VA is actually in a good place at this point. It has not been until the last year and a half. And we applaud VHA's efforts to add 800 new positions for doctoral psychologists since 2005, bringing us up to that 2,400 psychologists in the system. Most of those folks, I should add, are young psychologists entering the system at GS–11.

I should emphasize that every psychologist who comes out of a clinical or counseling program already knows how to treat PTSD, depression and so forth.

The thing that I wanted to emphasize, though, about recruitment is that the staffing levels are a very recent developments. It was only 2 years ago where we reached the staffing levels of psychologists in the VA of the 1995 years. So the curve has been going down until just very recently with the hiring of this new cadre of psychologists.

Additionally—and this gets to the issue of retention that I would like to spend a little bit more time on—additionally, the number of GS–14 and GS–15 psychologists in the system at the higher leadership levels are actually not increasing similarly. The GS–15 level is lower than it was in 1995.

The VA has done a good job of recruiting new psychologists coming into the system because it is hiring its own. We have approximately 600 psychology training positions within VA, and 75 percent of the new hires are past VA psychology trainees.

There are three major problems, however, that affect retention of the workforce that I can elaborate on later if you have questions.

One is a lack of uniform psychology leadership positions. We are the only mental health position without an officially designated leader at medical centers. There is a very inequitable access to key leadership positions throughout VA. And there are, as you have heard some from a colleague, very serious implementation issues with the hybrid title 38. In fact, I would describe the implementation of the hybrid title 38 system as an absolute boondoggle, bureaucratically and otherwise, for the system.

These problems—which, again, we can elaborate on later—have led to a number of very chilling situations for psychologists throughout the country, where folks are leaving the VA to go to the private sector, losing their positions, inability to get advancement and so forth.

And we consider those kinds of problems as the most serious obstacles to making VA the workplace of choice for psychologists now and in the future, because without clear advancement systems in place, VA faces critical long-term recruitment and retention problems. As psychologists come to believe that there is little possibility for advancement in the system, regardless of the level of complexity of their responsibilities, fewer VA psychologists will be willing to accept positions of greater responsibility.

And, in addition, high-potential trainees coming into the system the VA would like to recruit for the future will increasingly, and are increasingly, seeing VA as a dead-end for their careers and will be attracted to other career options with more potential for advancement.

And we thank you very much for this opportunity to testify today. Thank you.

[The prepared statement of Dr. Phelps appears on p. 38.]

Mr. MICHAUD. Thank you.

Ms. Mund.

STATEMENT OF ANGELA MUND, CRNA, MS

Ms. MUND. Chairman Michaud, Ranking Member Miller and Members of the Subcommittee, good morning. My name is Angela Mund. I am a Certified Registered Nurse Anesthetist, or a CRNA, at the Minneapolis VA. I also serve as President of the Association of VA Nurse Anesthetists. And I am pleased to appear before you on behalf of my profession, the American Association of Nurse Anesthetists and its 39,000 members in the United States.

You have my written statement, and I ask unanimous consent for it to be entered into the record.

Mr. MICHAUD. Without objection.

Ms. MUND. America's CRNAs provide some 30 million anesthetics annually in every healthcare setting requiring anesthesia care, and we provide that safely. The Institute of Medicine reported in 2000 that anesthesia is 50 times safer now than it was in the 1980s. For over 125 years, nurse anesthetists have met the mission of caring for our veterans, caring for those who have borne the battle, their widows and orphans.

Nurse anesthetists are the predominant provider of anesthesia services in the VA and are the sole anesthesia provider in 12 per-

cent of VA facilities. In the days before I left for this hearing, I personally provided anesthesia for our veterans. Any of the more than 500 CRNAs in the Veterans Health Administration could say the same.

But the average VA CRNA is 53 years old, 7 years older than the profession's average, and is approaching retirement. In any recent year, nearly one in five VA CRNAs leaves or retires from the VA. Twenty-four VA facilities report CRNA vacancies. We believe that actual number is closer to 40, and the U.S. Government Accountability Office (GAO), in their report, used 70 as the number. Contract personnel also fill about 150 of the VA CRNA posts.

We are increasingly concerned that without a sufficient number of CRNAs in the VA system, our veterans won't get the care they need and deserve. They may have to wait too long for that care, which ultimately may increase cost to the U.S. Treasury.

A report last December from the GAO confirmed what we, in the VA, have long known. The GAO found 54 percent of VA facilities have had to close operating rooms, and 74 percent have had to delay surgeries for lack of CRNAs. Twenty-six percent of VA CRNAs plan to retire within the next 5 years, and the agency has struggled to both recruit and retain nurse anesthetists. Seventy-four percent of VA respondents to the GAO survey said they had difficulty recruiting CRNAs.

The VA's struggle has not been for lack of CRNAs in the marketplace. In 2007, accredited nurse anesthesia educational programs produced over 2,000 graduates, an 88 percent increase in just 5 years, in order to meet the growing demand for anesthesia services. Rather, the GAO found, and we agree, that the VA CRNA compensation is far below market levels in many localities.

The issue of below-market compensation was cited by 90 percent of chief anesthesiologists reporting difficulty recruiting CRNAs and by 77 percent of chief anesthesiologists reporting difficulty retaining CRNAs. In some facilities, bad working conditions also sent good CRNAs elsewhere.

We have three recommendations to close this gap and to ensure American veterans have the necessary anesthesia care for the surgical and invasive diagnostic procedures they require.

First is to enhance the VA relationship with the nurse anesthesia educational programs. Already some 70 VA hospitals serve as clinical practice education sites for nurse anesthesia schools. Many hospitals find serving these clinical practice sites helps them recruit new CRNAs.

Second is to continue nurturing the VA's joint relationship with the U.S. Army Nurse anesthesia educational program at Fort Sam Houston, Texas, which educates CRNAs for VA service. The current program uses the VA Employee Incentive Scholarship Program, or EISP, to fund tuition, fees and salary reimbursement for nurse anesthesia students who then fulfill a service commitment to the VA.

Third is to bring VA's CRNA compensation closer to local market rates. The GAO recommends VA facilities take advantage of VA locality pay policies. But that will not be enough to close the gap. In addition, Congress should act to lift the statutory cap on VA CRNA

pay so that local facilities can set compensation at rates closer to market levels.

Of all the options available to close the VA's CRNA workforce gap and ensure veterans gets the high quality of care they deserve, these three suggestions are the most cost-effective and the easiest to carry out.

Thank you, and I would be happy to take your questions.

[The prepared statement of Ms. Mund appears on p. 42.]

Mr. MICHAUD. Thank you very much.

Mr. Wommack.

STATEMENT OF JAY W. WOMMACK

Mr. WOMMACK. I would like to start with a quote. "In times of change, learners inherit the Earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists"—Eric Hoffer.

I don't need to repeat the nursing shortage; everybody up here knows that. The baby boomers are about to retire. We, 2 years ago, entered the first baby boomer turning age 60. This year, the first baby boomer started to retire at 62. And this generation looks like a basketball going through the belly of a snake, and behind it we do not have enough people to fill the needs in the healthcare industry.

On top of that, we have a declining dollar. A declining dollar causes devaluation of the currency, which means the Canadian dollar is more powerful. We are seeing nurses leave the United States, to go back up north.

We see all these things and we see the nursing shortage is in quite a state, but I think there is a worse shortage than that out there, and the worst shortage is the shortage of qualified, well-trained, recruiting personnel, not just to recruit nurses and medical personnel, but also to go out and actively recruit people to teach in the schools, because we are short on educators. We had to turn down 38,000-plus, in the last few years, going to schools to learn how to be medical personnel.

Each month, millions of dollars are spent on advertising to draw people into not just the private sector, but into the public sector, both sectors, to draw them into the medical community, to recruit them for institutions. Millions of dollars are spent to generate leads and phone calls. And guess what happens? We have dealt with the private sector, and 82 percent of the phone calls for people that would like to have jobs go unanswered. I cannot speak for the VA system; I haven't worked with them. But in the private sector, that is an astounding number, and that number is shocking.

Mr. Chairman, Members of Subcommittee, my name is Jay Wommack. I am the Chief Executive Officer of a company called Vertical Alliance Group. We are an Internet-based training, recruiting company. We were founded in 1999. We have 80 Web sites, sub-domains and domains, of which a couple of them represent the medical community, one called NurseUniverse, one called MedVotech. Obviously, the names imply they are out to recruit nurses and people for the medical vo-tech schools. We operate those Web sites.

And I have to tell you, I am honored to be here to make this presentation. It is a wonderful experience and wonderful opportunity, and I appreciate you all taking the time to hear us and our testimony.

I don't make any claim to be a professional in the healthcare services area. However, we do know quite a bit. In the last 9 years, we have developed quite a bit about the process of recruiting and retaining good employees. Now, we do this with boot camps. And let me address that issue real quick.

There is a dire lack of training for people that know how to go out and deal with the society today. The Internet changed everything. It made us an immediate-gratification society. Things happen fast. I mean, when I go to Amazon and I go and order a book, I want it, I want it now. I don't like waiting till tomorrow. And this is how people are when they are looking for jobs. They go fill out an application or make a phone call. These people are hanging up before 1 minute when no one is answering the telephone. They are sending in applications, and you have seen the medical applications. It takes time to fill out an application. They send those in, and they get no response.

So what we did as a company is we started to develop processes that basically said we are going to train people from being paper processors, the old style of human resource, into active, proactive salespeople. Because that is what it takes to compete in this environment.

We train them to be salespeople through our boot camps. We empower people and teach the salespeople—we call them salespeople—we teach them sales training. We teach them direct-response marketing. We teach them what it costs to actually recruit a nurse. Many people don't know. Advertising cost per hire is $10,000 to recruit a nurse, according to AMA. It costs between $35,000 and $70,000 to recruit a nurse, not to mention a nurse anesthetist. So we are training these people, we are empowering them, teaching them what it takes to go out and be a proactive recruiter.

Have we had success? The standard average of a recruiting department gets between 1 and 2 percent closing on the people that apply for a job. Our companies, on a bell curve, at the top of it, get an average of 12 percent closing. Some, obviously, have gotten much more than that, some less, but on the average, on the bell curve. That is significant savings to the bottom line. The process lends itself to the lowest cost per hire.

But you have to inspect what you train, and you have to continue to teach what you train. So we developed a process, an online, Internet, databased program that basically teaches, tracks, trains and follows up on all the education we provide at the boot camps. We do it daily, weekly, monthly. It is available 24/7.

It doesn't just happen, though. In order for a program to be successful, it must have buy-in from the top. Obviously, we wouldn't be sitting here if there wasn't buy-in from the top.

I visit with a number of VA healthcare facilities. The executives at those facilities, they absolutely care. They would like to push forward, and they have put together great programs, but they like to push forward and get their hiring in order.

I am excited to be here. I appreciate the opportunity to speak, and I will be glad to answer any questions.

[The prepared statement of Mr. Wommack appears on p. 46.]

Mr. MICHAUD. Thank you very much. I appreciate it.

My first question will be for Mr. Cox.

You talked about H.R. 4089, the bill that is pending. If that is passed, what impact will that really have on recruitment and retention, in your opinion?

Mr. COX. We believe that it would give the registered nurses and physicians the same rights that other employees have in the VA; that if there are workplace disputes, that they would have an avenue to resolve those disputes and to seek relief in that arena.

It is a message we hear from our membership and the VA employees over and over, and we believe that it would certainly make for a better workplace.

Mr. MICHAUD. But as far as the recruitment or retention, do you think it will have a positive effect?

Mr. COX. I think it will definitely have a positive effect on the recruitment and retention, because, again, when you are able to resolve problems in the workplace through a negotiated agreement to resolve those issues, that makes people feel better. There is a way to seek relief if you believe things are wrong.

I believe, also, the fact that the pay data, that we have all the locality pay systems, but now if a request is made to the VA, "Share this data with us, show us what you are paying, give us information," it is, "No, we do not have to provide that to you, because that is a section 7422 issue." I believe it would bring more light to the issue of pay and the recruitment process. But it would definitely be a positive impact.

Mr. MICHAUD. Thank you.

Dr. Phelps, you had mentioned the impact of the hybrid title 38. What impact would moving psychologists to title 38 from the hybrid title 38 have on recruitment and retention of these professionals?

Dr. PHELPS. Mr. Chairman, that is an issue that we are—because we are so frustrated with the difficulties and the implementation problems with the hybrid system, that is an issue that we are looking at very seriously right now.

Preliminarily, we think it would be the way to go for psychologists. We are the only doctoral-level professionals in the VA system that are not in the title 38 system. So we are very much in favor of that direction.

Mr. MICHAUD. Thank you.

Ms. Mund, how many CRNA candidates rotate through the 70 VA training sites annually?

And my second question is, out of that, how many of those candidates actually choose the VA upon completion of their training?

Ms. MUND. I don't have those numbers with me, but I can have my staff look at that.

However, what I can speak to is—I am clinical director of a nurse anesthesia program through the University of Minnesota. And the VA in Minneapolis is our primary clinical site. We have had a relationship with them 25 years, I believe, recently. And we send 10 students per year through the VA. We get some support

from Central Office, which we appreciate. In previous years, as much as 75 percent of the graduating class have stayed at the VA. However, in the last 2 years, we have had one person out of 20.

And a lot of that is due to low pay, is the main thing. I mean, they come out with student loans and are unable to have a salary that makes it easier to pay those student loans off.

And the other big piece of it is the employee debt-reduction program that the VA has, it is not entirely, through issues with human resources, lack of understanding of the program. Not everybody who has been eligible has been able to take advantage of that as a student loan payback. So they have chosen to go to places where they can see exactly, when they apply, HR can tell them, "This is what you will make, this is what we will give you, and this is what your loan payback is." The VA is a little bit hazy on that, so students elect to go elsewhere.

Mr. MICHAUD. I believe it was in your written testimony, you recommended $400,000 in fiscal year 2009 appropriations to expand the joint education program. How many additional CRNAs would this funding affect?

Ms. MUND. What they have right now is they have had seven graduates and are working. They have three who are in what we call phase II, which a clinical portion, three that are in the first-year portion, and three that are starting.

I believe that they would like to increase that number, and the Army is available with slots, with seats for those, but they need additional funding to have the students come.

The benefit of going there is that you get your tuition, salary and your education paid for. And then they have a three-year commitment after completing the program.

Mr. MICHAUD. Thank you.

My last question is for Mr. Wommack.

What immediate action should the VA take to modernize their hiring system so that it is competitive with the private sector?

Mr. WOMMACK. That is a very good question.

The first thing I would do is I would start training the personnel on being very proactive. You have to train these people. They have the tools in place. The VA has done a great job of putting together a package of information, kits like that. But they have to be brought into the 21st century via the technology, the platforms of technology that they have at their disposal and that we offer.

They have to be trained, and they have to be trained in the value of what they are doing, the lead. The half-life of a lead, when someone picks up that phone to call or when someone sends in an application, the half-life of that lead is probably less than 4 hours. In other words, if you don't touch it in 4 hours, they are gone. That is what we found; it may be even shorter than that.

So the first thing I would do is set up training for them. And then you have to follow up and monitor exactly what you have taught. You have to inspect it every single week. We do that with our existing clients. We train them, and then we follow up every single week, and we make them respond to us, because that is where you ferret out what the real problems are. You find out what is working, what is not working, and then you adjust it and you change it. And then you continue the education process.

Mr. MICHAUD. Great. Thank you.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. Cox, can you give me a little feel for the difference between title 5 and title 38 in regards to the hiring process? How would title 5 be more or less stringent than title 38?

Mr. COX. Title 5 employees get on registers. They go through, as you know, the various places throughout the country. They apply with USAJOBS, those type things. They get on registries. They are hired. From that, they get veterans' preference, things of that nature.

Title 38, like registered nurses and physicians, they can go to a VA medical center, fill out an application and be hired. There is a boarding process that title 38s have to go through, the credentialing process, things of that nature, which takes a very lengthy period of time. And that is what really holds up a lot of the hiring process at the VA in the title 38 arena.

With the hybrid title 38s, again, the VA has not developed a lot of the qualification standards, so there is not the boarding processes to promote these people and to move them through the proper grades. It is a very, very complex hiring system.

Mr. MILLER. Well, you recommended establishing a pilot program streamlining title 5. I would like to know a little more in detail about, what that plan would—or how it would differ from the current title 5? Wouldn't it be just as useful to streamline or do a pilot program to streamline the hybrid title 38 hiring process?

Mr. COX. We believe that you can go to Office of Personnel Management (OPM) and the agency, VA, can work with OPM, do a demonstration project to—like, nursing assistants is one group that, if people are certified, that you could hire them through a title 5 process that would actually be easier than the hybrid title 38. Because with that, you have to develop the qualification standards, the boards that would then have to evaluate the people, determine their promotions and appointments and things of that nature.

So we believe that there are procedures with OPM that could actually streamline title 5 and make it easier than hybrid title 38. And one thing that we believe that that would also help, it would maintain the veteran preference for the employees.

Mr. MILLER. Give me a little indication of how the retirement benefits differ from the Federal worker and the private sector right now.

Mr. COX. The difference in the retirement benefits?

Mr. MILLER. Yes.

Mr. COX. I am not sure that I could give you a total picture on that.

Mr. MILLER. More, less, better, worse?

Mr. COX. I retired from the Federal Government myself 2 years ago, and I have friends that are in the private sector. And I would say, with the current FERS employees, it is about comparable to the private sector. Most employees in the private sector have some type of matching 401(k) plan and some other defined benefit plan, such as—available with that. But I would say this, we're fairly comparable in that arena.

And, in some areas, I believe the private-sector retirement may be better; in others, obviously, the Federal Government. I am not sure that I am——

Mr. MILLER. What about health insurance?

Mr. COX. Health insurance, private sector, in many cases, is better than the Federal employee health insurance.

Mr. MILLER. Dr. Phelps, what benefits do you see in bringing psychologists fully into the title 38 program?

Dr. PHELPS. As I said, Mr. Miller, we are looking more closely at that. We have tried to be good citizens with the hybrid system. So the benefits would be to eliminate some of these kinds of problems with the hybrid system.

Let me give you a couple of examples. As Mr. Cox said, that with the hybrid title 38 system there is required the creation of professional standards boards for each of those disciplines. Psychology has a national professional standards board, and it also has developed its quality standards. And so that process is under way.

But what has been happening for the last year or so is that psychologists with additional scope of responsibility—running huge treatment programs, 60 psychology staff under them and so forth—who have submitted to the professional standard boards and have then been recommended nationally for a grade increase have then been stymied at the level of the local medical center, in most cases. Some cases, it is at division level.

And the VA itself is issuing, in some cases certainly, informational missteps about who is qualified, who is not qualified, what do you have to submit and so forth.

So moving into a system that is based on the title 38 system, that is based simply on the professional is hired, promoted and retained based solely on their qualifications, as opposed to going through these very complex processes that VA has been unable to implement over the past 5 years. It has been 5 years since the Congress changed the hybrid statutorily.

So we believe that it would very much not only simplify the system for psychologists, but certainly improve the recruitment of new psychologists and, clearly, the retention of psychologists, the leadership. We have a lot of psychologists in the system who have been in 20 and 30 years that are operating at the GS–13 level. They are not there for the money. They are there because of the dedication to veterans. And they need to be the folks training the new cadre of professionals.

Mr. MILLER. Thank you very much.

I apologize to Ms. Mund and Mr. Wommack. My time for questions has expired.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Ms. Mund, I was wondering, could you please compare the differences between hiring, retention or educational benefits packages offered by the VA and the private sector for CRNAs? And does the VA excel in any of those areas more than the private sector?

Ms. MUND. Well, the main difference, I think, between the two is other places, what I have heard from my students, especially recent grads, are they can call up the University of Minnesota hospital and say, "I am a new grad. What am I going to start at for

salary? What kind of bonus am I going to get? What can I see for loan paybacks?" And they can get that number from human resources immediately.

The problem with the VA is often they will call human resources and they will get a range just like it is posted on VA Jobs. So the student does not know where they are starting until they sign on. Often they are not going to take that chance when the range is anywhere from $89,000 to $139,000. It is difficult to see where you would fit on that scale.

The other thing is the employee debt-reduction program, which I spoke to before, which I think is a great recruitment tool. The problems is there is a 6-month window that, if you don't apply for it within that time, you are no longer eligible. Well, if for some reason paperwork has been lost, the human resources person covering that student has some lack of information, all of a sudden that 6-month window is gone and the debt-reduction program they are no longer eligible for. Other things related to that is human resources also, if it does not say on the Web site that you are eligible for the Education Debt Reduction Program (EDRP), they cannot offer that to you once you sign on.

So I think a lot of it is the transparency for when students apply for jobs. They need to see that in the VA. They need to know that these things are going to be available and rather than getting lost in the shuffle of paperwork and time.

Mr. HARE. Because it would seem to me, somebody graduates and they know at one hospital what their bonus is going to be, their salary is going to be, their compensation is going to be, almost to the penny——

Ms. MUND. Right.

Mr. HARE [continuing]. And then you have the VA who gives them a range. So if you are getting out of school with a lot of debt load, and I am sure the debt load is significant, it has got to really put us at a disadvantage, I am assuming.

I can't blame the student, I mean, obviously, because they have spent this time and, as I said, built up a lot of debt.

Ms. MUND. And I think the unfortunate thing is they primarily had their training site in the VA, and they loved taking care of veterans. There really is not another population that is like that. But after having the time and expense of school, sometimes you have to weigh those things. And I think that if we did a better job of a transparent benefit package, I think the VA could be very comparable.

Mr. HARE. Mr. Cox, can you talk a little bit more about the hybrid hiring process and what makes it so long and complicated for prospective applicants?

Mr. COX. The hybrid—again, the VA has to develop qualification standards. The way that it is sold to everyone in the beginning is that, okay, hybrid, you can just walk in, fill out an application and apply for a job. That is fine; that process is simplified. But then there is the qualifications standards, the professional standards boards. These people have to be brought in. The boards have to meet. They have to review the qualifications of the people, then establish their grade, those type things.

That is what really complicates the process. While it is not the actual application process, it is the professional standards boards, the qualifications standards that create the problems in it.

Mr. HARE. And my last question here. Dr. Phelps, outside of fair compensation, how else would uniformed leadership in the VA facilities benefit recruitment and retention of psychologists?

Dr. PHELPS. The issue of uniformed leadership is this. In the mid-nineties, when Dr. Kaiser came in, regionalized the system, got rid of discipline-based services, what happened was, not just to psychology but with other professions as well, social work—I am most familiar with the mental health side—is we had staffs reporting to other disciplines who had no understanding of what the standards of practice are within that particular discipline.

What has happened since then is a recognition by the system that the ability to certify the qualifications, the skill sets and so forth of psychologists in the system requires somebody in psychology. So we have a system where there is no uniformity. Facilities appoint a lead psychologist or a senior psychologist; there are many different terms. And this gets back to the issue of, sort of, fair pay for a fair day's work, Mr. Hare. Those folks operate in those positions in addition to their regular job description.

And part of our issue with the hybrid is national standards boards and the quality standards have recognized that those are additional responsibilities that should bring additional pay, but there is no uniformity even at the level of what those types of positions are.

Mr. HARE. Thank you.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you, Mr. Hare.

Once again, I would like to thank our panelists. We will have some additional questions for the record, so if you could answer the questions for the record, we would appreciate it very much. Once again, thank each and every one of you for coming out this morning.

Our second panel is comprised of Fred Cowell, who works for the Paralyzed Veterans of America (PVA); Adrian Atizado, of the Disabled American Veterans (DAV); and Cecilia McVey, who is the Associate Director of Patient Care and Nursing in the VA Boston Healthcare System, and Immediate Past President of the Nurses Organization of Veterans Affairs (NOVA).

I would like to welcome our second panel. I am looking forward to your testimony here this morning.

And we will start off with Mr. Cowell.

STATEMENTS OF FRED COWELL, SENIOR ASSOCIATE DIRECTOR FOR HEALTH ANALYSIS, PARALYZED VETERANS OF AMERICA; CECILIA McVEY, BSN, MHA, RN, ASSOCIATE DIRECTOR FOR PATIENT CARE/NURSING, VETERANS AFFAIRS BOSTON HEALTHCARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND IMMEDIATE PAST PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS; AND ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF FRED COWELL

Mr. COWELL. Chairman Michaud, Ranking Member Miller and Members of the Subcommittee, on behalf of the Paralyzed Veterans of America, I am pleased to offer our views concerning the human resource challenges within the Department of Veterans Affairs.

Mr. Chairman, the Subcommittee's interest in the issues concerning VA healthcare personnel is well-placed and timely. Congress must assist VA's efforts to recruit and retain its corps of healthcare professionals as the demand for healthcare increases because of today's wars and the aging of veteran population from previous wars.

Currently, the Nation is experiencing serious shortfalls in its supply of physicians, nurses, pharmacists, therapists and psychologists. Competition for experienced medical personnel and newly licensed professionals is keen.

PVA believes that Congress must take the lead in revamping outdated personnel policies and procedures, that includes salaries, benefits and working conditions, that may place VA at a disadvantage in today's labor market and will prevent VA from becoming a medical care employer of choice in the future.

PVA also believes that the broken VA appropriation process, which delays VA funding, is a major barrier to VA's healthcare professional recruitment processes.

VA nurse recruitment and retention efforts: As has been stated earlier, the United States is currently in the 10th year of a critical nursing shortage which is expected to continue through 2020. The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our Nation.

The VA must be able to recruit the best nurses and retain a cadre of experienced, competent nurses. Providing high-quality nursing care to the Nation's veterans is integral to VA's healthcare mission.

VA physician recruitment and retention: PVA is concerned about VA's current ability to maintain appropriate and adequate levels of physician staffing at a time when the Nation faces a pending shortage of physicians. Recent analysis by the Association of American Medical Colleges indicates the United States will face a serious doctor shortage over the next few decades. The subsequent increasing demand for doctors as many enter retirement will increase challenges to VA's recruitment and the retention efforts.

VA's psychologist recruitment, retention and appropriate promotions: According to the American Psychological Association, VA

is the largest single employer of psychologists in the Nation. Congress and VA have recognized the need to increase the number of psychologists and have added more than 800 new psychologists since 2005, thereby raising the number of the psychologists in the VA system to approximately 2,400.

VA must also strive to retain and promote its more experienced psychologists in order to meet new training and supervision requirements. Since the vast majority of new psychologist hires in VA are less experienced professionals, VA must ensure they are properly trained and supervised. VA must also strive to retain and promote its more experienced psychologists in order to meet new training and supervision requirements.

Recommendations to enhance VA's recruitment retention efforts: Congress must revamp outdated VA personnel policies and procedures to streamline the VA hiring process and avoid recruitment delays that become barriers to employment.

Conduct Congressional oversight hearings to determine the extent of problems regarding national standardization and availability of VA locality pay.

Congress should implement a title 38 specialty pay provision for VA nurses providing care in VA specialized service areas, such as spinal cord injury, blind rehabilitation, mental health, and traumatic brain injury.

Review and adopt the recommendations developed by the VA's National Commission on VA Nursing. PVA believes these recommendations have broad application and can serve as a template for improvements that can assist VA's human resource management recruitment and retention efforts.

Congress should improve the provisions of VA's Education Debt Reduction Program, the EDRP. Currently, the EDRP is limited to not more than $49,000 spread out over 5 years of service. This program has not kept pace with the soaring costs of medical specialty education. Expanding benefit levels in EDRP will make VA more competitive than the national healthcare professional marketplace.

VA must also become more flexible with its work schedules to meet the needs of today's healthcare professionals.

Other benefits, such as child care, and a less stringent policy regarding mandatory overtime will make VA employment more attractive.

Congress should also consider reinstating the VA Health Professional Education Assistance Scholarship Program. This program was sunset in 1998, and the program would be an excellent medical care student incentive to future VA employment.

Finally, Mr. Chairman, PVA believes that Congress must find a solution to delays with the VA appropriation process. Delays in VA appropriations hamstring VA managers' recruitment efforts all across the country.

Mr. Chairman, this concludes my remarks. I will be happy to answer any questions you may have.

[The prepared statement of Mr. Cowell appears on p. 48.]

Mr. MICHAUD. Thank you very much.

Ms. McVey.

STATEMENT OF CECILIA McVEY, BSN, MHA, RN

Ms. MCVEY. Mr. Chairman and Members of the Committee on Veterans Affairs' Subcommittee on Health, the Nurses Organization of Veterans Affairs, NOVA, would like to thank you for inviting us to present testimony on human resource issues in VA.

I am Cecilia McVey, Associate Director for Patient Care/Nursing at the VA Boston Healthcare System, and I am here today as the Immediate Past President of NOVA. NOVA is the professional organization for registered nurses employed by the Department of Veteran Affairs.

NOVA respects and appreciates what our labor organizations, such as AFGE and the National Association of Government Employees (NAGE), do for VA nurses. NOVA clearly deals with VA on RN professional matters, not working conditions, for which VHA RNs have the union representative. Because this Committee has invited NOVA to share its views on this bill however, I am here to offer the following observations.

Nursing and other medical center workforce members are dependent on timely and efficient recruiting. Human resource departments across VHA are not able to function optimally due to systems that have not kept pace with our private-sector recruitment abilities. Although there are numerous barriers to timely and efficient recruiting, the following are the top three.

Although certain pay flexibilities do exist, such as recruitment bonuses, retention allowances and the special rate authority, additional pay flexibilities are needed in order for VA to be able to successfully compete for the best candidates in the marketplace. The current general schedule and locality pay system, which works hand in hand with the classification system, is antiquated and cannot respond quickly enough and has a number of major barriers.

For example, retention allowances are not considered base pay for benefits such as retirement and life insurance. And candidates have declined positions based on this limitation. VA's special pay rates—there are restrictions on how far the table can be expanded, and the approval process for special rates is too slow to address the current market conditions. Above-the-minimum rates allow a manager to appoint an applicant above the minimum step, but there is no mechanism, for example, to increase the pay of existing staff to maintain pay parity.

The application process, how to apply, is very cumbersome and confusing to those in the private sector who are used to a much faster and simpler process. Staffing specialists must help many of the would-be applicants to navigate through the maze of the Federal application process.

A consistent theme across the country is that applicants are looking for money for professional development, not just in clinical occupations but in administrative as well. Tuition reimbursement is limited to a few select occupations at this time, such as nurses, that still require expansion.

Some suggested policy changes recommended are as follows: More pay flexibility should be provided. Pay reform similar to the physician pay reform, where there is a market pay component, would provide the needed flexibility for VA facilities at the local level.

Classification standards are in need of review and revision. Many of them are too old and no longer reflective of the types of duties and responsibilities that are typically performed. Given that these are used to determine the pay, they can often serve as a barrier to appropriate and effective pay setting.

Given the sizable number of employees at or near retirement age, succession planning is becoming increasingly important, especially for those critical positions.

One other critical area of concern relates to the impact on patient care if 38 U.S.C. 7422 exclusions were to be repealed. Some of the issues that I foresee would have a negative impact on the care of our veterans include the following: RN reassignment decisions made on the basis of clinical competence, performance appraisals, and proficiency reports; fitness for duty issues as determined by a professional standard board; clinical competence issues as determined by a professional standard board; and disciplinary and major adverse actions based on patient care or clinical competence issues. Determination of clinical competence is best reserved for those responsible for ensuring that quality care is delivered.

VA has been a leader in healthcare and has earned an excellent reputation as one of the best healthcare providers in the country. In order to continue this reputation, VHA's staff will need to have new skills and competencies to treat this new generation of veterans. Nimble and flexible human resource processes are critical to VA's future success.

Thank you, Mr. Chairman and Members of this Subcommittee, for this opportunity to testify here about these important personnel issues. And I would be happy to answer any questions.

[The prepared statement of Ms. McVey appears on p. 52.]

Mr. MICHAUD. Thank you very much.

Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, I thank you for inviting the Disabled American Veterans to testify on human resource challenges within the Department of Veterans Affairs' Veterans Health Administration.

As you have been made aware by this panel, as well as the previous panel, the human capital needs of VHA are quite a concern. There are a few factors I think that we must talk about before I can fully deliver my oral testimony. We have to understand that the workforce shortage in the Nation is primarily defined in three factors: supply, demand and, obviously, the compensation package.

Congress has seen fit to address compensation package with regards to the physician pay bill reform as well as VA changing the nurses' compensation package.

Also, VA has been creating some new initiatives with regards to the supply end of the issue. You just heard the concern about not enough trainers and preceptors for the healthcare fields. And I think that should also be addressed, not only by VA, but by this Committee as well.

I would like to highlight a few factors within VHA that drive the human capital needs of VHA. There is a distinct variation in demo-

graphics and behavior of the newest generation of VA's patient population compared to the veterans of previous conflicts.

On the attrition of its workforce, by 2012, nearly 92,000 VHA employees who would be eligible for full civil service retirement. Over 46,000 of those are projected to retire. In fact, the health resources and services administration division of the Department of Health and Human Services projected a national shortage of nearly 500,000 nurses by 2010 and over 1 million by 2020.

Moreover, the unbalanced matriculants and supply of prepared healthcare workers, as well as the maldistribution of these workers across the U.S., will demand much more of VHA's human resource program.

Without question, recruitment management and providing direction for VA employees on such issues as hiring compensation, performance management, and organizational development are critical to the success of VHA's mission to provide high-quality care to sick and disabled veterans.

While, as I have mentioned, most recent actions by Congress to affect the compensation package of VHA to offer to prospective employees necessitates additional implementation oversight, as mentioned by the previous panel.

We believe an equally important problem within the realm of recruitment that requires additional attention is the Federal hiring process itself. This was touched upon by the previous panel. Hiring a new wave of Federal employees to succeed those that leave is paramount, given the frequent civil service hiring freezes of the past 2 decades and the inadequate funding levels in the unpredictable nature of the discretionary budget process.

Fortunately, there is a perennial and widely acknowledged complaint by applicants for Federal employment about cumbersome Federal hiring procedures and practices which require too much time and excessive paperwork. Of those who submit applications, many say they never received feedback from agencies of interest.

The most recent Merit Systems Protection Board's survey of entry-level hires and upper-level hires showed that substantial numbers had to wait 5 months or longer before being hired. This is much, much too long to expect a high-quality applicant to wait, particularly in the healthcare arena, which is extremely competitive.

As the Subcommittee is aware, VHA's workforce is covered under title 5, title 38 and title 38 hybrid. The greater majority of VHA employees fall in title 38 as well as the title 38 hybrid. Personnel rules under both were designed to allow greater flexibility and expedite VHA's hiring and promotion processes. However, the reality of hiring and promotion processes are facing extraordinary delays, particularly in the boarding process across health disciplines from nurses to psychologists, as well as background searches. The Federal hiring process is so daunting that it often reinforces applicants' worst fears of government as an ineffective, unresponsive and incomprehensible bureaucracy.

In addition, at times there is often poor communication between Federal managers and Human Resource professionals on the qualities and skills needed in a candidate. Attrition of experienced VHA human resources employees has a direct impact on the quality of

recruitment and retention efforts, as well as providing needed assistance to train new and inexperienced staff to successfully hire needed VHA employees. Only by insisting that VHA make recruiting talent a top priority, that both agency leaders and managers are held responsible for results, and that the individuals involved in the hiring process be held more accountable can we ensure that VHA recruits the talent needs to meet the challenges ahead.

Mr. Chairman, this concludes my testimony. I will attempt to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 54.]

Mr. MICHAUD. Once again, I would like to thank all three of you for your testimony this morning. Just a couple of quick questions.

You all touched upon retention and talked a lot more about recruitment. What additional programs or tools do you feel that the VA can use in trying to retain the employees that they currently have?

I'll start with Mr. Atizado.

Mr. ATIZADO. Well, the retention package of VA should first be seen in a different light than the recruitment package. As previously mentioned, there are certain things that current employees, direct healthcare providers in VHA, look to when they make a decision whether to stay in VA or not, whether it be the education reimbursement package which, by the way, my colleague has mentioned, has expired back in 1998. We believe and we actually recommended that be addressed in a previous testimony last year before the House Veterans' Affairs Committee.

In addition, I believe there is a great concern in the Nurse Corps with regards to the pay bands. A lot of the well experienced nurses in VA are very much at the top tier of the pay band and have nowhere to go. They are, to look across the street at a private healthcare system, which will offer more; and obviously there is an unequal footing.

Ms. MCVEY. The pay band cap is an issue for nurses and for nurses anesthetists as was testified early. That is one thing.

Ongoing educational benefits are critical for retention and not just for nursing. I think it is very important for the succession planning for other deliverers of healthcare, such as human resource departments that support the work for nursing, and the workforce.

To have educational moneys for these people for succession planning would also be very valuable support for the VA Nursing Academy program. This is a program I am not sure you are familiar with where the VA has funded last year four pilot programs with a VA and an adjoining university, to help bring more nurses into the workforce for VA. But it is also an opportunity for VA staff to become educators in these universities and give them additional opportunities, while still remaining a VA employee, to deliver care and also expand our workforce and give that workforce another opportunity to expand their horizon. And that would indeed also help retention.

Mr. COWELL. Mr. Chairman, just to build on what has been said, I think VA needs to look at doing a better job with its internal scholarship programs. These are great incentives for people to improve their skills, get higher education, and remain loyal employees of the VA.

We mentioned earlier the EDRP, the Education Debt Reduction Program, the cost, especially of medical education, is soaring. For people who want to improve their position, improve their skills and seek higher educational opportunities, these types of programs can help reduce some of that debt that goes with higher medical education. We think that would be an excellent incentive.

Locality pay is certainly an issue. It needs to be more fairly distributed and available across the system.

We think flexible schedules are important. It was testified about earlier. And in addition, you know, bonuses are not just a recruitment tool, but they are also a retention tool; and we think that pot of money needs to be more fairly distributed and available across the system. Even, perhaps, a set-aside pool of money in the VA for bonuses would be a good idea. Currently, we hear that local facility managers have to take that available money out of their existing FTEE budget, so when they do that and they have bonus money available, then they are not as able to hire the additional staff they really need.

So it is a lot of issues out there and a lot of personnel issues. We think a review of section chapter 74 and 76, both the personnel and the educational benefits, to take a good look.

Mr. MICHAUD. Thank you very much.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. Cowell, in your testimony—excuse me, I am sorry. I have this about the nurse organization.

Ms. McVey, in your testimony you raise concerns about including matters relating to direct patient care and clinical competence in collective bargaining rights.

Please explain in more detail your concerns.

Ms. MCVEY. I think—if section 7422 were to be repealed, I think that it would cause perhaps some delays because inherent in the bargaining process itself is the element of time; and if certain issues needed to be negotiated, such as mandatory training on traumatic brain injury, as an example, it may delay—not always, but in some cases. The implementation of being able to effect that training might be one example.

I also think there is some inconsistent application of section 7422 across the United States, and this may also be an issue. Perhaps it is invoked not appropriately when it should not have been or should have been; and I think that is some of the concern right now.

Mr. MILLER. Mr. Cowell, you reiterated in your testimony several recommendations for improving VA's recruitment process from the National Commission on VA Nursing.

Can you give me an idea of what you think may be the top one, two, or three of those recommendations?

Mr. COWELL. Yes.

We had a meeting with Cathy Rick, who is the head of VA nursing, and we talked a lot about the Commission's recommendations. She told us that many aspects of that have been implemented, and it is becoming good policy. But she talked about some of the problems that VA nurses, even though they are in—somewhat always in need of more compensation; but there is a lack of organizational

sharing responsibility that they feel would be a great incentive to make them feel more important and more a part of the healthcare team.

That was something that really came through in our discussion with nurses across the system, that they just think they could share a greater responsibility in unit planning and unit organization and have a greater responsibility in the administration of those areas.

Mr. MILLER. What effect do you think specialty pay rates for certain nursing professions would have on the recruitment and retention of nurses and physicians that don't have specialty pay?

Mr. COWELL. Well, we have—our analysis of the data of the spinal cord injury system, and that is our expertise, there is an agreement and a rule that the nursing service that works in the spinal cord injury service, 50 percent of those are supposed to be RNs. Our data reveals that very few of the 22 SCI centers in the four long-term care facilities meet those requirements. So there is a dearth of RNs available to veterans with spinal cord injury. We think that is true in the other specialized services as well.

One of the issues that happens, particularly in the spinal cord injury service, is that patients have high acuity needs, and it is labor-intensive work. Many of the nurses that work in spinal cord injury centers suffer personal injuries. They are on light duty. There is a lot of lifting to meet the needs of these veterans that are in these hospitals and centers. So it works as a disincentive to stay on board those services.

We think specialty pay will help attract nurses to that type of labor-intensive work and help to fulfill that RN requirement.

Mr. MILLER. The VA has established a Travel Nurse Corps. Can you talk a little about that? Do you think it is——

Ms. MCVEY. Yes. It is a pilot for the VA to have its, really what could be considered its own agency nurses, but these are VA employees; and the goal is to have a trained workforce of VA employees that could theoretically go anywhere in the country and serve in the VA in times of need. So there is a pilot project which is under way.

I am not as familiar with it as perhaps Cathy Rick would be at this time, but I am aware of it and everyone is very pleased and seems to think it is a very good thing.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. I just have one question for the panel. Maybe you could just each take a shot at this.

Does the VHA coordinate in any capacity with Veterans Service Organizations (VSOs) as a resource or recruitment tool, to find veterans who could be hired here? And if not, how do you think that could be useful, if they are, you know, A, to what degree and how effective have you found that to be?

Mr. COWELL. I would just say, in my experience, there hasn't been a great deal of collaboration between human resources people across the country and the VSOs that PVA has.

As you know, PVA has started an employment program. It is in Minneapolis and in Richmond, Virginia, and it seems like the emphasis is on our end to try to discover what local physicians might

feel available and how we can place a veteran in that kind of a position.

But we haven't had much contact from the VA toward us.

Mr. HARE. Would that be helpful to you? Do you think that is something that——

Mr. COWELL. I think anything that can help get certainly our members employed and other veterans is a good idea. And I don't think it would be a real tough step to implement. I think it is a matter of communication.

Ms. MCVEY. I also think it is a very excellent idea.

We have collaborated with the PVA on local open houses at our facility in Boston, and it has worked very well. And as you said, any extension on collaboration and the ability to bring in more staff into the VA workforce is an excellent idea.

Mr. ATIZADO. I agree, Mr. Hare. We, DAV, does not have a very established relationship with VA's human resources. It is not one of our fortes as more—as it would be for PVA, because it does affect directly on their membership, although we do work very closely with the ancillary organizations like NOVA and APA and those organizations to try and highlight VHA as a place to work.

I do believe we would more than welcome in any kind of collaboration we can make with VHA to increase their exposure on that end.

Mr. HARE. I am not sure how we would go about doing that, but it would seem to me that if the VHA would coordinate with the VSOs, you probably could give them a number of people, or at least it would be a resource for them.

So that, given the need—I want to get the numbers again. The shortage of nurses that we are going to see is what? I am sorry; I forget who testified about that, but somebody mentioned the shortages now or what we are looking at down the road.

What were those numbers again?

Mr. ATIZADO. Half a million by 2010.

Mr. HARE. Half a million.

Mr. ATIZADO. One million through 2020. This is through Health Resources and Services Administration Division of the U.S. Department of Health and Human Services.

Mr. HARE. We are going to have to get rolling, it would seem to me, because that is a huge, huge hole that we are going to have to try to fill.

So, again, I think anything that would work, Mr. Chairman, getting the VHA to talk to the VSOs, would be great, because again you are great resources. You have the people, you know them; and when you are looking at that kind of shortages down the road, that just seems to me to be a natural thing to do.

So I thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. I am sorry I was late getting here.

Ms. McVey, before I started in this, I made my living as a family doctor, and I generally found if I did what the nurses say, I would stay out of trouble. So I am going to ask my question to you.

I met with Mr. Wommack yesterday and did not hear his testimony today, but it seems like, as far as the veterans healthcare system—in order to get healthcare professionals on board it seems like there are two basic things. Number one, you can flood the input with such great numbers that sooner or later enough will float through and fill the positions; or you can deal with the input that is coming in in such a way that you can increase the percentage of those you end up hiring to fill your positions.

And my question is, have you—have you done—do you do any kind of formal testing, your organization, where you either sample people, folks who are making application to the VA system? Or do you ever go online yourself or make the phone calls yourself just to see what the process is like?

Do you have any formal way that you judge how people are treated when they actually are interested in working for the VA healthcare system?

Ms. MCVEY. That is a excellent point.

I chair our local succession planning Committee and we have not done that although we have discussed that. What we have done is, we have done some research; and we found that many VA employees, and nurses in particular, are vulnerable to leaving the system between the third and seventh year of employment.

So what we did through our succession planning Committee was go out and survey a random group of these employee nurses, and other employees as well, that are thought to be at the point at which they may consider leaving VA employment, and tabulated the results to see why they stayed, with the thought being that if we could tap into those things and incentives to make them stay, we could have a better retention rate for all of our VA employees in the Boston VA Healthcare System.

I am happy to say, for nursing RNs in particular, we have now a 5 percent turnover rate, which is extraordinarily low. Nine years ago it was 18 percent, so I think things are going well in that particular group.

But we are also concerned about turnover, though we haven't had as much in the RN group; but that is not necessarily true across the country. There have been no other departments that support the work of nursing; there are challenges, and many of them—some of which I stated in my testimony—had to do with recognition, the ability for a career ladder for non-nursing personnel, the moneys for education, et cetera. So we have been trying to tackle those on a local level, and it has been very interesting.

But I also like the thought of serving a group that has not yet come. We do hear informal feedback from our staff who are friends of the staff that have applied for positions, and that feedback is, they are very concerned about the very long and excessive timeline between when they apply for employment and when we are actually able to bring them in.

And so they do tend to get discouraged, and that is a concern of ours.

Mr. SNYDER. You did bring up—in my simplistic analysis, the third component is, if you can cut down on people quitting, then you don't have so many openings that you need to fill.

But the issue of—I have actually done this before in different things, where I get an internist, say, Here, call this help line, and here is the story I want you to read; see what kind of information.

I would think that a group like yours could get some nurses and kind of test how quickly—once you make an inquiry, how quickly do you get responded to.

As you know, the market is such out there, if somebody applies for a job or goes online and makes an initial inquiry, the nurses market being what it is, if it is a week or 2 or 3 days before they hear back from somebody, they will have other job offers if they are very aggressive and have a reasonable-to-average work record.

That might be helpful information both for you and this Committee if you, with your—you probably have the ability to do something that we don't have, which is, you can do those kinds of test cases to different VAs around the country, and because I think that would be helpful.

I know Mr. Wommack is concerned about streamlining. And the streamlining basically is, we need to have a description of what the current process is. And I don't know that we have that yet, but——

Thank you for you all's participation today.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Once again, I would like to thank our panelists for coming out and for your testimony as well. Thank you very much.

Our last panel is Joleen Clark, who is the Chief Officer of Workforce Management and Consulting with the VHA.

I want to thank you, Joleen, for your willingness to come here this morning as well. We probably will be having votes shortly, so if you can, summarize your written testimony and the complete copy will be submitted for the record.

STATEMENT OF JOLEEN CLARK, CHIEF OFFICER, WORKFORCE MANAGEMENT AND CONSULTING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. CLARK. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for the invitation to appear before you to discuss human resource challenges within the Department of Veterans Affairs, Veterans Health Administration. As the Nation's largest integrated healthcare delivery system, VHA's workforce challenges mirror those of the healthcare industry as a whole.

VHA performs extensive national workforce planning and annually publishes a workforce succession strategic plan. VHA's strategic plan addresses current and emerging initiatives, the areas of including, but not limited to, recruitment and retention, mental healthcare, polytrauma traumatic brain injury and rural health to address workforce efforts.

VHA's workforce plan is one of the most comprehensive in government and has been recognized by OPM as a Federal best practice. It is important that the supply of appropriately prepared healthcare workers meets the need of a growing and diverse population. Enrollment in nursing schools needs to grow to meet the projected future demand for healthcare providers.

In an effort to initiate proactive strategies to aid in the shortage of clinical faculty, VA launched the VA Nursing Academy to address the nationwide shortage of nurses. The VA Travel Nurse Corps is an exciting new program that establishes a pool of registered nurses in VA who can be available for temporary short-term assignments at VA medical centers throughout the country. This program is being piloted at two sites, Phoenix and San Diego.

Student programs such as the VA Learning Opportunities Residency Program, the Student Career Experience Program and the Hispanic Association of Colleges and Universities Internship Program have helped VA meet the workforce succession needs. The Graduate Health Administration Training Program provides practical work experience to students and recent graduates of healthcare administration Master's programs.

VA recognizes that rural communities face additional healthcare workforce challenges. VA is working to develop an effective rural workforce strategy to recruit locally for a broad range of healthcare professionals.

Experiential training opportunities for young medical students are important investments for creating a veteran and rural friendly physician workforce. Last year VHA's Human Resource Committee chartered a work group to streamline the recruitment process for title 5 and for title 38 physicians within VHA. The work group initially analyzed the recruitment process and identified barriers and lengthy processes for registered nurses. The work group recommendations were then piloted and are now in the process of being implemented nationally.

One retention strategy that has proven very successful for VHA was approved in Public Law 108–445. The public law improves VA's ability to recruit and retain the best qualified workforce capable of providing high-quality care for eligible veterans. The VHA Healthcare Recruitment and Retention Office administers national programs to promote employment branding within VHA as a healthcare employer of choice.

Both a recruitment and retention tool, the Employee Incentive Scholarship Program pays up to $35,900 for academic healthcare-related degree programs. Between 1999 and May of 2008, over 7,500 VA employees have received scholarship awards for academic education programs related to title 38 and hybrid title 38 occupations. And more than 4,200 employees have graduated from those programs.

The Education Debt Reduction Program provides tax-free reimbursement of education loans debt to recently hired employees, both title 5 and hybrid title 38. EDRP is similar to the student loan repayment programs for title 5 employees. VHA routinely uses hiring and pay incentives established under title 5 and title 38. Recruitment and retention incentives are used to reduce turnover rates and help fill vacancies.

In 2000, VA began to use an electronic database to capture survey information from employees entering and exiting VA's service. The entrance survey is an excellent tool for comparing and contrasting reasons new employees have come to work for VHA.

The Under Secretary for Health has made a personal commitment to succession planning and ensuring VHA has a comprehen-

sive recruitment, retention, development and succession strategy. This is a continuous process which requires ongoing modifications and enhancements to our current programs.

I would like to thank the Subcommittee for your interest and support in implementing legislation that allows us to compete in the healthcare market. Thank you.

Mr. MICHAUD. Thank you very much for that enlightening testimony.

[The prepared statement of Ms. Clark appears on p. 56.]

Mr. MICHAUD. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. I have several questions that I am going to submit for the record in view of time.

[No questions were submitted.]

Mr. MILLER. But how does VA use the tools that it currently has at its disposal to help recruit staff that have been hard to recruit and retain?

Ms. CLARK. The Education Debt Reduction Program is one of the most successful tools that we do have, and that, as mentioned, has been used to recruit healthcare professionals in both title 38 and hybrid title 38. So far, over 6,500 participants have received funding with an average award of $29,000. Right now, the cap is at just over $50,000 for those awards. And, yes, some students are coming out of school with higher debt than that, but it has been very effective in recruiting healthcare professionals.

We also use recruitment incentives extensively in areas where they have felt that they are needed to recruit staff. We draw people in with our scholarship program, our Employee Incentive Scholarship Program that we have for both title 38 and hybrid title 38 occupations.

Mr. MILLER. Talk to me about that just a little bit, the scholarship program.

Ms. CLARK. The scholarship program is available to employees after they have had 1 year of employment. We have had 7,500 that have entered into the program. It is open to all occupations that fall under title 38 and hybrid title 38. It is up to 3 years of schooling, up to 35—it is over $35,000 that it pays out for scholarships in those occupations.

Mr. MILLER. Thank you.

Ms. CLARK. You are welcome.

Mr. MICHAUD. Mr. Hare

Mr. HARE. Thank you, Mr. Chairman.

The RAND Corporation recently released reports stating that about 300,000 soldiers report symptoms of PTSD or major depression, and only half of those are seeking treatment. This conflict in particular has put a new focus on the importance of treating mental health problems.

Should the VA be reexamining if psychologists should continue to be in the hybrid title 38 program, do you think?

Ms. CLARK. The difference between hybrid title 38 and title 38 doesn't reside in how the person is boarded. It resides in—the two things that are covered by hybrid title 38 are pay and appointments, and they are covered under title 5 for everything else.

The setting of the pay and the grade that they go to is the same under title 38 and hybrid title 38, so that would not make a dif-

ference; and I don't know how it would make a difference in how care is provided.

Mr. HARE. Do you think that VA should diversify its loan repayment or scholarship programs? For certain medical professions, a physician can accrue about $150,000 in debt in medical school costs, yet they are only eligible for about $46 to $50,000 from the VA.

Ms. CLARK. Yes. We have found that many of the doctorate programs, along with the physicians, are coming out of school with debt in excess of $100,000. And although the Education Debt Reduction Program certainly helps with $50,000, you know, many of them would benefit from larger loan repayment.

Mr. HARE. One last question I had asked the last panel because it seemed to make a little sense about the working with—the VA working with different VSOs to try to find some folks who might be interested in going into the field.

I was, candidly, very alarmed when I asked the question about, you know, the half-million or 500,000 nurse shortage and then up to 1 million; and it just seemed to me that anything and everything that the VA can do, or that we can do, or whoever can go do to try to fill that hole, because we are going to see more veterans coming back. Obviously, the need is going to be greater.

So I wonder if you had a thought or two on that.

Ms. CLARK. That was a great suggestion. There are new positions that have been added to the organization called Veterans Employment Coordinators, that are placed strategically through the country; and that will be a great opportunity for them to contact the local VSOs and try to coordinate with them and get information out on any of the recruitment activities that we have going on in the local areas.

Mr. HARE. I appreciate that because, again, I think it would be—I think we have to have all hands on deck to try to help the program out here.

Mr. MICHAUD. Ms. Clark, you had mentioned the VA's working to integrate rural areas into the residency rotation.

How far along are you with that program and who are you working with to accomplish that.

Ms. CLARK. The Office of Academic Affiliations is working closely with the medical schools in the local areas to address that. I don't know how far they are along in that. I can get that information back to you.

[The VA response is included in the response to Question #4(b) in the post-hearing questions for the record, which appears on p. 63.]

Ms. CLARK. But that is something that we have been really concerned about and thought, if we get those students, trainees and residents into those rural areas and have them do their training programs and residencies there, the likelihood that they would return and stay in that area for employment is much higher.

So that was the thought behind doing that and increasing the employment in those areas in our critical occupations.

Mr. MICHAUD. Do you have programs doing that and how many States are involved in that?

Ms. CLARK. There is not a pilot program yet. I am sure we will have pilot programs that we will have doing the rural health, the residencies in the rural areas.

Mr. MICHAUD. You heard the other two previous panels talk about the hiring process and dealing with hybrid title 38, which is onerous and potentially actually could cause VA to lose good employees.

What is the number one reason that candidates are turned down for employment within the VA system?

Ms. CLARK. We are aware of the problem, and as I mentioned we have done a redesign look and see at the whole process and our end process of implementing numerous changes.

It is not just one thing. It is our paperwork; we have way too much paperwork. It is some of our internal policies that we are finding are really obsolete with some of the things we have to do with the credentialing process. Our credentialing process is very onerous, but very necessary to make sure that our staff have the appropriate credentials for patient care.

But we are looking at a process that we can do simultaneously, so it doesn't take as long, eliminating steps that don't need to be taken.

The background investigations that we have to do take some time, but also looking at combining processes and trying to eliminate unnecessary steps is helping tremendously. I think, just looking internally, we can probably, without changing regulation or statute, improve the process tremendously; and we are working toward that.

In the pilot they showed that it can be done in 30 days to bring somebody on and going through all these credentialing processes and background investigations, et cetera; and we are rolling that out throughout the country, having targeted Human Resource cluster meetings so that word can get out, they can understand what we are looking for and assist them in getting there.

Mr. MICHAUD. What do you believe VHA's number one challenge is in filling the shortage in the positions that you have? Is it more prominent in any one region of the country than another?

Ms. CLARK. I can't say that it is more prominent in any region, but there are specific areas, certain rural areas, certain demographic areas that might not have schools in the area that have greater challenges in certain occupations. Through our succession and workforce planning, we look at those things and try to build recruitment and marketing strategies to address those areas where we are having the recruitment problems.

We have—throughout the Nation, when the workforce planners do their plans, we come up with a list of what we consider our critical occupations in VA; and we target those occupations for additional recruitment strategies to look and ensure that we have the appropriate workforce.

Mr. MICHAUD. What are the top three critical occupations it needs?

Ms. CLARK. Medical doctor positions and pharmacists, are always our top three.

Mr. MICHAUD. When you look at pharmacists, you are looking at working in the academic world as well? I know pharmacy schools

are pretty expensive to have. Are you looking in that area as well—in the rural areas?

Ms. CLARK. We haven't looked at the rural areas yet.

What they have just recently started, last year in 2007, is the VALOR program, VA Learning Opportunity Residency, for pharmacists; and they have increased the number this year. And some of those are in—I don't know if I would call them rural, but in less-populated areas, and they are continuing to expand.

The pharmacy leadership has been really excited about how the program has taken off and is looking to expand it; and this is with the pharmacy doctorate programs. And it is working really well, and we are hoping that they stay in the VA after they finish their residency program.

So we think this will be a great recruitment tool.

Mr. MICHAUD. Is there anything that we can do to help deal with the shortage that you foresee?

Ms. CLARK. Thank you for the offer.

Right now, what we are trying to do is work through some of the issues internally to see how we can improve the hiring and on boarding process; and if there is something you can do to help, we certainly will let you know. Thank you.

Mr. MICHAUD. And how long is that internal review going to take? As you heard earlier, there is a severe problem out there, and the longer we wait, the less likely we are able to get these good, qualified healthcare providers in the VA system.

Ms. CLARK. We certainly understand that.

We have already implemented it in several of our networks, and it is going to be a performance measure for all of the network and medical center directors for 2009 to have it down to the 30-day hiring process. We anticipate that it will be happening by the time 2009 gets here; though, you know, there are a lot of challenges. A lot of people are at really long timeframes, so will they get down to the 30. But we are hoping at least they can cut their timeframes in half.

Mr. MICHAUD. What Veterans Integrated Services Network (VISN)?

Ms. CLARK. VISN 4 is the one that piloted the recruitment redesign, but several other networks have already implemented it as well.

Mr. MICHAUD. What are you doing to work with the Office of Rural Health, as well, to look at some of these needs, realizing that the office is, in my opinion, adequately understaffed.

Ms. CLARK. We are working hand in hand with them in the recruitment issues to try to come up with a recruitment plan so that we can—they can identify some of the things and then we can work with them on how, trying to meet those challenges. And I think that is how Academic Affiliations came up with the plan for working with the schools to try to get some of those residents into those under-served areas.

Mr. MICHAUD. My other question involves rural areas where there is a healthcare shortage, not only within the VA system. If you look at the Capital Asset Realignment for Enhanced Services (CARES) Process, 2004, when their report came out, they rec-

ommended a lot of access points, particularly in rural areas, and they haven't moved as aggressively as a lot of us would like to see.

My question is, what are you, the VA, doing to work with local healthcare providers in States to deal with the healthcare shortage, and are there ways that you can partner with the healthcare providers currently out there, keeping in mind the CARES Process, might recommend to provide access points in rural areas?

Ms. CLARK. I am not sure what they are doing. I know that some local facilities do contract with those in areas where they have the clinics, et cetera, but I can take that question back for the record.

[The VA response is included in the response to Questions #4(a) in the post-hearing questions for the record, which appears on p. 62.]

Mr. MICHAUD. Do you have any additional questions?

Once again there will probably be additional questions, later on, in writing.

Mr. MICHAUD. We really appreciate your willingness to come today. It has been very helpful. This is an extremely important issue, one that we are going to have to deal with soon if we are going to make sure that our veterans have adequate healthcare here. Once again, thank you very much for your testimony today. We look forward to working with you as we move forward in this Congress.

So if there are no other questions, this hearing is adjourned. Thank you.

[Whereupon, at 11:40 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

Thank you everyone for coming today.

The Veterans Health Administration's mission is to provide patient centered healthcare that is comparable with or better than care available in the non-VA sector. To do this, VHA must have a viable healthcare workforce that is competent, well trained and happy.

Over the past 5 years, VA has built a reputation of delivering healthcare efficiently and effectively. VA has been touted as the "best care anywhere" and the Department has been recognized on numerous occasions for healthcare quality and patient satisfaction.

However, in order to carry that banner forward, careful planning and efficient processes must be put into the system to ensure continued success.

We know that VA's workforce is aging, with an average age of 48.6 years. We know that at the end of 2012 a significant percentage of the employees will be eligible to retire.

This Subcommittee has held many hearings that examined the appropriateness and quality of care and treatment that veterans receive within the healthcare system.

This hearing today will focus on the human resource challenges that VHA must address in order to ensure there will not be a gap in the expertise and quality of care provided to veterans.

The Committee realizes that this is a complex issue. But we also recognize that it is an important one that deserves serious thought and consideration.

Thank you again for coming today.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this hearing today to examine the many challenges VA faces in hiring and keeping healthcare workers.

Healthcare workers are the frontline of VA healthcare. Every day they care for our servicemembers who have honorably served our country. And the high quality of healthcare available to our veterans is dependent on the ability of VA to recruit and retain qualified healthcare personnel.

One of the most pressing problems we face as a Nation is the marked shortage of virtually all healthcare workers. This includes, among others, nurses, physicians, physician assistants, psychologists, pharmacists, and physical and occupational therapists.

Competition for these and other healthcare personnel is intense and VA must aggressively vie with the private sector to bring the very best staff into the VA system.

To do that, VA must effectively use innovative recruitment tools and offer a good work environment with educational opportunities.

The VA healthcare system has been recognized for the significant benefit of its use of electronic medical records and focus on preventative care. And, to make sure that our veterans continue to receive the best care, it is critical that it is also seen as the workplace of choice.

I look forward to hearing from our witnesses today to learn about issues they see and ideas they have for improving VA's ability to recruit and retain a first-class healthcare workforce.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Prepared Statement of J. David Cox, RN, National Secretary-Treasurer, American Federation of Government Employees, AFL-CIO

The American Federation of Government Employees (AFGE) appreciates the opportunity to present its views on human resources challenges within the Veterans Health Administration (VHA). AFGE represents nearly 160,000 employees in the Department of Veterans Affairs (VA), more than two-thirds of whom are VHA professionals on the front lines treating the physical and mental health needs of our veteran population.

The vast majority of VHA's workforce is covered by personnel rules known as "pure Title 38" providers (e.g. registered nurses (RN), physicians and physician assistants (PA)) or "hybrid Title 38" (e.g. licensed practical nurses (LPN), pharmacists, psychologists and social workers). The Title 38 boarding process for appointment and promotion of these two groups of VHA professionals was designed to be more flexible and expeditious than Title 5, but as will be discussed, the process faces extreme delays and backlogs. A small number of VHA direct patient care positions remain under Title 5, e.g., Nursing Assistants and Medical Technicians.

AFGE's testimony focuses primarily on two significant human resource challenges facing VHA today:

- Loss of grievance rights for "pure Title 38" employees;
- Extreme delays in the "hybrid Title 38" boarding process;

In my nearly 25 years as a registered nurse and union official at the Salisbury, North Carolina VA Medical Center, I have seen the impact of many Veterans Health Administration (VHA) personnel policies on recruitment and retention of healthcare professionals. In the eighties, I saw first hand how regular collaboration between frontline providers and management helped transform the VA into a world-class healthcare system, becoming a model in patient safety, healthcare information technology, and best practices.

Sadly, what I have seen over the past 7 years is a sea change in VA's personnel practices that now hurt, rather than help, recruitment and retention, and exclude frontline providers from medical affairs. The current culture of exclusion is very demoralizing to these dedicated providers who are extremely committed to the mission of the VA and work so hard to care for our veterans. For example, according to a January 2008 VA national RN satisfaction survey, for the past 2 years, "Participation in Hospital Affairs" was one of two areas where RNs at VA medical facilities were the *least* satisfied.

Loss of grievance rights for "pure Title 38" employees

The most harmful, far-reaching VHA personnel policy in place today is the severe erosion of collective bargaining rights (hereinafter "grievance rights") of RNs, physicians, PAs and other pure Title 38 providers ("providers".) These rights include the right to challenge management personnel actions through grievances, arbitrations, labor-management negotiations, unfair labor practices (ULPs) and litigation before the Federal Labor Relations Authority (FLRA) and courts.

VHA denies these rights by asserting an arbitrary and unsupported interpretation of 38 USC §77422 ("7422"), the law that provides collective bargaining rights to these providers. VA's 7422 policy blocks virtually every provider grievance on the basis of three narrow exceptions in the law: professional conduct and competence (defined as direct patient care or clinical competence); peer review; and compensation.

VHA's 7422 policy has undermined Congress' attempts to improve VHA recruitment and retention through rights to better pay and schedules. The effect, to quote the old adage, is "rights without remedies" which "are no rights at all."

AFGE greatly appreciates the support of Chairman Michaud and Subcommittee Members Berkley, Brown and Doyle for H.R. 4089, legislation introduced by Committee Chairman Filner to amend section 7422 and restore these critical rights. This bill is an *essential* enforcement tool for all past and future legislation that addresses VHA recruitment and retention of pure Title 38 providers, as well as Federal statutes that provide rights to information and prohibit employment discrimination.

VHA's 7422 policy directly contradicts Congressional intent as to the scope of these three exceptions. Specifically:

- Congress viewed Title 38 and Title 5 employees as having the same collective bargaining rights when it enacted the Civil Service Reform Act (CSRA) in 1978.

- Congress enacted section 7422 in direct response to a 1988 Federal appeals court decision involving annual nurse "comparability pay" increases. The Court held that the VA could not be compelled by the CSRA to engage in collective bargaining over conditions of employment for Title 38 providers. *Colorado Nurses Ass'n v. FLRA,* 851 F.2d 1486 (D.C. Cir. 1988).
- The plain language of the 1991 law narrows the scope of the exceptions by specifying that the matter must relate to "*direct* patient care" or *clinical* competence."
- The 1990 House Committee report on the underlying bill defined the "direct patient care" exception as "medical procedures physicians follow in treating patients." This report also cited guidelines for RNs wishing to trade vacation days as falling *outside* the exception. (H. Rep. No. 101–466 on H.R. 4557, 101st Cong., 2d Sess., 29 (1990)).

VHA's 7422 policy also contradicts its own 1996 agreement with labor to clarify the scope of the law and resolve remaining disputes in a less adversarial manner. Sadly, the VA unilaterally abandoned this useful, inclusive agreement in 2003. More specifically, in that agreement:

- **The VA committed to a new process for resolving 7422 disputes** that departed from the "adversarial, litigious, dilatory . . . nature of past labor-management relations."
- **The VA acknowledged that providers provide valuable input into medical affairs:** "We recognize that the employees have a deep stake in the quality and efficiency of the work performed by the agency."; "The purpose of labor-management partnership is to get the frontline employees directly involved in identifying problems and crafting solutions to better serve the agency's customers and mission."
- **The VA recognized the narrow scope of the direct patient care exception,** i.e., it does not extend to "many matters affecting the working conditions of Title 38 employees [that] affect patient care only *indirectly*" (emphasis provided).
- **The VA agreed that scheduling matters may be grievable:** "For example, scheduling shifts substantially in advance so that employees can plan family and civic activities may make it more expensive to meet patient care standards under certain circumstances. That does not relieve management of either the responsibility to assure proper patient care or to bargain over employee working conditions."
- **The VA agreed that pay matters other than setting pay scales are grievable:** "Under Title 38, pay scales are set by the agency, outside of collective bargaining and arbitration. Left within the scope of bargaining and arbitrations over such matters as: procedures for collecting and analyzing data used in determining scales, alleged failures to pay in accordance with the applicable scale, rules for earning overtime and for earning and using compensatory time, and alternative work schedules."

The 7422 appeals process:

Section 7422 gives the Undersecretary of Health (USH) the sole authority to determine what matters are grievable. USH decisions are posted on the VA Web site (http://www1.va.gov/lmr/page.cfm?pg=28). The VA does not keep AFGE apprised of unpublished decisions or pending cases.

AFGE is very concerned by the lack of meaningful, balanced review by the USH and by failure of local facilities to comply with the USH review process.

A review of posted decisions and member reports received by AFGE reveals how VA's 7422 policies directly undermine recruitment and retention legislation passed over the past decade and deprive providers of a fair appeals process.

For example:

- *No right to grieve over denial of request to review nurse locality pay survey data*
  - Background: Congress enacted legislation in 2000 to authorize directors to conduct third party surveys to set competitive nurse pay (P.L. 106–419).
  - USH Ruling: "Compensation" exception blocks employees' access to third party survey data. (Decision dated 1/06/05)
- *No right to grieve over VA nurse mandatory overtime policy*
  - Background: Congress enacted legislation in 2004 requiring facilities to establish policies limiting mandatory overtime except in cases of "emergency" (P.L. 108–445).

- USH Ruling: National grievance over definition of "emergency" for requiring overtime is barred by the "professional conduct or competence" exception. (Decision dated 10/22/07).

- *No right to grieve over composition of panels setting physician pay*
  - Background: Congress enacted legislation in 2004 to use local panels of physicians to set market pay that would be competitive with local markets (P.L. 108–445). AFGE contended that management unfairly excluded practicing clinicians and employee representatives from the panels.
  - USH Ruling: Grievance barred by "compensation" exception. (Decision dated 3/2/07).

- *Other grievances blocked by VA's 7422 policy* (based on member reports of pending disputes or unpublished USH decisions)
  - *No right to challenge intimidation of arbitration witnesses:* After two VA nurses testified for the union at arbitration, management sent them letters questioning their conduct and suggesting that they could be subject to discipline. The union filed an unfair labor practice with the FLRA which initiated steps to file charges against management. Management invoked the "professional conduct or competence" exception to suspend FLRA action pending an USH ruling.
  - *No right to challenge performance rating based on use of approved leave:* Management invoked 7422 when a nurse tried to grieve the lowering of her performance rating that was based on her authorized absences using earned sick leave and annual leave, and carried out without any written justification.
  - *No right to challenge error in pay computation:* Management invoked 7422 when a nurse was incorrectly denied a within-grade pay increase because of lost time arising out of a work-related injury covered by workers compensation.
  - *No right to challenge low reimbursement for costs of required training:* Management invoked 7422 when a nurse tried to grieve the amount of reimbursement she received for attending required training to maintain her Advanced Practice RN certification.
  - *Exclusion from hospital affairs:* Management invoked 7422 to block a local union's efforts to have input into the drafting of medical staff bylaws that impact personnel policies.
  - *No right to challenge unfair bonus policies:* VA physicians are unable to challenge policies that are not in compliance with the 2004 physician pay law because managers set arbitrarily low bonuses and impose unfair performance measures based on factors beyond the physician's control.

Recent court decisions confirm the need for Congressional action on 7422:

- *AFGE Local 446 v. Nicholson*, 475 F.3d 341 (D.C. Cir. 2007). The Federal court held that the VA operating room nurses could not file a grievance over denial of premium pay weekend and evening shifts.
- *AFGE Local 2152 v. Principi*, 464 F.3d 1049 (9th Cir. 2006).

  A VA physician was removed from his surgical duties at age 76 and his specialty pay was discontinued. The court held that the physician's grievance alleging unlawful age and gender discrimination was barred by the "professional conduct or competence" exception in 7422.

  The court rejected the union's contention that management's 7422 assertion was a mere pretext for unlawful discrimination. Similarly, in a posted USH decision dated 6/1/07, a nurse alleging that management's denial of specialized skills pay was racially motivated was not allowed to pursue a grievance.

Amending 7422 will not hurt patient care. Those defending VA's current 7422 policy are likely to suggest that labor will try to disrupt patient care if 7422 is amended. In fact, Title 5 makes the three exceptions in 7422 redundant and unnecessary. Federal sector unions are only authorized to negotiate on "conditions of employment" as that term is defined in 5 USC 7103(a)(14). In contrast, 5 USC 7106(a)(1) makes it a management right (i.e., not to be modified at the bargaining table) for an agency to determine its "mission."

Furthermore, a review of published cases that have come before the USH did not reveal even *one* attempt to interfere with medical procedures or other direct patient care matters.

Finally, if grievance rights can interfere with VHA operations, then why do hybrid Title 38 providers hired under Title 5 and working side by side with "pure" Title 38 providers have rights to grieve over these prohibited matters? For example, psychologists have full grievance rights while psychiatrists do not; licensed practical nurses have full grievance rights while RNs do not.

The current dispute resolution process for 7422 is broken and biased against employees. Those defending VA's current 7422 policy are also likely to argue that employees already have a fair process though the USH for resolving 7422 disputes. Numbers tell a very different story: Of the 25 published USH decisions over the past 3 years, the USH ruled in favor of management *one hundred percent* of the time. Opponents are unlikely to mention that many, many more cases never get to the USH even though the law clearly states that he has sole authority to make these rulings. Across the country, human resource departments with no authority regularly make 7422 determinations and refuse to go through the proper USH channels.

The current 7422 process wastes taxpayer dollars. Finally, the VA's 7422 policies result in a great waste of taxpayer dollars that would be much better spent on patient care. The Asheville case previously discussed was pending for *seven* years. HR departments in facilities around the country regularly block or delay the section 7422 review process, draining resources and staff time away from the VA's mission of caring for veterans.

Extreme delays in the hybrid Title 38 boarding process

Congress' primary objective in establishing hybrid Title 38 positions (i.e., employees are hired under Title 5 but appointed and promoted at the facility level under Title 38) was to expedite the appointment and promotion of more VHA employees involved in direct patient care. Unfortunately, the hybrid boarding process has been anything but expeditious. Employees involved in medical care and mental health treatment, including the large numbers of psychologists and social workers the VA is trying to bring on board, are facing extreme delays in appointment and promotion

A second concern is the impact of this process on veterans' preference in employment. OIF/OEF veterans experience great difficulty in securing and retaining employment, including reservists and members of the National Guard who return to Federal service following active duty. VA employees lose veterans' preference protections when they are converted from Title 5 to Title 38 status. *All* veterans, whether they are covered by Title 38 or Title 5, should have equal employment opportunities in the VA, which strives to be a model employer of veterans.

We urge the Subcommittee to reject proposals to convert additional Title 5 employees to hybrid status. A substantial increase in the number of covered employees would be disastrous. Rather, we recommend the suspension of all hybrid boarding pending completion of a pilot project using a streamlined Title 5 hiring process and comparative study of the two systems. AFGE would like to work with the Subcommittee to develop this pilot project. A pilot project using an alternative Title 5 process can also provide valuable lessons for other Federal agencies.

Other human resources challenges

Physician Pay Law:

AFGE urges this Subcommittee to conduct oversight into the many problems surrounding the implementation of the physician and dentist pay provisions in P.L. 108–445, Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004.

Congress' primary objective in enacting these provisions was to reduce the use of expensive fee basis physicians and dentists and fill vacancies at medical facilities has clearly not been achieved. The law required the VA to provide an initial report on progress toward this goal to Congress followed by five annual reports. AFGE is not aware of a *single* report having been published to date. Meanwhile, many facilities face severe recruitment problems and the VA continues to spend substantial sums on costly contract care, including Project HERO, a pilot project impacting 23 States.

Problems are evident both in the law's market pay and performance pay systems for physicians and dentists, specifically:

- Improper composition of local compensation panels setting market pay for individual providers;
- Management's refusal to share market pay survey data;
- The VA's unilateral reduction of the maximum performance pay award set by Congress;

- In many facilities, there have been severe delays in developing performance pay criteria;
- Most criteria were developed without any input from frontline provider or employee representatives;
- Many of the criteria are improper, for example penalizing missed patient appointments, which is clearly beyond the provider's control.

AFGE urges the Subcommittee to conduct its own study of the law's effectiveness, including the following criteria including in the law's reporting requirement: rates of pay by facility and specialty; rates of attrition; number of unfilled positions in each specialty and length of time positions have been unfilled; and, a yearly comparison of staffing levels, contract expenditures, and average salaries.

Nurse Alternative Work Schedules: In 2004, Congress authorized facility directors to offer nurse alternative work schedules (AWS) in the form of full-time pay for three 12-hour work days. This schedule option is widely available in the private sector. AFGE is not aware of a *single* VA facility that has offered AWS to date. We urge the Subcommittee to stop relying on the discretion of facility directors who are resistant to implementing AWS, and mandate by law that facilities offer this option consistent with their prevalence in the local labor market.

Equality for Part-Time Nurses: Part-time nurses represent a valuable resource to VHA. We recommend that Title 38 be amended to enable part-time nurses to earn the same rights and job security as their full-time colleagues. Also, many full-time nurses convert to part-time status for family and other personal reasons after they acquire permanent status. Changing to a part-time schedule should not result in a loss of permanent status.

Thank you.

Prepared Statement of Randy Phelps, Ph.D., Deputy Executive Director for Professional Practice, American Psychological Association

Chairman Michaud, Ranking Member Miller, and distinguished Members of the Committee, I am Dr. Randy Phelps, Deputy Executive Director for Professional Practice of the American Psychological Association ("APA"), the largest association of psychologists, with approximately 90,000 full members and 50,000 graduate student members engaged in the study, research, and practice of psychology. I am a licensed clinical psychologist, a former practitioner, clinical researcher and educator, and for the past 15 years on the APA executive staff, have served as APA's liaison to professional psychology in the Department of Veterans Affairs (VA).

APA appreciates the opportunity to testify today about human resource challenges within the Veterans Health Administration (VHA) that have a direct impact on the recruitment and retention of doctoral psychologists to provide care to this Nation's heroes. I should note at the outset that VHA is the workplace of choice for many of our members, with about 2,400 psychologists currently in the system. VA is, in fact, the largest single employer of psychologists in the country. APA supports VA's recent and aggressive efforts to recruit new psychologists but has concerns about a number of policies and procedures which are negatively affecting both recruitment and retention.

APA's Contribution to Growing Needs

Professional psychology as a discipline was "born" as a result of the needs of this Nation's returning World War II heroes, and psychologists are acutely aware of the debt we owe to those veterans and to the brave men and women who have followed in their footsteps, as well as to the system of care this country has evolved to minister to their healthcare needs.

And, APA is acutely aware that there are over 200,000 homeless veterans on America's streets today; that the risks of Post Traumatic Stress Disorder (PTSD) and traumatic brain injury (TBI) appear to be at unprecedented levels in the population of 1.7 million servicemembers who have been deployed in the War on Terror; that there has been a resulting influx of veterans from previous theaters of war who are increasingly seeking VA services; and that the healthcare needs of aging veterans continue to grow.

To assist with those needs, APA has many initiatives currently underway, including two Presidential Task Forces on the Needs of Military Servicemembers and Their Families, and the recently adopted "Blueprint for Change: Achieving Integrated Healthcare for an Aging Population", which is consonant with VA's groundbreaking work on primary care integration.

APA's Committee on Rural Health is addressing ways for psychologists to help extend services to veterans in rural areas where existing VA and Department of Defense (DoD) facilities are simply beyond the reach of patients. As well, APA's public interest component works on issues of direct concern to VA, such as homelessness, military sexual trauma, and family violence. In education, we are creating training pipelines for specialty training of psychologists and other mental health professionals regarding soldiers' pre and post deployment needs, through both the Center for Deployment Psychology (with the DoD) and in proposing expansion of our Graduate Psychology Education program. We also have recently provided testimony proposing funding increases over the Administration's FY '09 VA Medical and Prosthetic Research Account funding levels.

Recruitment and the Psychology Workforce Within VHA

As I indicated, VHA is the single largest employer of psychologists in the Nation, and has been for many years. Yet, VA continues to recognize the need to increase its psychology staffing levels in response to ever-increasing needs for services to veterans.

As a result, VHA has added more than 800 new positions for psychologists since 2005; thereby rapidly increasing the number of psychologists in the system to a current high of approximately 2,400, now surpassing the previous 1995 high of approximately 1,800 psychologists nationally. The 2,400 psychologists now employed by VA range from the GS–11 to GS–15 levels.

The APA applauds VA for these tremendous and serious recent efforts to recruit additional psychologists into the system, and we have actively partnered with VA to promote the news of these openings, have attempted to assist with recruiting neuropsychologists (who are needed in increasing numbers due to TBI), and have worked to promote VA career choices by the newer generations of psychologists.

I need to emphasize, however, that these increased psychology staffing levels are a very recent development over approximately the last year and a half only. Psychology staff levels were actually significantly BELOW 1995 levels until 2006. Moreover, the vast majority of new psychologist hires in VHA are younger, lesser experienced psychologists who have come into the system at the GS–11 to GS–13 levels.

However, the contrast between the VA's success in recruiting new professionals into the system versus VA's retention and promotion of those existing VA psychologists with years of experience treating veterans is dramatic.

For example, at the end of 2007, the number of GS–14s in the entire system nationally was no different than it was 12 years prior in 1995 (at 130 GS–14s total). Of additional concern to the APA is that the number of GS–15 psychologists nationally as of the end of 2007 (approximately 50) was actually *considerably lower* than the number of GS–15s in 1995.

To the system's credit, VA has also recognized and capitalized on the fact that the best source of recruiting new psychologists has been the Department's own training systems. Over the past 2 years, approximately 75 percent of all new psychologist hires have been prior VA trainees. And, VA is rapidly increasing its funding of psychology training. In the 2008–2009 training year, VA has added approximately 60 new psychology internship positions and 100 new postdoctoral fellowship positions, spending approximately $5 million to do so. This will bring the total psychology training positions to approximately 620 per year nationwide.

Retention of the Psychology Workforce

Despite positive developments in recruitment, VA's advancement and retention policies continue to be driven by outdated and overly rigid personnel and retention systems. In addition to hiring new staff, the VA needs to retain those existing psychologists who are qualified, possess specialized skills, and who are already acculturated within VHA. These psychologists are vital to service provision because of both their professional expertise and their knowledge of the system and its resources for veterans.

1. Lack of Uniform Psychology Leadership Positions

Since 1995, independent mental health discipline services at most facilities have been replaced with interdisciplinary Mental Health Service Lines. As a result, there has been a decrease in the number of discipline chiefs across the system. The dissolution of discipline specific services has left a clear leadership gap in terms of professional practice accountability, guidance on the proper use of professional skills, and promotion and oversight of profession-specific staff and pre-licensure training.

Psychology remains the only major mental health discipline without an officially designated leader in every medical center, analogous to the Social Work Executive.

While there are a small number of "Chief Psychologists" remaining, the far more prevalent positions of discipline-based professional leadership are those such as "Supervisory Psychologist", "Lead Psychologist", or "Psychology Director". Notably, these positions are all too frequently unrecognized at the level of additional pay for the additional professional leadership responsibilities they entail.

2. Inequitable Access to Key Leadership Positions

Psychologists are also not represented equitably in all levels of leadership in the VA's healthcare delivery system. In 1998, the Under Secretary for Health (USH) attempted to correct this situation with the issuance of VHA Directive 98–018, later reissued in 2004 as VHA Directive 2004–004, which stated that "it is important that the most qualified individuals be selected for leadership positions in mental health programs regardless of their professional discipline."

Unfortunately, the only requirement within the Directive was that announcements of VA mental health leadership positions not contain language that restricts recruitment to a specific discipline. As a result, this Directive has had little practical impact on the appointment of highly qualified psychologists to VA mental health senior leadership roles, particularly at medical school affiliated VA facilities.

3. Serious Implementation Problems in Hybrid Title 38

Psychologists remain the only doctoral healthcare providers in VA who are not included in Title 38. In late 2003, the Hybrid Title 38 system was statutorily expanded to provide psychologists (and a wide range of other non-physician disciplines) some of the same personnel and pay considerations as their physician counterparts. The hybrid model requires Professional Standards Boards to make recommendations on employment, promotion and grade for psychologists, and is still more subjective than a pure Title 38 program; unlike Title 38 where professionals are hired, promoted and retained based solely on their qualifications.

The implementation of the new Title 38 Hybrid boarding process has been extremely variable and chaotic across the system. Many Psychologist leaders from facilities throughout the country have reported that their facilities and Veterans Integrated Service Networks (VISNs) have denied GS–14 and 15 promotions that have been recommended by the national boarding process. Even more frequent are reports of facilities and VISNs that have delayed or refused to forward boarding packets to the national board and/or have refused to reveal the results of the national board action.

Informational missteps and technical problems have also plagued the national psychology boarding process. Just last month, VA Central Office (VACO) sent instructions to the field that eliminated the national cap on GS–14 levels for psychologists. However, these same instructions tied the award of GS–15 psychology positions to the facility's level of complexity, making many senior psychologist leaders ineligible for grade increases commensurate with the scope and complexity of their actual duties.

APA was optimistic that the Hybrid Title 38 system would modernize the pay system and foster greater retention of senior psychologists within the VHA system. Given that 5 years after its passage, implementation continues to be such a boondoggle, we are now seriously reconsidering our support for the Hybrid system, and considering instead a policy change to bring psychologists fully into the Title 38 system. The basic concept of Title 38 is "rank-in-person" rather than rank in position, basing rank and pay on one's qualifications brought to the job rather than on some of the duties of the position. Hybrid 5/38 uses the procedures of Title 38 for recruitment, but not for rank and pay boards, preferring a mixture of Title 5 types of position descriptions, now re-titled in Title 38 language as "functional statements". The functional statements are used with Title 5 kinds of considerations, including scope of supervisory or managerial responsibilities, leaving no room for advancement in rank for senior psychology clinicians who are not part of medical staff.

For example, efforts to make it easier for outstanding research clinicians to advance in rank have been virtually unsuccessful because in many cases it is written into their jobs as clinicians that research is part of their function; they are denied any special advancement for published papers, grants awarded from merit review bodies, etc. Indeed the bar of publications has been set so high that few of them have been able to advance in rank, again based on the kinds of measures one would have used under Title 5.

Most physicians, under this rank in person concept, used to achieve a base pay equivalent to a GS–15, step 10. More recent changes to physician pay have resulted in psychiatric physicians being paid a minimum of $91,500 to a maximum of $225,000, with four levels of pay grade, each with a minimum and maximum, incorporating other elements such as "market pay" and "performance pay." The result

is that the typical psychologist, depending upon locality tops out at about $101,000 after 15–20 years of service (GS–13, step 10), while a senior physician typically may make 30 to 125 percent higher salary.

Also, physicians have long had an annual bonus for board certification. Psychologists are now eligible for a one-time step increase, but only if they were to become newly board certified within a narrow window prior to, or since the inception of hybrid Title 5/38. Senior psychologists who have topped out in their grade (GS–13) are not eligible for anything other than a one-time award.

Additional Factors Affecting Recruitment and Retention of Psychologists

1. Medical Staff (Clinical) Privileges vs. Full Medical Staff Membership

VA is based on a medical model, and doctoral psychologists are excluded from the decisionmaking process by being denied full medical staff privileges in many facilities, particularly those that are not affiliated with medical schools. Not being a member of the medical staff is to be a second class citizen. Psychologists are most typically "clinically privileged" practitioners, i.e., those who are not full members of the medical staff, and who are called "Licensed Independent Practitioners". But they have no formal say in hospital policy, and may not sit on the governing body of the medical staff in those facilities where they are not members.

There are a number of important reasons to support psychologists having full medical staff membership throughout the VHA healthcare system. In recent years there has been a significant increase in the number of psychologists who have assumed leadership roles in important medical center programs. These include many of the new post traumatic stress disorder (PTSD), Recovery, Pain, Substance Abuse programs, and so forth. These psychologists are responsible for the supervision of various disciplines and provide direct clinical care for the medical center. These are certainly responsibilities that are consistent with full membership on the medical staff. In addition, many of the new Home Based Primary Care (HBPC) psychologists are working independently and away from the physical umbrella of the VA medical centers. They are doing important and demanding work in the veteran's homes. Again, the level and complexity of work is what one would expect from a full member of the staff. Without membership, there is restricted input into many important decisions that impact programming and ultimately on patient care.

2. Prescriptive Authority

One of the most difficult current challenges for VHA is how to extend care into those areas, particularly in rural America, where VA facilities do not exist or are at great distance from the veteran. One option that VHA has long resisted, but should more carefully consider, is granting expanded authority for appropriately trained psychologists to provide both psychological and psychopharmacological care to veterans in these under-served rural areas. Experience in both States where licensed psychologists have this expanded statutory authority to prescribe (New Mexico and Louisiana), as well as a decade of data from the original DoD psychopharmacology program, have shown these practices to be safe and effective for the public.

Both New Mexico and Louisiana, States with large rural populations, have passed laws to allow psychologists to prescribe. New Mexico, which passed its prescriptive authority law in 2002, and Louisiana, which passed its law in 2005, permit appropriately trained licensed psychologists with additional postdoctoral training in psychopharmacology to prescribe. These laws have been very successful, and to date nearly 50 psychologists prescribing in these States have written more than 40,000 prescriptions without adverse incident.

Furthermore, a Federal demonstration project set up nearly two decades ago has set a clear precedent that psychologists can successfully prescribe in a large Federal health system. The Department of Defense Psychopharmacology Demonstration Project (PDP) also proved that psychologists can be trained to prescribe safely and effectively. Begun in 1991, ten psychologists participated in the PDP, which was designed to train and use psychologists to prescribe psychotropic medications. These psychologists treated a wide variety of patients, including active duty military, their dependents and military retirees, with ages ranging from 18 to 65.

The PDP was highly scrutinized. The American College of Neuropsychopharmacology (ACNP) conducted its own independent, external review of the PDP and in 1998 presented its final report to the DoD. Likewise, the General Accounting Office (GAO) issued a positive report on the PDP. Both reports repeatedly stressed how well the PDP psychologists had performed, and noted that with prescriptive authority, psychologists were able to offer holistic, integrative treatment, which includes psychotherapy and medication, where appropriate.

It is clear that already licensed doctoral psychologists are being trained to prescribe safely and effectively. The precedent for the VA system to recognize psychologist prescriptive authority is clear both from State action and the DoD's program. In addition, APA Division 18 psychologists—Psychologists in Public Service—including those who serve in the VA, are already supporting training of a cadre of public service psychologists to be able to prescribe as recognition expands along with the need for services. The VA should begin to utilize such professionals to the full extent of their licensure and training. Psychologists are willing and able to help fill the gap and ease the strain on the VA health system particularly in rural areas.

Summary and Examples

Two dramatic, but not apparently unusual examples of how these problems are affecting services have recently crossed my desk. In one, a new hire, who happens to be a former State Psychological Association President and representative to APA's Committee on Early Career Psychologists, was dismissed during his probationary year after being hampered in his abilities to effectively discharge his dual leadership duties as the facility's new Local Recovery Coordinator as well as the Acting Supervisory Psychologist. In another facility, a more senior psychologist who was approved by the National Standards Board was denied locally for a GS–14 upgrade for her position as Psychology Program Manager and tendered her resignation on April 1st.

APA considers the issues and problems addressed in this testimony as serious obstacles to making VA the workplace of choice for psychologists. Without clear advancement systems in place, VA faces critical long term recruitment and retention problems. As psychologists come to believe that there is little possibility for advancement, regardless of the level or complexity of responsibilities, fewer VA psychologists will be willing to accept positions of greater responsibility. In addition, high potential trainees whom the VA would like to recruit will increasingly see VA as a "dead end" for their careers, and will be attracted to other career options that offer more potential for advancement.

Thank you for this opportunity to provide testimony today on behalf of the American Psychological Association. We stand ready to assist with the Committee's work to further improve recruitment and retention of psychologists to assist in providing care to this Nation's honored veterans.

Prepared Statement of Angela Mund, CRNA, MS, Clinical Director, University of Minnesota Nurse Anesthesia Area of Study, Minneapolis Veterans Affairs Medical Center, Veterans Health Administration, U.S. Department of Veterans Affairs, on behalf of American Association of Nurse Anesthetists

Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee:

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 39,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. Over 500 CRNAs are employed by the Department of Veterans Affairs (DVA) healthcare system. We appreciate the opportunity to present our testimony to the Subcommittee. With our military personnel and Veterans' access to safe and high quality healthcare our first priority, we want you to know that the profession of nurse anesthesia is working creatively and effectively with the Department of Veterans Affairs (DVA), in partnership with the U.S. Army, to improve its retention and recruitment of CRNAs, so that high quality anesthesia services remain available and accessible for our Nation's Veterans. This work is crucial for several reasons; most importantly, because the anesthesia workforce needs in the DVA are increasing. Our request of the Committee is to understand these needs and to examine more closely the VA anesthesia workforce to ensure the safest, most cost-effective anesthesia services for our Veterans.

CRNAs AND THE VA: A TRADITION OF SERVICE

Let us begin by describing the profession of nurse anesthesia, and its history and role with the Veterans Administration health system.

In the administration of anesthesia, CRNAs perform the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer some 30 million anes-

thetics given to patients each year in the United States. Nurse anesthetists are also the sole anesthesia providers in the vast majority of rural hospitals, assuring access to surgical, obstetrical and other healthcare services for millions of rural Americans.

Since the mid-19th Century, our profession of nurse anesthesia has been proud and honored to provide anesthesia care for our past and present military personnel and their families. From the Civil War to the present day, nurse anesthetists have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged. In May 2003, at the beginning of "Operation Iraqi Freedom," 364 CRNAs had been deployed to the Middle East to ensure military medical readiness capabilities. For decades CRNAs have staffed ships, remote U.S. military bases, and forward surgical teams, often without physician anesthesiologist support. The U.S. Army Joint Special Operations Command Medical Team and Army Forward Surgical Teams are staffed by CRNAs.

As our military personnel advance from active service to retired and Veteran status, their anesthesia care in VA facilities is provided predominantly by nurse anesthetists. In 12 percent of VA healthcare facilities, the necessary anesthesia services are provided solely by CRNAs, ensuring our Veterans the safe anesthesia care that they deserve and have earned.

Our tradition of service to the military and our Veterans is buttressed by our personal, professional commitment to patient safety, made evident through research into our practice. In our professional associations, we state emphatically "our members' only business is patient safety." Safety is assured through education, high standards of professional practice, and commitment to continuing education. Having first practiced as registered nurses (RNs), CRNAs are educated to the master's degree level, and some to the doctoral level, and meet the most stringent continuing education and recertification standards in the field. Thanks to this tradition of advanced education and clinical practice excellence, we are humbled and honored to note that anesthesia is 50 times safer now than in the early eighties (National Academy of Sciences, 2000). Research further demonstrates that the care delivered by CRNAs, physician anesthesiologists, or by both working together yields similar patient safety outcomes. In addition to studies performed by the National Academy of Sciences in 1977, Forrest in 1980, Bechtoldt in 1981, the Minnesota Department of Health in 1994, and others, Dr. Michael Pine, MD, MBA, recently concluded once again that among CRNAs and physician anesthesiologists, "the type of anesthesia provider does not affect inpatient surgical mortality" (Pine, 2003). Thus, the practice of anesthesia is a recognized specialty in nursing and medicine. Most recently, a study published in *Nursing Research* confirmed obstetrical anesthesia services are extremely safe, and that there is no difference in safety between hospitals that use only CRNAs compared with those that use only anesthesiologists (Simonson et al, 2007). Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures from the simplest to the most complex, either as single providers or together.

NURSE ANESTHESIA PROVIDER SUPPLY AND DEMAND: SOLUTIONS FOR RECRUITMENT AND RETENTION IN THE DVA

While both types of health professionals can provide the same high quality anesthesia care, CRNAs provide the DVA an additional advantage of cost-effectiveness. Consequently, both our Veterans and our VA health system are best served by policies and initiatives that secure adequate numbers of CRNA employees in the DVA. We believe that this Committee can help accomplish this objective by supporting nurse anesthesia education programs, both within the VA itself and in partnership with military and civilian schools of nurse anesthesia.

It is essential to understand that while there is strong demand for CRNA services in the public and private healthcare sectors, the profession of nurse anesthesia is working effectively to meet this workforce challenge. The AANA anticipates growing demand for CRNAs. Our evidence suggests that while vacancies exist, the demand for anesthesia professionals can be met if appropriate actions are taken. As of January 2008, there are 108 accredited CRNA schools to support the profession of nurse anesthesia. The number of qualified registered nurses applying to CRNA schools continues to climb. The growth in the number of schools, the number of applicants, and in production capacity, has yielded significant growth in the number of nurse anesthetists graduating and being certified into the profession. The Council on Certification of Nurse Anesthetists reports that in 2007, our schools produced 2,021 graduates, an 88 percent increase since 2002, and 1,869 nurse anesthetists were certified. The growth is expected to continue. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) projects the 108 CRNA schools to produce over 2,300 nurse anesthetists in 2008.

The number of VA anesthesia vacancies is causing us concern. We believe that they can be filled through creative partnership between the VA system and the profession of nurse anesthesia, and commitment by the DVA to effectively recruit and retain CRNAs. More than half of the VA nurse anesthesia workforce is over the age of 53, an age some years above the mean for all CRNAs nationally. The annual turnover and retirement rate among CRNAs within the VA has risen to about 19 percent over the past few years and continues to rise as the workforce ages, more lucrative employment is offered in the private sector, and new graduates from CRNA educational programs find the VA employment and practice package comparatively uncompetitive. Currently, 24 stations show vacancies on public Federal job posting sites. However, we have reason to believe that the numbers of stations with actual vacancies is closer to 40, with staff vacancies either being left vacant for extended periods of time, or filled by contract personnel. Approximately 150 CRNA slots in the DVA are being filled by contract personnel.

As the nurse anesthesia profession is working to meet the demand for CRNAs generally, we believe that the DVA specifically can meet its CRNA recruitment needs by pursuing three strategies. First, DVA should expand its relationships with existing CRNA schools. Second, the DVA should expand its joint CRNA educational program together with the Department of Defense (DOD) health system. Third, the DVA should upgrade its recruitment, retention, and practice environment factors to make VA service more competitive with the private market for anesthesia services, within the context of the DVA's mission.

To a degree, some of these strategies are already under way and achieving results for the VA health system. A recent AANA survey shows our nurse education programs use some 70 VA hospitals and healthcare facilities as clinical practice education sites, helping to educate CRNAs, provide superior patient care, and aid the VA in recruiting nurse anesthetists. In addition, we recommend that the DVA pursue nurse anesthesia resource sharing programs with civilian CRNA schools through faculty exchange initiatives.

Because nurse anesthesia is a safe and highly cost-effective means to secure anesthesia services for our Veterans, we have expressed concern that the DVA has introduced "anesthesiologist assistants" (AAs) to the VA health system, through new qualifications standards that do not require them to be licensed in any State, or subject to any State's oversight or discipline, or to have graduated from an accredited educational program, or to have secured certification, or to be appropriately supervised by anesthesiologists in a manner consistent with AAs' training as assistants. Though the DVA handbook VHA–1123 updated March 2007 authorizes anesthesiologists to delegate anesthesia care to unqualified, uncredentialed individuals, the VHA has not yet hired such individuals. There are other substantive concerns with the handbook. Our Veterans deserve better. We have requested the policy be withdrawn, and have met with the agency to promote our shared interest in ensuring our Veterans access to safe, high quality anesthesia care.

U.S. ARMY-VA JOINT PROGRAM IN NURSE ANESTHESIA, FT. SAM HOUSTON, SAN ANTONIO, TX

The establishment of the joint U.S. Army-VA program in nurse anesthesia education at the U.S. Army Graduate Program in Anesthesia Nursing, Ft. Sam Houston, in San Antonio, TX holds the promise of making significant improvements in the VA CRNA workforce, as well as improving retention of VA registered nurses in a cost effective manner. The current program utilizes existing resources from both the Department of Veterans Affairs Employee Incentive Scholarship Program (EISP) and VA hospitals to fund tuition, books, and salary reimbursement for student registered nurse anesthetists (SRNAs).

This VA nurse anesthesia program started in June 2004 with three openings for VA registered nurses to apply to and earn a Master of Science in Nursing (MSN) in anesthesia granted through the University of Texas Houston Health Science Center. In the future, the program is granting degrees through the Northeastern University Bouve College of Health Sciences nurse anesthesia educational program in Boston, Mass. Due to continued success and interest by VA registered nurses for the school, the program increased to five openings for the June 2005 and 2006 classes. This program continues to attract registered nurses into VA service, by sending RNs the strong message that the VA is committed to their professional and educational advancement. In order to achieve the goal of expanding the program further, it is necessary for full funding of the current and future EISP to cover tuition, books, and salary reimbursement.

The 30-month program is broken down into two phases. Phase I, 12 months, is the didactic portion of the anesthesia training at the U.S. AMEDD Center and

School (U.S. Army Graduate Program in Anesthesia Nursing). Phase II, 18 months, is clinical practice education, in which VA facilities and their affiliates would serve as clinical practice sites. In addition to the education taking place in Texas, the agency will use VA hospitals in Augusta, Georgia, increasing Phase II sites as necessary. Similar to military CRNAs who repay their educational investment through a service obligation to the U.S. Armed Forces, graduating VA CRNAs would serve a 3-year obligation to the VA health system. Through this kind of Department of Defense—DVA resource sharing, the VA will have an additional source of qualified CRNAs to meet anesthesia care staffing requirements.

At a time of increased deployments in medical military personnel, VA-DOD partnerships are a cost-effective model to fill these gaps in the military healthcare system. At Ft. Sam Houston nurse anesthesia school, the VA faculty director has covered her Army colleagues' didactic classes when they are deployed at a moment's notice. This benefits both the VA and the DOD to ensure the nurse anesthesia students are trained and certified in a timely manner to meet their workforce obligation to the Federal Government as anesthesia providers.

We are pleased to note that the Department of Veterans Affairs Acting Deputy Under Secretary for Health and the U.S. Army Surgeon General approved funding to start this VA nurse anesthesia school in 2004. In addition, the VA director has been pleased to work under the direction of the Army program director LTC Thomas Ceremuga, CRNA, PhD to further the continued success of this U.S. Army-VA partnership. With modest levels of additional funding in the EISP, this joint U.S. Army-VA nurse anesthesia education initiative can grow and thrive, and serve as a model for meeting other VA workforce needs, particularly in nursing.

We recently recommended that $400,000 be included in the FY 2009 appropriations to expand this joint educational program.

LOCALITY PAY

In order to meet demand for nurse anesthetists, each VA facility's administrator may make use of existing locality pay structures as authorized and funded by Congress. Competitive salaries assist the DVA with retention of CRNAs to provide anesthesia services for our Nation's veterans. Though providing competitive salaries for excellent employees is an ongoing challenge, using locality pay to keep personnel is most cost-effective. This is where Congress can help, by providing adequate funding for personnel through locality pay adjustments where base salaries are not sufficiently competitive with the local private market. Further, this Subcommittee should examine whether the 2004 authorization to expand incentive professional pays for physicians and nurse executives should also be applied to the recruitment and retention of nurse anesthetists, or, alternatively, whether other means should be pursued to lift the statutory cap that keeps VA nurse anesthetist compensation below local market levels.

For several reasons, ensuring sufficient locality pay flexibility is in the interest of both our VA and our Veterans. The DVA faced a severe shortage of CRNAs in the early nineties, which was moderately corrected with the implementation of a locality pay system in 1991. In 1992, Congress expanded the authority to the local medical directors and allowed them to survey an expanded area to determine more competitive average salaries for CRNAs, which boosted pay and morale. Implementation of this expanded authority helped assist the DVA in making great leaps in retention and recruitment of CRNAs at that time. However, times and the local labor markets for healthcare professionals have continued to change. In the past few years CRNAs' salaries have increased in the private sector, while the VA has not adjusted to these new salary rates. This means that in some markets the DVA locality pay system is no longer competitive with the private sector, and new nurse anesthetist graduates are choosing not to work in the VA health system. We believe that the VA would benefit by providing CRNAs competitive salaries in VA facilities and making use of effective locality pay adjustments, which reduces VA hospital administrators' requirements for contracted-out services at higher rates.

Though nurse anesthetists provide the lion's share of anesthesia services to U.S. Department of Veterans Affairs (VA) healthcare facilities, the agency is facing a wave of retirements and having challenges recruiting CRNAs because the compensation it offers is below local market levels, a Government Accountability Office (GAO) report highlighted ("Many Medical Facilities Have Challenges in Recruiting and Retaining Nurse Anesthetists," GAO–08–56, 12/13/2007) The GAO recommended that the VA apply its locality pay system more vigorously to recruit and retain nurse anesthetists.

At the time the report was issued, the AANA issued a statement, saying, "The profession of nurse anesthesia is committed to caring for our Nation's Veterans.

Nurse Anesthesia continues to be a safe, flexible and highly cost-effective means for the VA to ensure our Veterans the healthcare that they need and deserve. We look forward to continuing work with the Department of Veterans Affairs, the Congress, and the members of the Association of Veterans Affairs Nurse Anesthetists (AVANA) to help carry out the recommendations of this report."

The GAO found that VA medical facilities have had to temporarily close operating rooms or delay elective surgeries due to a shortage of CRNAs. While demand for CRNA services is increasing, the report says 26 percent of the VA's CRNAs are projected to retire or leave the department in the next 5 years. The GAO said that the VA's CRNA recruitment and retention challenges are caused primarily by the agency's below-market compensation compared with local market conditions around the country. The GAO made its findings based on surveys of VA CRNAs, VA managing personnel in local VA facilities and at VA headquarters, and through other data sources. The report says the nurse anesthesia profession has been working effectively to meet high U.S. demand for anesthesia workforce by increasing the number of qualified practitioners graduating from accredited nurse anesthesia programs.

The report recommended that the agency deploy and carry out its existing locality pay system to adjust salaries so that they are more competitive. Any locality pay system should be structured to set competitive salary levels for nurse anesthetists working in VA healthcare facilities. The DVA could implement a system that guarantees accurate surveys on pay are being conducted in a timely manner. This salary data will be used to adjust Nurse 1 (Step 1) to be competitive within the local market to assist VA facilities in hiring new nurse anesthesia graduates.

Finally, with adjustments in the pay structure to include professional pays for recruitment and retention of CRNAs, VA facilities may well realize cost savings by contrast with other arrangements for securing anesthesia services.

Recently, Senator Daniel Akaka (D-HI) introduced the Veterans' Medical Personnel Recruitment and Retention Act of 2008 (S. 2969), and several of its provisions are intended to help the VA recruit and retain CRNAs to the VA healthcare system. We applaud Senator Akaka's efforts to bring VA healthcare professionals' pay closer to the private sector. Our first priority remains ensuring our Veterans' access to a high quality of healthcare. The quality of healthcare services, and the qualifications expected of healthcare professionals, and the numbers of healthcare professionals, all together have bearing on the quality of life of our Veterans, and should be kept in mind in equal measure.

CONCLUSION

In conclusion, we recognize that the VA has nurse anesthesia staffing needs. Through an effective partnership with the nurse anesthesia profession, the DVA can help meet its future CRNA workforce requirements through three cost-effective models, which exist today and can be expanded. Our VA hospitals can serve as clinical practice sites for CRNA schools. Going one step further, the VA health system can pursue resource sharing and faculty exchange agreements with nurse anesthesia schools. Further still, the VA and DOD can share resources outright to educate nurse anesthetists for the Veterans and military settings alike, particularly with modest additional funding. This VA commitment to CRNA education helps secure the nurse anesthesia workforce our Veterans need, and attracts registered nurses into VA service, by sending the strong message that the VA is committed to RNs' professional and educational advancement. Last, the VA should examine and improve the effectiveness of its recruitment, retention and practice environment for CRNAs.

Thank you. If you have further questions, please contact the AANA Federal Government Affairs Office at 202–484–8400.

Prepared Statement of Jay W. Wommack, Founder, President and Chief Executive Officer, Vertical Alliance Group, Inc., Texarkana, TX

Mr. Chairman and Members of the Committee, I am Jay Wommack, Founder, President and Chief Executive Officer of Vertical Alliance Group, Texarkana, TX. Thank you for the opportunity to express our views on the important issues relating to "Human Resources Challenges within the Veterans Health Administration."

As the Nation's largest integrated healthcare system, the Veterans Health Administration (VHA), due in large to the efforts of this Committee has made impressive strides in improving the quality of care for our Nation's Veterans. VHA has established itself as the "Trendsetter" in healthcare reform with programs such as the electronic medical records innovation. You are to be applauded.

In the way of introduction, I make no claim to being an expert in the Health Service arena; rather, over the past 9 years, I have been involved in the development, evaluation, and evolution of a comprehensive recruiting process for businesses that include health services. If I were to provide a title for my testimony today it would be "How to convert 40 percent of the applicants that come through VHA's door into employees."

I recall shortly after college when I applied for my first "real" job, taking an hour or more filling out an application, turning it in and waiting patiently by the mailbox for weeks for a response that never came. And you can probably recall the excitement of receiving that four-inch thick mail order catalog. How you thumbed through every page, in my case mostly the toy section, and the anticipation and anxiety as you waited the 4 to 6 weeks for delivery—now I order online and it is at my door by the next day. Paper applications are fast going the way of the Pony Express and the new Sheriff in town is the Internet. Fundamental changes to the way we perceive and process applications must emerge if we are to meet the demands of tomorrow's career markets. In today's world, instant gratification is the norm. Not only do employers want quality employees, they want them now. Potential employees want the job of their dreams and they want it now. Applicants are all too often greeted with outdated processes that might have worked well in the sixties but fail to meet the demands of our high tech, Internet savvy society. A dramatic paradigm shift must take place to allow the conversion of new technologies into our recruiting process. We must consider how we merge today's technology with this paperwork world. Applicants don't want to wait for the hiring process to find the job of their dreams while their application is subjected to the confines of an electronic maze, they want immediate, personalized attention. With just a few changes in how we view and respond to these applicants our process can become more effective and efficient providing a lower cost per hire ratio.

In 1999 Vertical Alliance Group, Inc. (VAG) began a long and thorough process to find out what works "BEST" in attracting and recruiting employees. *With great efficiencies come great rewards.* Operating on the premise that the Internet provides the most efficient/effective venue to attract and recruit quality employees VAG has created some proven processes that advance recruit productivity. Current statistics indicate the recruiting closing rate of U.S. businesses to be approximately 2 percent of all applications received. A forty percent (40 percent) closing rate doesn't constitute the norm, however, these results can and have been attained utilizing the process we developed. Recruiting, training and retaining quality employees is paramount to the success of any business and directly affect it's bottom-line. The amount of time, money and effort dedicated to recruiting/replacing staff can be reduced with just a few changes in our attitude and processes about how we recruit and what efforts are being made to retain quality employees.

Our efforts have produced the following conclusions:

- All levels of management must buy into and participate in the recruiting process.
- Training of current personnel at all levels is an essential element if we are to change the dynamic of how we respond to leads and become more proactive in streamlining the hiring process. Conversion of Human Resource personnel from the world of paper processor to high tech "Sales Ambassadors" is essential to provide the immediate gratification demanded by today's society.
- We must provide timely follow-up to closure that ensure(s) prompt attention is given each lead.
- We must improve the "quality" of prospective applications received. A success rate of 2 percent of "spammed" or database derived leads cost money and wastes time.

Training is the essential element to a quality recruiting process. All levels of management must understand and value the recruiting process and recognize their role not only in recruiting but also the retention of highly qualified personnel. Understanding the direct response marketing strategy that includes an industry overview, how to rate/rank leads, selling skills, technique to close, selling points, the hiring cycle, are all necessary skills in providing a quality recruiting process. Knowledge of the current "shelf life" of applications is essential. In this competitive market, often the first quality response, usually within minutes not hours, days or weeks wins the deal. Human Resource personnel who are properly trained, highly motivated and who understand the value of this process provide the largest "bang for the buck" in recruiting and maintaining a strong workforce.

Understanding the benefits and limitations of modern technology and the balance between them can also improve your odds in closing the deal. The "human" element

is still one of vital importance in the process. First impressions still count. Potential employees still want a response from a real person, not a computer. In the words of Walt Disney, "*There is no magic in magic, just details.*" Timely, polite, professional communication will work magic in the recruiting process.

Massed, unranked or inappropriately filtered leads provide "volume" but lack "quality" and generate large amounts of paperwork generally resulting in minimal success. Quality leads, appropriately ranked by source first allow Human Resource personnel to come out of the paper processor role and become more proactive in the recruiting process. Targeted leads focused on essential hiring criteria provide optimal potential for successful closure and lower cost for hire rates.

In an agency the size of VHA arguments can be made pro and con between centralized and decentralized recruiting processes. Each has its own unique values and barriers. Training of all personnel in their respective roles in the recruiting and retention process will provide a more prolific recruiting effort on behalf of the VHA.

There are a number of issues and complexities that challenge our Human Resource efforts . . . But the good news is, there are solutions. Amy Gruver, Call Center Team Leader for Swift Transportation Company, one of the largest trucking companies in America, has stated that the VAG process has resulted in their lowest cost per hire rate. Small businesses to Fortune 500 companies have effectively implemented and assimilated this process with phenomenal success saving valuable resources.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or other Members of the Subcommittee may have at the appropriate time.

Prepared Statement of Fred Cowell, Senior Associate Director for Health Analysis, Paralyzed Veterans of America

Chairman Michaud, Ranking Member Miller, and Members of the Subcommittee, on behalf of the Paralyzed Veterans of America (PVA), I am pleased to be here today to offer our views concerning the "Human Resource Challenges within the Department of Veterans Affairs."

PVA's primary concern, and the basic reason for our existence, is the health and welfare of our members and of our fellow veterans. The thousands of VA healthcare professionals and all of those individuals necessary to support their efforts are at the core of VA's primary mission. These individuals serve on the front line every day, caring for America's wounded veterans from Iraq and Afghanistan and seeing to the complex medical needs of our countries older veterans from previous wars. PVA believes thatVA's most important asset is the people it employs to care for those who have served our Nation.

Mr. Chairman, the Subcommittee's interest in the issues concerning VA healthcare personnel is well placed and timely. Congress must assist VA' efforts to recruit and retain its corps of healthcare professionals as the demand for healthcare increases because of today's wars and the aging of the veteran population from previous wars. Currently, the Nation is experiencing serious short falls in its supply of physicians, nurses, pharmacists, therapists and psychologists. Competition for experienced medical personnel and newly licensed professionals is keen.

PVA believes that Congress must take the lead in revamping outdated personnel policies and procedures (salaries, benefits, and working conditions) that may place VA at a disadvantage in today's labor market and will prevent VA from becoming the medical-care employer of choice in the future. PVA also believes that the broken VA appropriation process, which delays VA funding, is a major barrier to VA's healthcare professional recruitment process.

America's National Nurse Shortage

The United States is currently in the tenth year of a critical nursing shortage which is expected to continue through 2020. The shortage of registered bed-side nurses and registered nurse specialists is having an impact on all aspects of acute and long-term care. America's nursing shortage has created nurse recruitment and retention challenges for medical-care employers nationwide and is making access to quality care difficult for consumers.

Three national issues are directly contributing to America's national nursing shortage. First, the number of new nursing students entering nursing education programs is insufficient to meet rising medical care demand. Second, the number of nursing students seeking admission to nursing schools is restricted because of a lack of qualified nursing educators. According to the American Association of Colleges of

Nursing, 38,400 nursing school applicants were turned away because of a lack of faculty. Third, a large percentage of the Nation's nurse workforce is nearing retirement and will soon need to be replaced.

The current and emerging gap between the supply of and the demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our Nation. According to VA, it employs more than 64,000 nursing professionals, and has one of the largest nursing staffs of any healthcare system in the world. Of that 64,000, VA has 43,000 registered nurses, 12,000 licensed practical nurses, and 9,000 nursing assistants. VA also says that approximately 4,300 nurses retire or leave each year. VA must be able to recruit the best nurses, and retain a cadre of experienced, competent nurses. Providing high quality nursing care to the Nation's veterans is integral to the healthcare mission of VA.

Like other healthcare employers, VA must actively address those factors known to affect recruitment and retention of nursing personnel such as: fair compensation, professional development, work environment, respect and recognition, underlying issues of sucessful VA nurse recruitment and retention. Failure to do so will undermine the quality of VA care and will jeopardize the health of our veterans.

Mr. Chairman, The National Commission on VA Nursing submitted its final report to then VA Secretary, Anthony J. Principi on March 18th, 2004.[1] The report titled, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce* is as vital today as it was then.

PVA supports the following recommendations contained in that report and believes they serve as a sound template for improvements to VA's policies and procedures that govern its healthcare workforce. The recommendations of the National Commission on VA Nursing were:

Leadership

- The facility nurse executive should have line authority, responsibility, and accountability for nursing practice and personnel.
- The facility nurse executive should be a member of the executive body at VISN and facility levels.
- The facility nurse executive should be accountable for (a) the effective performance of nurse managers, (b) leadership development of all nursing staff, (c) development and implementation of clinical leadership roles at the point of care, and (d) compliance with standardized Nurse Professional Standards Boards (NPSB) protocols.
- VHA should clearly define Nurse Qualification Standards to facilitate consistent interpretation across VA's system of care.

Professional Development

- VHA should structure career development opportunities to assure that every nurse in VHA can actualize his/her goals within one or more career paths with the opportunity for professional growth and advancement.
- VHA should establish policy guidelines for schools of nursing comparable to the medical school model and actively promote nursing school affiliations.
- VHA should assure that VA's Health Professionals Educational Assistance Program is funded and available nationwide.

Work Environment

- VHA should develop, test, and adopt nationwide staffing standards that assure adequate nursing resources and support services to achieve excellence in patient care.

  NOTE: PVA believes that nurse staffing standards must consider the acuity level of patients for these standards to be meaningful.
- VHA should review and adopt appropriate recommendations outlined in the Institute of Medicine report , *Keeping Patients Safe: Transforming the Work Environment of Nurses*, to determine specific strategies for implementation across VHA.

Respect and Recognition

- VHA should expand recognition of achievement and performance in its nursing service.
- VHA should create a sense of value and culture of mutual respect for nursing through all levels of VHA to include physicians and other colleagues, management, and stakeholders.

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[1] National Commission on VA Nursing 2002–2004, Final Report, *Caring for America's Veterans: Attracting and Retaining a Quality VHA Nursing Workforce.*

Fair Compensation

- VHA should amend Title 38 to establish procedures for assuring that RN locality pay policies are competitive with local RN employer markets.
  NOTE: PVA supports specialty nurse pay for VA nurses working in VA's specialty care areas such as: spinal cord injury rehabilitation and sustaining care, blind rehabilitation, mental illness and traumatic brain injury.
- VHA should change hiring and compensation policies to promote recruitment and retention of licensed practical nurses and nursing assistants.
- VHA should strengthen its human resources systems and departments to develop an active hiring and recruiting process for nursing staff that is consistent, to the extent possible, across facilities and VISN's.

Technology

- VHA should give priority to the continued rollout of the VA Nursing Outcomes Database (VANOD) as the repository for nursing performance standards and the evaluation of effective patient care delivery models.
- VHA should engage experts to evaluate and redesign nursing work processes to enhance patient care quality, improve efficiency, and decrease nurse turnover through the use of technology.
- The Agency for Healthcare Research and Quality (AHRQ) and VHA should partner in applying findings from information systems and technology research projects into patient care delivery.

Research and Innovation

- VHA should establish a Center for Excellence in Quality Nursing Care to create and implement a research agenda consistent with VHA mission.

Mr. Chairman, while these recommendations for VA improvement were directed toward VA's Nursing Service PVA believes that they have broad application to VA's entire healthcare workforce.

Specialty Pay for VA's Specialized Services Nurses

PVA would very much appreciate the committee's consideration of providing specialty pay for nurses providing care in VA's specialized service programs such as: spinal cord injury/disease (SCI/D), blind rehabilitation, mental health and brain injury.

Mr. Chairman, veterans who suffer spinal cord injury and disease require a cadre of specialty trained registered nurses to meet their complex initial rehabilitation and life-long sustaining medical care needs. PVA's data reveals a critical shortage of registered nurses who are providing care in VA's SCI/D center system of care. The complex medical and acuity needs of these veterans, makes care for them extremely difficult and demanding. These difficult care conditions become barriers to quality registered nurse recruitment and retention. Many of VA's SCI/D nurses are often placed on light duty status because of injuries they sustain in their daily tasks. When this happens it becomes a significant problem because it places additional patient care responsibility on those SCI/D nurses not on light duty. PVA believes SCI/D specialty pay is absolutely necessary if nurse shortages are to be overcome in this VA critical care area.

We strongly encourage your committee to create a Title 38 specialty pay provision that will assist VA's efforts to recruit and retain nurses in these specialized areas. PVA is eager to assist Committee staff in developing legislative language that will create specialty pay for VA nurses working in these critical care areas.

Nurse Anesthetists

VA is currently facing serious challenges to the recruitment and retention of Certified Registered Nurse Anesthetists (CRNA) who provide the majority of anesthesia care for veterans receiving care in VA medical facilities. GAO has reported that VA medical facilities have current challenges recruiting and retaining VA CRNAs and that these facilities will likely face challenges in retaining CRNAs over the next 5 years due to the number of VA CRNAs projected to retire from or leave VA.[2] The GAO further reported that their surveys of VA officials indicated that low VA salaries were the major barrier to VA's recruitment and retention efforts for this critical nursing skill.

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[2] GAO Report April 9, 2008, *VA Health Care: Recruitment and Retention Challenges and Efforts to Make Salaries Competitive for Nurse Anesthetists,* GAO–08–647T.

VA Physicians

PVA is concerned about the VA's current ability to maintain appropriate and adequate levels of physician staffing at a time when the Nation faces a pending shortage of physicians. Recent analysis by the Association of American Medical Colleges (AAMC) indicates the United States will face a serious doctor shortage in the next few decades.[3] The AAMC goes on to say that currently, "744,000 doctors practice medicine in the United States, but 250,000—one in three are over the age of 55 and are likely to retire during the next 20 years." The subsequent increasing demand for doctors, as many enter retirement, will increase challenges to VA's recruitment and retention efforts.

Mr. Chairman PVA has serious concerns regarding VA's current and future ability to match or exceed private sector physician salaries. Additionally, PVA believes that VA's recruitment efforts are hampered because VA's Education Debt Reduction Program (EDRP) is limited to $49,000 spread out over 5 years of service. The average medical education indebtedness has climbed to over $140,000 in 2007, therefore the limited VA EDRP awards fail to provide an adequate incentive for VA recruitment.

PVA is also concerned that the P.L. 108–445, the Department of Veterans Affairs Personnel Enhancement Act, is being manipulated by facility management to reduce operation costs. The American Federation of Government Employees (AFGE), AFL-CIO testified before the Senate Committee on Veterans Affairs that, "At many VA facilities, management has imposed improper performance criteria that determine bonuses based on factors beyond the practitioners control, such as missed appointments."[4] The AFGE goes on to say that annual physician performance pay awards under this law have been inconsistent and unjustifiably lower than the maximum amounts set by Congress.

The Independent Budget veterans service organizations (IBVSOs) believe that appropriate committees should use their oversight authority to study the impact of P.L. 108–445 on recruitment and retention of VA physicians and dentists.

VA Psychologists

According to the American Psychological Association (AAPA), VA is the largest single employer of psychologists in the Nation. Congress and VA have recognized the need to increase the number of psychologists and have added more than 800 new psychologists since 2005, thereby raising the number of psychologists in the VA system to approximately 2,400. The demands placed on VA's mental health service have increased dramatically because of the wars in Iraq and Afghanistan (OIF/OEF). However, it should be noted that these increased psychology staffing levels are a recent development. Since the vast majority of new psychologist hires in VA are less experienced professionals, VA must ensure they are properly trained and supervised. VA must also strive to retain and promote its more experienced psychologists in order to meet new training and supervision requirements.

Despite VA's positive recruitment efforts, VA's advancement and retention policies continue to be driven by outdated and overly-rigid personnel and retention mandates. PVA urges the Subcommittee to utilize its oversight authority to investigate VA's on-going psychologists recruitment efforts to determine if VA is providing adequate levels of mental healthcare to meet the demands imposed by OIF and OEF while ensuring that adequate treatment opportunities continue to exist for veterans with prior service.

Summary

Mr. Chairman, the Veterans Health Administration has made great strides over the last decade to improve the quality of care it provides to our Nation's veterans. Despite these gains, VA now finds itself in a precarious situation if it expects to retain its position as a vastly improved healthcare system. Challenges associated with maintaining a highly qualified medical care workforce are a major issue for VA. Competition to hire medical care professionals, during a national period of low supply, is making it more-and-more difficult for VA to successfully recruit and retain qualified personnel.

If VA is to succeed it must have the resources required to offer competitive salaries and benefits and to make improvements to its work environment. VA must bet-

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[3] Statement before the Senate Committee on Veterans Affairs, April 9, 2008, *Making VA the Workplace of Choice for Health Care Providers,* by John A. McDonald, M.D., Ph.D. Vice President for Health Services and Dean of the University of Nevada Medical School and member of the Association of American Medical Colleges, Veterans Affairs—Deans Liaison Committee.

[4] Statement before the Senate Committee on Veterans Affairs, April 9, 2008, *Making VA the Workplace of Choice for Health Care Providers* by Valerie O. Meara, N.P. Professional Vice President, AFGE Local 3197 VA Puget Sound Health Care System, Seattle, Washington.

ter utilize existing policy provisions that provide locality pay, premium and overtime pay, create flexible work schedules, relieve restrictions on mandatory overtime, and fully fund its excellent educational programs such as the Education Debt Reduction Program and the National Nursing Education Initiative.

Mr. Chairman, PVA believes that Congress must assist VA's employment efforts by up-dating provisions of Title 38 that will enhance VA's competitive position as it vies to attract healthcare professionals to its ranks. Additionally, Congress must embrace a VA appropriation process that promptly funds the VA healthcare system so VA management can be confident that resources are available to support a health-care workforce that can meet the medical care demand of a growing veteran population.

Mr. Chairman, this concludes my remarks. I will be happy to attempt to answer any questions you or Members of the Subcommittee may have.

Prepared Statement of Cecilia McVey, BSN, MHA, RN, Associate Director for Patient Care/Nursing, Veterans Affairs Boston Healthcare System, Veterans Health Administration, U.S. Department of Veterans Affairs, and Immediate Past President, Nurses Organization of Veterans Affairs

Mr. Chairman and Members of the Committee on Veterans' Affairs Subcommittee on Health, the Nurses Organization of Veterans Affairs (NOVA) would like to thank you for inviting us to present testimony on Human Resource issues in the VA.

I am Cecilia McVey, BSN, MHA, RN, Associate Director for Patient Care/Nursing at the VA Boston Healthcare System and am here today as the Immediate Past President of NOVA. NOVA is the professional organization for registered nurses employed by the Department of Veterans Affairs.

NOVA respects and appreciates what our labor organizations, such as AFGE and NAGE, do for VA nurses. NOVA clearly deals with VA on RN professional matters, not working conditions for which VHA RNs have their union representatives. Because this Committee has invited NOVA to share its views on this bill, however, I am here to offer the following observations.

The Veterans Health Administration (VHA) is the third largest civilian employer in the Federal Government and one of the largest healthcare providers in the world. VHA is facing significant challenges in ensuring it has the appropriate workforce to meet both current and future workforce needs. This workforce is critical to ensure we are able to provide the care our Nation's heroes deserve. These challenges are further exacerbated by an aging workforce in general and in nursing specifically and the high number of employees' retirement eligible each year.

Nursing and other Medical Center workforce members are dependent on timely and efficient recruiting. Human Resources Departments across VHA are not able to function optimally due to systems that have not kept pace with private sector recruitment abilities.

Although there are numerous barriers to timely and efficient recruiting the following three are the top three:

1. Although certain pay setting flexibilities do exist, such as recruitment bonuses/retention allowances, above minimum entry rates, and the special rate authority, additional pay flexibilities are needed in order for VA to be able to successfully compete for the best candidates in the marketplace. The current general schedule and locality pay system which works hand in hand with the classification system is antiquated, cannot respond quickly enough and has a number of major barriers. For example:

   a. Retention allowances.

      1. They are not considered base pay for benefits such as retirement and life insurance. Candidates declined positions based on this limitation.

   b. Special pay rates.

      1. There are restrictions on how far the pay table can be expanded.
      2. You cannot use special rates to address recruitment/retention issues of a subgroup within an occupation
      3. Approval process for special rates is too slow to address current market conditions.
      4. The major focus of the criteria is whether you are getting qualified candidates to apply and not whether the candidates are highly qualified.

   c. Above minimum rates.

1. Allows manager to appoint the applicant above the minimum step. There are many situations where the manager needs to offer a highly qualified candidate more money than the existing experienced staff. There is no mechanism to increase the pay of the existing staff to maintain pay parity.
2. The application process (how to apply) is too cumbersome and very confusing for those in the private sector who are used to a much faster and simpler process. Staffing Specialists must help many of the would-be applicants to navigate through the maze of the Federal application process. Applicants are frustrated by the duplication of information that they are required to provide, such as the information on Federal application for employment, information for background investigations, and credentialing. The enormous amount of paperwork, data base entries, and checklists associated with fulfilling all of the hiring requirements further delays the process. This leads to hiring additional FTEs to manage the processes.
3. A consistent theme across the country is that applicants are looking for money for professional development not just in clinical occupations but administrative as well. Tuition reimbursement is limited to a few select occupations at this time such as Nurses.

Some suggested policy changes recommended are as follows:

1. More positions should be converted to Excepted Service, i.e., hybrid Title 38 such as Nursing Assistants, Health Technicians, Medical Support Assistants, Radiation Safety Officers, and Information Technology Specialists, for example. Due to the constraints associated with recruiting through the Delegated Examining Units, the process is often too difficult and generally does not provide a list of "highly qualified candidates" and discourages potential hires.
2. More pay flexibilities should be provided. Pay reform similar to the Physician pay reform where there is a market pay component would provide the needed flexibility for VA facilities at the local level. Another option would be to provide legislation that would address the barriers in paragraph 1 above.
3. Classification Standards are in need of review and revision. Many of them are too old and no longer reflective of the types of duties and responsibilities that are typically performed. Given that these are used to determine the pay, they often serve as a barrier to appropriate and effective pay setting.
4. Given the sizeable numbers of employees at or near retirement age, succession planning is becoming increasingly more important, especially for critically important positions. In order to successfully transition workload from retirees who possess a wealth of experience to their successors; transitional recruitment is required, which can take up 3 to 6 months of addition FTE per situation.

One other critical issue of concern relates to the impact on patient care if 38 U.S.C. 7422(b) exclusions were to be repealed. Some of the issues that I foresee would have a negative impact on the care of our Veterans include the following:

- RN reassignment decisions made on the basis of clinical competence.
- Performance appraisals/proficiency reports.
- Fitness for duty issues as determined by Professional Standards Boards.
- Clinical competence issues as determined by Professional Standards Boards.
- Disciplinary and major adverse actions based on patient care or clinical competence issues.

Determination of clinical competence is best reserved for those responsible in ensuring that quality patient care is delivered. Our veterans deserve the best that VA has to offer, and although the majority of our employees are excellent, there are a few marginal performers who put patient safety at risk. Moreover, clinical supervisors and managers must retain the authority to make clinical decisions such as which personnel are best suited for particular assignments and the appropriate staff mix for a given clinical setting.

Inherent in bargaining is the element of timeliness. If an employee needs to be removed from direct patient care or if providers' hours must be extended to meet growing patient care needs, those changes must be made immediately and cannot wait for the completion of protracted negotiation. National Level bargaining on policy or program changes is currently taking 120 days or longer. Local bargaining usually takes less time but still can result in delays, despite the best of intentions. If clinical matters were subject to bargaining, critical clinical programs such as extending the hours of mental health clinics or mandating traumatic brain injury

training for all providers could not be implemented for months, which would unacceptably put patients at risk.

VHA has been a leader in healthcare and has earned an excellent reputation as one of the best healthcare providers in the country. In order to continue this reputation, VHA staff will need to have new skills and competencies to treat this new generation of Veterans. Nimble and flexible HR processes are critical to VA's future success.

Thank you, Mr. Chairman and Members of the Subcommittee, for the opportunity to testify here today about these important personnel issues.

Prepared Statement of Adrian M. Atizado,
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify on human resources challenges within the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA).

The human capital needs of VHA are driven by needs of the population VA serves. VA is experiencing a gradual slowdown in the growth of its enrollees due to declining veteran population, mortality in the Priority 8 enrollee population since the suspension of enrollment, and deaths in the pre-enrollee population. New enrollments of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans do not reverse the trend. Further, the reliance and utilization rates of veteran enrollees from prior conflicts are more established and better defined than the medical care consumerism of the OEF/OIF enrollee population.

A number of undefined variables, such as duration of the conflict, demobilization requirements, and impact of outreach efforts, will influence the number and types of services that VA will need to provide OEF/OIF veterans. What is known today is that the current OEF/OIF veterans appear to have different utilization patterns than the rest of the VA enrollee population, needs that will demand greater flexibility in human resource management within the VA. Specifically, initial findings indicate OEF/OIF enrollees use half as much inpatient surgery and acute medicine, but it is expected that they will need three times the number of PTSD residential rehabilitation services, and have greater needs for physical medicine, prosthetics and outpatient psychiatric and substance abuse services. Correspondingly, enrollees from previous wars making up the vast majority of the population continue transitioning to higher enrollment priorities, and the aging morbidity of this population are driving the type and intensity of healthcare needs—even with the acknowledged declining reliance on VA once they qualify for Medicare.

In the general civil service arena, the Office of Personnel Management (OPM) estimates about one-third of full-time government workers will retire by 2012, but some occupations are more sensitive to external forces and agency initiatives than others. In April 2007, VHA conducted a national conference, titled, VHA Succession Planning and Workforce Development. The conference report indicated the average age of all VHA employees in 2006 was 48 years. It estimated that by the end of 2012, approximately 91,700 VHA employees, or 44 percent of current full time and part time staff, would be eligible for full civil service retirement. The report also indicated approximately 46,300 VHA employees are projected to retire during that same period. In addition, a significant number of healthcare professionals in leadership positions would also be eligible to retire by the end of 2012. With regard to the three mission critical occupations—registered nurse, pharmacist and physician, a startling finding in the report concluded that 97 percent of VA nurses in pay band "V" positions would be eligible to retire, and that 56 percent were expected to retire; and, that 81 percent of VA physicians in pay category 16—including many current Chiefs of Staff, would be eligible to retire, with 44 percent projected to actually retire from Federal service.

Furthermore, the supply of healthcare providers poses an added hurdle for VA to be a patient-centered and integrated healthcare organization for veterans providing excellence in healthcare, research, and education; an organization where people choose to work; an active community partner and a back-up for national emergencies. In recognition, VA's more recent commonly used description is that, "[t]here is a growing realization that the supply of appropriately prepared healthcare workers in the Nation is inadequate to meet the needs of a growing and diverse population. This shortfall will grow more serious over the next 20 years. Enrollment in professional schools is not growing fast enough to meet the projected future demand for healthcare providers."

Without question, recruitment, management, and providing direction for VA employees on such issues as compensation, hiring, performance management, and organizational development are critical to the success of VHA's mission to provide safe, high quality healthcare services to sick and disabled veterans. While the most recent actions by Congress to affect the compensation package VHA may offer to prospective employees necessitates additional implementation oversight, an equally important problem within the realm of recruitment that requires attention is the Federal hiring process itself.

Hiring a new wave of Federal employees to succeed those that leave is paramount given the frequent civil-service hiring freezes of the past 2 decades due to cross-government rescissions and dictated "management efficiency" savings, inadequate funding levels, and the unpredictable nature of the discretionary appropriations process. Moreover, the passive approach to recruiting applicants by Federal agencies including VA puts themselves on unequal footing compared to the recruitment and retention programs used by many competitive private employers. With over 100,000 healthcare trainees receiving clinical learning experiences annually in VA facilities, hiring from this pool should provide VHA with an increased advantage over private healthcare facilities. Unfortunately, there is the perennial and widely acknowledged complaint by applicants for Federal employment about cumbersome Federal hiring procedures and practices, which require too much time and excessive paperwork. Of those who do submit applications, many say they never receive feedback from agencies of interest.

According to a survey conducted by the Merit Systems Protection Board (MSPB), supervisors and upper-level new employees reported that the hiring process is complex and takes too long. The most recent MSPB survey of entry-level hires and upper-level hires showed that substantial numbers had to wait 5 months or longer before being hired—much too long to expect a high-quality applicant to wait. These findings harken back to the 2002 survey indicating an average of about 3 months are required for the government to hire anyone, while 70 percent of college students say that they are unwilling to wait more than 4 weeks for a job offer.

OPM has publicly acknowledged this problem in Federal hiring and has agreed that the process has become cumbersome. To address this, it has urged Federal agencies to take advantage of recent laws that encourage quick hiring decisions and permit the use of bonuses to recruit and retain Federal employees. Unfortunately, a myriad of rules and procedures are still in place to restrict the use of these tools. These restrictions in Federal hiring decisions were designed to ensure equity, consistency, and accountability, while also protecting against fraud, waste and abuse. This design does not compete well with private sector recruitment practices.

While Federal job applications are only the first tedious part of the process, agencies require approval from their personnel departments, which in turn cannot go beyond the level of appropriated or designated funds. If the agency, department, or facility does get approval, its managers must produce a proper position description, get the vacancy announcement approved and posted, rate the applicants, interview the candidates, get higher-level approval for the hire, then conduct boarding, and finally complete any required background checks, (and for professionals, complete credentialing and privileging). Each step adds more time to the process. In some cases security and background checks have caused several months delay due to increased security requirements. Candidates for the top tier career appointments to the Senior Executive Service (SES must pass yet another review board, composed of SES members. The 5-month average for the government to hire anyone is infeasible for many applicants—especially younger job-seekers.

VA recently testified on streamlining its cumbersome hiring process, stating the Human Resource Committee of the VHA National Leadership Board chartered a workgroup last year to streamline the recruitment process for title 5 and title 38 positions within VHA. This included an analysis of the recruitment process and identification of barriers and lengthy processes that could be streamlined. The recommendations were piloted in Veterans Integrated Service Network (VISN) 4 (generally, Pennsylvania) with the implementation and results of the pilot rolled out nationwide. During the spring and summer of 2008, training in systems redesign will be offered nationally at Human Resources Cluster meetings. At these sessions, VA testified it will focus on new strategies and systems redesign elements that can be used to help meet the daily challenges of attracting and retaining critical healthcare professionals.

In addition to time, there is often poor communication between Federal managers and HR professionals on the qualities and skills needed in a candidate. Attrition of experienced VHA human resources employees has had a direct impact on the quality of recruitment and retention efforts as well as providing needed assistance to train new and inexperienced staff to successfully hire needed VA healthcare pro-

viders. In the end, those individuals who make it to the end of this process are often not the optimum candidates, nor the best qualified for the position. In fact, in the 2006 Federal Human Capital Survey, less than half of government workers said that their work unit is able to hire people with the right skills.

VHA's workforce is covered under Title 5, Title 38, and Congress has provided VHA a unique Title 38 "hybrid" authority, combining elements of both titles. As the greater majority of VHA employees fall under Title 38 and Title 38 hybrid systems, personnel rules under both were designed to allow greater flexibility and expedite VHA's hiring and promotion processes. The Title 38 hybrid model requires Professional Standards Boards to make recommendations on employment, promotion and grade. This model is viewed as more subjective due to the level of transparency than Title 38, where professionals are hired, promoted and retained based solely on their professional qualifications. Moreover, the reality of the hiring and promotion processes under Title 38 hybrid is facing extraordinary delays particularly in the boarding process across healthcare disciplines from nurses to psychologists.

The Federal hiring process is so daunting that it often reinforces applicants' worst fears of government as an ineffective, unresponsive and incomprehensible bureaucracy. Only by insisting that agencies make recruiting talent a top priority and that both agency leaders and managers be held responsible for results, can we ensure that the government recruits the talent it needs to meet the challenges ahead. A simple practice (but time consuming due to inadequate VHA human resources staffing) that could be employed is to ensure that the human resources staffs responsible for recruiting applicants provide some meaningful and timely feedback to job applicants. Feedback, which puts some personal touch to an impersonal process, can help maintain applicants' interest in the agency as well as throughout a hiring process that can be lengthy as I have indicated.

Again, we thank you for this opportunity to testify. This concludes my testimony, and I will be happy to address any questions from the Chairman or other Members of the Subcommittee.

Prepared Statement of Joleen Clark, Chief Officer, Workforce Management and Consulting, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, thank you for the invitation to appear before you to discuss "Human Resources Challenges" within the Department of Veterans Affairs (VA) Veterans Health Administration (VHA). Our challenges cover recruitment and retention programs, improving and streamlining the recruitment process, and other issues related to developing and maintaining a qualified and diverse workforce of healthcare professionals.

As the Nation's largest integrated healthcare delivery system, VHA's workforce challenges mirror those of the healthcare industry as a whole. VHA experiences pressures equal to or greater than other healthcare organizations. VHA performs extensive national workforce planning and annually publishes a Workforce Succession Strategic Plan that includes workforce analysis and planning for each Veterans Integrated Service Network (VISN) and national program office. VHA's Strategic Plan addresses current and emerging initiatives in areas including, but not limited to, recruitment and retention, mental healthcare, polytrauma, traumatic brain injury, and rural health to address workforce efforts.

VHA's Strategic Plan identifies mission-critical occupations which are considered shortage categories, as well as recruitment and retention initiatives at the local, regional and national levels. For each of the nationally ranked mission critical occupations, VA conducts a thorough historical and projected workforce analysis. Plans are established at every level to address turnover, succession planning, developmental opportunities, and diversity issues. VHA uses equal employment opportunity comparison data for each of the critical occupations, as well as the workforce nationwide, to ensure that VHA maintains a diverse workforce.

VHA's workforce plan is one of the most comprehensive in government and has been recognized by OPM as a Federal best practice. VA has presented it to other Federal agencies as well as by means of OPM's "A Best Practice Leadership Forum On Succession Management" conference.

Efforts to Recruit Health Care Professionals

It is important that the supply of appropriately prepared healthcare workers meet the needs of a growing and diverse population. Enrollment in nursing schools needs to grow to meet the projected future demand for healthcare providers.

More than 100,000 health professional trainees come to VA facilities each year for clinical learning experiences. Many of these trainees are near the end of their education or training programs and become a substantial recruitment pool for VA employment as health professionals. The annual VHA Learners' Perceptions Survey shows trainees were twice as likely to consider VA employment after completing their VA learning experiences than they were before. This demonstrates many trainees were not aware of VA employment opportunities or the quality of VA's healthcare environment prior to VA training, but became considerably more interested after their VA clinical experiences.

An informal survey of all VA facilities in 2007 found that 74 percent of the 800 psychologists hired over the last 3 years received some training in professional psychology through VA. This year, VHA's Offices of Academic Affiliations (OAA) and Patient Care Services significantly expanded VA's psychology training programs in anticipation of the ongoing need for additional VA psychologists.

The Healthcare Retention and Recruitment Office (HRRO) is distributing a new recruitment brochure titled "From Classroom to Career" to VA trainees. The Office of Academic Affiliations in VA Central Office emphasizes trainee recruitment to education leaders in VA facilities. The VHA leadership has raised the trainee recruitment issue to a higher priority.

In an effort to initiate proactive strategies to aid in the shortage of clinical faculty, VA launched the VA Nursing Academy (Academy) to address the nationwide shortage of nurses. The purpose of the Academy is to expand the number of nursing faculty in schools, increase student nursing enrollment by 1,000 students, increase the number of students who come to VA for their clinical learning experience, and promote innovations in nursing education and clinical practice. Four partnerships were established for the 2007—2008 school year. Four additional partnerships will be selected each year in 2008 and 2009 for a total of twelve partnerships.

The VA Travel Nurse Corps is an exciting new program that established a pool of registered nurses (RNs) in VA who can be available for temporary, short-term assignments at VA medical centers throughout the country; this program is being piloted at two sites, San Diego and Phoenix. The VA Travel Nurse Corps meets nurses' needs for travel and flexibility while meeting VA medical center needs for temporary, high quality nurses. The goals of the program are to maintain high standards of patient care quality and safety; reduce the use of outside supplemental staffing; improve recruitment of new nurses into the VA system; improve retention by decreasing turnover of newly recruited nurses; provide alternatives for experienced nurses who may leave the VA system; and establish a potential pool of RNs for national emergency preparedness efforts. The VA Travel Nurse Corps program may also serve as a model for an expanded multidisciplinary VA Travel Corps in the future.

Student programs, such as the VA Learning Opportunities Residency (VALOR) Program, the Student Career Experience Program (SCEP), and the Hispanic Association of Colleges and Universities (HACU) Internship Program, have helped VA meet its workforce succession needs. VALOR is designed to attract academically successful students of baccalaureate nursing programs and pharmacy doctorate programs. VALOR offers a paid internship and gives the honor students the opportunity to develop competencies in their clinical practice in a VA facility under the guidance of a preceptor. In response to the success of the VALOR program for nurses, VA added a pharmacy component in 2007. SCEP and HACU offer students work experience related to their academic field of study. VHA's goal is to actively recruit these students for permanent employment following graduation. VA National Database for Interns is a newly designed database developed to track students in VA internship/student programs and to create a qualified applicant pool.

The Graduate Health Administration Training Program (GHATP) provides practical work experience to students and recent graduates of healthcare administration masters programs. On an annual basis, 40–45 GHATP residents and fellows are competitively selected and, upon successful completion of the programs, are eligible for conversion to a permanent position. The Technical Career Field program is designed to fill entry level vacancies in areas like Budget, Finance, Human Resources, and Engineering, where shortages are predicted and VA-specific knowledge is critical to success. Recruitment is focused on colleges and universities. Each intern is placed with an experienced preceptor in a VHA facility. The program is designed to be flexible and responsive to the changing needs of the workforce, as the target positions and the number of intern slots are determined based on projected needs.

Challenges Hiring Health Professional in Rural Areas

VA recognizes that rural communities face additional healthcare workforce challenges. Many of the access and quality challenges rural patients face begin with a

shortage of healthcare providers. VA is working to develop an effective rural workforce strategy to recruit locally for a broad range of health-related professions.

Experiential training opportunities for young medical students are important investments for creating a veteran- and rural-friendly physician workforce. VA is working to integrate rural areas into residency rotations, since evidence shows those who serve residencies in rural areas are more likely to practice in rural areas.

Streamlining the Hiring Process

Last year, VHA's Human Resource Committee chartered a workgroup to streamline the recruitment process for Title 5 and Title 38 positions within VHA. The workgroup initially analyzed the recruitment process and identified barriers and lengthy processes for Registered Nurses. VHA conducted a pilot program in VISN 4 (Pittsburgh, PA) where the group's recommendations were put into practice. The recommendations were piloted there with the implementation and results of the pilot rolled out nationwide using information from this pilot. This spring and summer, VA is offering training in systems redesign nationally at Human Resources Cluster meetings. These sessions will focus on new strategies and systems redesign elements that can be used to help meet the daily challenges of attracting and retaining critical healthcare professionals.

VA has direct appointment authority for several Title 38 occupations, including physical therapists. We recognize that physical therapists are essential to the rehabilitation of injured veterans, and VHA is in the final stages of working with the Office of Human Resources Management to develop a new qualification standard, which should be implemented later this year.

In October 2007, VHA consolidated the Delegated Examining Units from 19 decentralized units to eight centralized units, fully automated offices which process all VHA requests for external Title 5 job applicants. The centralization, consolidation and automation of this function have helped VHA achieve reductions in the timeframes for announcing Title 5 positions to the general public; qualifying candidates and generating certificates of eligible candidates for hiring managers. Metrics have been established and tracking implemented to measure the competitive hiring process within VHA. Improvements in timelines for processing are expected to continue throughout the year.

Innovative Retention Strategies

One retention strategy that has proven very successful for VHA was approved in Public Law 108–445 (dated December 3, 2004 and effective January 8, 2006). VHA physician and dentist pay consists of three elements: base pay, market pay, and performance pay. P.L. 108–445 improves VA's ability to recruit and retain the best qualified workforce capable of providing high quality care for eligible veterans. VA is committed to ensuring the levels of annual pay (base pay plus market pay) for VHA physicians and dentists are fixed at levels reasonably comparable with the income of non-VA physicians and dentists performing similar services. Between the time the pay bill went into effect and the end of February 2008, we have increased the number of VA physicians by over 1,430 FTE. Also as a component of this legislation, VA has the discretionary ability to set Nurse Executive Pay to ensure we continue to successfully recruit and retain nursing leaders.

National Recruitment/Media Marketing Strategies

The VHA Healthcare Retention & Recruitment Office (HRRO) administers national programs to promote employment branding with VHA as the healthcare employer of choice. Established almost a decade ago, the brand "Best Care—Best Careers," reflects the care America's veterans receive from VA and the excellent career opportunities available to staff and prospective employees.

Recent marketing studies for nursing and pharmacy have been the driving force for many of our successful campaigns. HRRO works at the national level to promote recruitment branding and to provide tools, resources, and other materials to support both national branding and local recruiting. The current annual recruitment advertising budget is $1.8 million. Some of the features of this program are:

- Integration of VHA's recruitment website search engine (*www.VACareers.va.gov*) with the USA Jobs (*www.USAjobs.opm.gov*) search engine. This combined resource provides consolidated information on careers in VHA, job search capability, and information on Federal employment pay and benefits information. This integration was completed in March 2008.
- Public Service Announcements (PSAs) promote the "preferred healthcare employer" image of VHA. PSAs emphasize the importance and advantage of careers with VA and focus on the personal and professional rewards of such a career.

- A comprehensive online advertising strategy where VA positions are promoted on commercial employment websites like Career Builder, Healthcareers, and others. Advertising on online health information networks expands our reach to over 5,000 discrete websites at a cost of just over $500,000 annually. VA's strategy includes banner advertising directing traffic to the VACareers website for employment information and adding keyword searches to Google and Yahoo! to elevate VA jobs to the top of the list of search results on these sites. This advertising results in over 100,000 visits to the VA recruitment website each month.
- Print advertising includes both direct classified advertising and national employment branding. The national program provides ongoing exposure of VA messaging to potential employees and promotes VA as a leader in patient care. VHA print advertising reaches over 34 million potential candidates.
- VHA Health Care Recruiters' Toolkit is a unique virtual community internal to VHA. This toolkit is an online management program coordinating national and local recruitment efforts for healthcare professionals and serves as a resource by providing available recruitment tools, materials, advertisements, and other related information at recruiters' fingertips.
- VHA's National Recruitment Advisory Groups represent top mission critical occupations that collaborate on an interdisciplinary approach to address recruitment and retention.

In Fiscal Year 2007, HRRO developed a comprehensive recruitment marketing plan for mental health professionals using some of the strategies mentioned earlier, as well as financial recruitment incentives. Funding was dedicated for Mental Health Enhancement Initiative Education Debt Reduction Program (EDRP) positions. As of May 1, 2008, awards had been made to 144 participants. The total payout for these participants is over $5,235,000 over a 5-year service period. The average total award is $36,355.

Financial Incentives for Recruitment and Retention

Both a recruitment and retention tool, the Employee Incentive Scholarship Program (EISP) pays up to $35,900 for academic healthcare-related degree programs. Between 1999 and May 1, 2008, 7,524 VA employees have received scholarship awards for academic education programs related to Title 38 and Hybrid Title 38 occupations, and more than 4,200 employees have graduated. Scholarship recipients include RNs (93 percent), pharmacists, and many other allied health professionals. Focus group market research shows staff education programs offered by VHA are considered a major factor in individuals selecting VA as their choice of employer. A 5-year analysis of program outcomes demonstrated positive employee retention. Less than 1 percent of nurses leave VHA during their service obligation period, from one to 3 years after completion of degree.

The Education Debt Reduction Program (EDRP) provides tax free reimbursement of education loans/debt to recently hired Title 38 and Hybrid Title 38 employees. EDRP is similar to the Student Loan Repayment Program, under Office of Personnel Management (OPM) regulations. VA has the authority to award up to $50,824. Currently, the maximum award amount is capped at $48,000 and is tax free. The maximum award amount is usually increased each fiscal year. As of May 1, 2008, 6,467 healthcare professionals were participating in EDRP. The average amount authorized per student, since the inception of EDRP, is $18,394. The average award amount per employee has increased each fiscal year from over $13,500 in FY 2002 to over $29,000 in FY 2008 as education costs have increased. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations: registered nurses, pharmacists and physicians. These figures include the mental health initiative EDRP awards discussed previously.

Resignation rates of EDRP recipients are significantly less than non-recipients as determined in a 2005 study that showed:

- The resignation rate for nursing EDRP recipients was 14.3 percent while the resignation rate for non-EDRP recipients was 28 percent—a 13.7-percent difference. The resignation rate for physician EDRP recipients was 15.9 percent while the resignation rate for non-EDRP recipients was 34.8 percent—an 18.9-percent difference. The resignation rate for pharmacy EDRP recipients was 13.4 percent while the resignation rate for non-EDRP recipients was 27.6 percent—a 14.2-percent difference.

A study of the EDRP program retention rates in 2007 showed 75 percent of pharmacists and nurses who received EDRP awards in 2002 were still employed by VA at the end of the initial 5-year period of the program's operation. Among physicians,

65 percent were still employed. Although a smaller percentage, it represents a substantial retention level.

VHA routinely uses hiring and pay incentives established under Title 5 and Title 38. Financial recruitment incentives, retention incentives (both individual and group), special salary rates, relocation incentives and other incentives are routinely used and documented in VHA's Workforce Succession Strategic Plan. Recruitment and retention incentives are used to reduce turnover rates and help fill vacancies. In Fiscal Year 2007, nearly $24 million in *recruitment* incentives were provided to over 3,150 Title 38 and Title 38 Hybrid employees, while more than $34 million in *retention* incentives were given to 5,300 Title 38 and Title 38 Hybrid employees.

Employee Entrance and Exit Survey Analysis

In 2000, VA began using an electronic database to capture survey information from employees entering and exiting VA service. The entrance survey is an excellent tool for comparing and contrasting reasons the new workforce has come to work for VHA and for determining recruitment sources used by candidates (for example, newspaper advertisements, employee referrals, online job postings, etc.). The exit survey tracks the reasons why staff leaves VHA employment.

Survey results of 2006 and the first half of 2007 show advancement and development opportunities, benefits, and job stability were the top reasons to work for VA. VA's mission of serving veterans and pay were also highly rated. The exit survey shows the top reasons for leaving VHA in FY 2006 and the first half of 2007 were normal retirement, advancement opportunities elsewhere, and family matters (marriage, pregnancy, etc.). These findings provide valuable insight for developing recruitment marketing messages and establishing programs to improve retention.

Conclusion

The Under Secretary for Health has made a personal commitment to succession planning and ensuring VHA has a comprehensive recruitment, retention, development and succession strategy. This is a continuous process which requires on-going modifications and enhancements to our current programs.

I would like to thank the Committee for your interest and support in implementing legislation that allows us to compete in the healthcare market.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
June 5, 2008

Honorable James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

Thank you for the testimony of Joleen Clark, Chief Officer, Workforce Management and Consulting, Veterans Health Administration, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health hearing that took place on May 22, 2008 on "Human Resources Challenges Within the Veterans Health Administration."

Please provide answers to the following questions by July 17, 2008, to Chris Austin, Executive Assistant to the Subcommittee on Health.

1. **In your statement you reference the VHA's Strategic Plan and that it identifies mission-critical occupations which are considered shortage categories.**
   - Could you tell this Subcommittee what are the top three mission-critical occupations?
   - What initiatives have been undertaken in the past year to help alleviate the shortages of these three critical occupations?
   - How successful have the initiatives been?

2. **Let's talk about the hiring process. We know that the application process is extremely onerous to a potential employee, not to mention it takes months to fill a position.**
   - For the mission-critical occupations, what is the average length of time it takes to fill a position?
   - What is the number one reason a potential candidate turns down employment with VA?
   - What has VHA done to help expedite the hiring process?
3. **What do you believe is VHA's number one challenge in filling shortage positions?**
4. **Regarding the challenges facing VHA with hiring in rural areas. You state in your testimony that "VA is working to integrate rural areas into residency rotations, since evidence shows those who serve residencies in rural areas are more likely to practice in rural areas."**
   - How does that program work and who are you working with to accomplish that?
   - Please tell me how far along VHA is with "working to integrate rural areas into residency rotations?

Additionally, please answer the following questions for Congressman Vic Snyder:

1. **For each category (i.e. Title 38, Title 5 and hybrid), what is the current total cost per hire?**
2. **What are the existing advertising costs?**
   - What are the total advertising costs per hire?
3. **What is the total volume of generated leads by source per month?**
   - What is the average hire rate based on that source?
4. **What are the projected staffing requirements (RN nurse positions only) considering existing vacancies, losses due to anticipated turnover, and anticipated retirement losses through 2015?**
5. **What is the current cycle timeframe from a commitment to hire an application and to actual hire date?**
6. **Would you please rank in descending order the percentage of closing of each source (i.e., walk-ins, Internet, phone inquiries, billboard, radio, etc.)?**

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by July 17, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael H. Michaud, Chairman
Subcommittee on Health
House Committee on Veterans' Affairs
May 22, 2008
Human Resources Challenges within the Veterans Health Administration

Question 1(a): In your statement you reference VHA's Strategic Plan and that it identifies mission-critical occupations which are considered shortage categories. Could you tell this Subcommittee what are the top three mission-critical occupations?

Response: The top three mission-critical occupations within the Veterans Health Administration (VHA) are registered nurses, physicians, and pharmacists.

Question 1(b): What initiatives have been undertaken in the past year to help alleviate the shortages of these three critical occupations?

Response: The Department of Veterans Affairs (VA) has undertaken several initiatives to help reduce the shortages of mission-critical occupations:

- Offering student loan repayment
- Tuition support/scholarship programs

- Special salary rates may be authorized for hybrid, title 38 and title 5 positions when:
  - hiring or retention efforts are likely to become significantly handicapped due to factors such as higher rates of pay being offered by private sector employers
  - the duty station is in a remote location
  - the nature of the work or working condition is unfavorable (i.e., exposure to occupational or health hazards)
- Retention/Recruitment Incentives (recruitment and retention payments provide monetary incentives for individuals to accept employment or remain employed in Federal Service) and
- Developmental/promotional opportunities

Question 1(c): How successful have the initiatives been?

Response: The initiatives have been successful in reducing turnover rates in the top three mission-critical occupations. Since 2002, these initiatives have been successful in reducing turnover rates in the top three mission-critical occupations. VA has also brought on board more employees in these occupations in fiscal year (FY) 2007 than any time in the last 10 years and increased the end-of-year onboard head count by an additional 968 physicians (6.3-percent increase), 2,449 registered nurses (6.2-percent increase), and 238 pharmacists (4.8-percent increase). This is more than double the increase seen in most of the previous 10 years for these occupations. VA expects to see a larger increase in each of these occupations this year. VA is projecting 7.2 percent, 8.7 percent, and 6.2 percent increases for the end of FY 2008. This means that our recruiting efforts have been phenomenal and our human resources shops have been working incredibly hard to bring on the additional physicians, nurses, and pharmacists VA needs to fulfill the mission.

Question 2(a): Let's talk about the hiring process. We know that the application process is extremely onerous to a potential employee, not to mention it takes months to fill a position. For the mission-critical occupations, what is the average length of time it takes to fill a position?

Response: After identifying a candidate, the average length of time to fill a mission-critical occupation is approximately 10 days (if being hired as temporary) to 180 days. There are a number of steps in the hiring process that must be completed before a candidate can be appointed on a permanent basis. VA performs reference checks and credentials are verified through the necessary sources. Title 38 and hybrid title 38 candidates must be evaluated by a Professional Standards Board, and compensation panels need to recommend pay for physicians and dentists. Additionally, preemployment physicals have to be performed and candidates have to give proper notice to their previous employer.

Question 2(b): What is the number one reason a potential candidate turns down employment with VA?

Response: Non-competitive salary with the local market is the number one reason why a potential candidate turns down employment with VA.

Question 2(c): What has VHA done to help expedite the hiring process?

Response: VHA has several initiatives underway to shorten the hiring and review process. The initiatives involve: policy revisions, software development, retooling and focusing on streamlining the hiring process. VHA is looking at credentialing timelines and background investigations. In addition, facilities are undertaking a systems redesign process that will focus on improving the staffing process.

Question 3: What do you believe is VHA's number one challenge in filling shortage positions?

Response: VHA's number one challenge in filling shortage positions is the limited supply of medical professions, particularly in specialized areas. Private and Federal sectors are competing for hard-to-fill positions with a limited pool of professionals in certain specialties. This makes recruiting and retaining medical professionals in these core professions a challenge.

Question 4(a): Regarding the challenges facing VHA with hiring in rural areas. You state in your testimony that "VA is working to integrate rural areas into residency rotations, since evidence shows those who serve residencies in rural areas are more likely to practice in rural areas." How does that program work and who are you working with to accomplish that?

Response: The VHA Office of Academic Affiliations (OAA) oversees an extensive portfolio of training programs around the country, encompassing over 100,000 trainees per year having clinical experiences at VA sites. In recent years, OAA has encouraged and incentivized training in rural areas. Over 400 paid trainees (including 125 physician residents) and over 4,000 unpaid trainees participate in training at

rural sites. Training programs exist at 22 out of 31 medical centers that support rural or highly rural markets.

Through an initiative known as the graduate medical education (GME) enhancement program, OAA has funded medical training experiences in more remote VA sites. One specific component, *New Affiliations and New Sites of Care*, encourages trainee rotations at community based outpatient clinics (CBOC), as well as at other new sites of care. To date, OAA has funded over 80 new physician resident positions in 21 sites through this program; over 13 of these positions have been allocated to officially designated rural sites. More than 10 additional positions have been awarded to rural locations not officially designated as such (Boise, Idaho; Northampton, Massachusetts; and the CBOC in Pine Bluff, Arkansas).

VHA also recognizes the need for more infrastructure support at rural sites in order to ensure that residents have an excellent educational experience—without which they are unlikely to view rural practice in a favorable light. Thus, OAA and the Office of Rural Health are currently discussing the feasibility of partnering in order to further expand OAA's GME enhancement initiative to include more resource support for rural and highly rural hospitals and CBOCs as training locations.

Question 4(b): Please tell me how far along VHA is with "working to integrate rural areas into residency rotations."

Response: VHA's efforts to integrate rural sites into training programs are still evolving. VA's care initiatives, including new affiliations and new sites, are only in the second year of implementation. The Office of Rural Health is in the process of collaboration with OAA to pursue these initiatives.

Questions for the Record
Hon. Vic Snyder

Question 1: For each category (i.e. Title 38, Title 5, and hybrid), what is the current total cost per hire?

Response: VHA does not track the total cost per hire due to the complexities of allocating direct and indirect costs of multiple staffers involved in the hiring process.

Question 2: What are the existing advertising costs? What are the total advertising costs per hire?

Response: The Healthcare Recruitment and Retention Office (HRRO), a part of the Workforce Management Office, spends approximately $2.5 million per year on print advertising, collateral materials (brochures, flyers, and promotional items), web design and promotion and by participating in career fairs, conferences, trade shows and other events annually. HRRO also provides local and national VA recruiters with valuable tools through its toolkit of developed ads, banners, and event displays to promote consistent branding in support of recruitment efforts.

VA does not track the total advertising cost per hire due to complexities of properly allocating funds VHA may have expended at the local and national level to fill a position.

Question 3(a): What is the total volume of generated leads by source per month?

Response: VA does not collect data that provides the total volume of generated leads by source per month or data that provides the average hire rate based on that source; however, based on entrance surveys, we know that the number one method applicants find out about open positions is through the Internet—employee referral is the second source.

Question 3(b): What is the average hire rate based on that source?

Response: VA does not track the data that gives the exact breakdown as multiple sources could have influenced a new employee to accept a position within VA.

Question 4: What are the projected staffing requirements (RN nurse positions only) considering existing vacancies, losses due to anticipated turnover, and anticipated retirement losses through 2015?

Response: Currently, there are an estimated 1,700 vacancies (which equate to 10.7 percent vacancy rate) for registered nurses. The turnover rate for this fiscal year 2008 has been approximately 5 percent. Projections for future hires through 2013 are projected at an increase of 19 percent from approximately 42,000 to 50,000.

There is projected to be a loss of 7,600 registered nurses due to retirement by the year 2013 or approximately 15 percent over that same time period.

Question 5: What is the current cycle timeframe from a commitment to hire an applicant and to actual hire date?

Response: Generally, it takes approximately 30 to 180 days from a commitment to hire an applicant to the actual hire date. Many facilities are moving closer to the 30-day timeframe as a result of ongoing initiatives.

Question 6: Would you please rank in descending order the percentage of closing of each source (i.e. walk-ins, Internet, phone inquiries, billboard, radio, etc.)?

Response: Based on the 2007 Entrance Survey Results, the following sources in descending order represent how a new hire heard about job opportunities within VA.

a. (33.25 percent) VA Internet Job Opportunities Site—*www.vacareers.va.gov*
b. (32.38 percent) VA Employee Referrals
c. (15.34 percent) Other (i.e. friend, veteran, colleague, conference)
d. (7.92 percent) College or University
e. (5.71 percent) Newspapers & Magazines
f. (4.58 percent) Office of Personnel Management Job Notice
g. (0.68 percent) Career Counselor
h. (0.13 percent) No Response