S. HRG. 110–767

OVERSIGHT HEARING: MAKING VA THE WORKPLACE OF CHOICE FOR HEALTH CARE PROVIDERS

HEARING

BEFORE THE

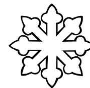
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

APRIL 9, 2008

Printed for the use of the Committee on Veterans' Affairs



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U.S. GOVERNMENT PRINTING OFFICE

41–918 PDF WASHINGTON : 2009

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OVERSIGHT HEARING: MAKING VA THE WORKPLACE OF CHOICE FOR HEALTH CARE PROVIDERS

WEDNESDAY, APRIL 9, 2008

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:35 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Rockefeller, Murray, Tester, Burr, Craig, and Wicker.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing will come to order. Good morning. I welcome everyone to today's hearing.

Health care matters affecting veterans are very important to this Committee and especially important to me. In recent years, the Committee has, by necessity, spent much time and effort delving into the health issues facing veterans today, including TBI and invisible wounds. The simple truth of VA health care is that its providers are the real backbone of the system. If the providers are not present or are there but unhappy in their jobs, it is likely that the veterans will not receive the quality care they need and deserve.

The Department of Veterans Affairs faces a dangerous shortage of health care professionals around the country. Services for veterans at too many facilities are limited due to staffing shortages. From nurses to senior executives to psychologists, VA competes with other health care systems for employees and too often comes up short.

In a recent publication by the Partnership for Public Service on employee satisfaction, the Veterans Health Administration ranked poorly in pay and benefits and in family support. VHA also rated very low among younger employees. However, a silver lining from this survey is that VHA has improved in almost all rankings. So, while there has been progress, clearly there is still much more to be done.

The task of this Committee and of the Congress is to provide VA with the resources and tools necessary to enable VA facilities to attract health care professionals of the highest caliber. This fiscal year, Congress provided VA with a significant infusion of funds. It

is my expectation that we will do so again this year for the next fiscal year.

During today's hearing, we will have the opportunity to examine the tools VA now has and those it might need in the future to bring in top-notch health professionals. In my view, VA has the potential to recruit and retain the very best clinicians. Scholarship programs used effectively could alleviate student debt burdens. An effective pay system will allow VA to compete in every labor market. VA operates a world-class research system that attracts clinicians who seek to push the boundaries of medical care. These are just a few examples of the effective recruitment and retention tools at VA's disposal. We must ensure that they are being fully utilized.

It is my hope that this hearing may lead to more effective use of existing methods of recruiting the best and brightest health care professionals to VA and then making sure that they choose to stay. We also will seek to identify new approaches to attract health care professionals to VA. Over the past decade, VA has made tremendous strides in becoming the premier health care provider for veterans. We must now ensure that VA can employ premier employees.

I offer a special thanks to our witnesses here today. We appreciate your taking the time to appear before the Committee and for your service to veterans.

Now I will call on our Ranking Member, Senator Burr, for his opening remarks.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Aloha, Mr. Chairman. Thank you, and I thank all of our witnesses today for what I think will be some very, very important testimony.

It goes without saying that if the VA is to continue to deliver top-notch health care to veterans, then it needs to be able to attract and retain qualified medical professionals. Of course, the challenge is that the VA competes for these professionals in a marketplace where they are high in demand and short in supply. The Health Resources Services Administration estimates that in 2020, the nationwide supply of primary care physicians will be around 270,000, but the need will be for nearly 340,000. For rural and inner-city areas, we can't wait until 2020. A shortage already exists today. In States with growing populations, the problem is particularly acute. In North Carolina, the provider-to-population ratio is expected to drop by 8 percent to 19 percent by 2030.

With these numbers, Mr. Chairman, it is imperative that the VA have the tools it needs to attract and to keep quality doctors and nurses. This means that pay and benefits need to be competitive. It also means that scholarship and debt repayment programs in return for working at the VA need to be fully utilized. And, of course, it means that a robust research program at the VA, which has proven to be a powerful enticement for the brightest of medical minds, needs to be supported.

I am pleased that we will hear today from Dr. Jennifer Strauss, an Assistant Professor at Duke University Medical Center's Department of Psychiatry and Behavioral Science, about how VA re-

search can be strengthened. I think we all look forward to that testimony.

In addition, Dr. Harvey Cohen, the head of Duke University's Department of Medicine and a career VA researcher, has submitted testimony for the record to give the Committee his thoughts on this subject.

In addition to research, one of the greatest recruiting tools available to the VA is its noble mission. The job satisfaction that comes with serving America's veterans is one all of us on this Committee can attest to and it certainly exists for those who provide veterans with health care on a day-to-day basis.

Before I conclude, Mr. Chairman, let me make an important point that is relevant to today's hearing. There are approximately 24 million veterans living in America today. Almost eight million of them are enrolled in the VA health system. Thus, 16 million veterans currently receive health care outside the VA system. The national shortage in medical providers is just as real for these veterans as it is for the VA patients. Although our primary focus for this hearing is on the recruitment and retention of VA medical professionals, we should also be aware of the impact that VA hiring has on the larger health care system.

For example, VA has hired nearly 3,800 mental health workers since the year 2005 and may add an additional 500 in the near future. We need to ask the question, what impact does this have on the available supply of mental health workers in the communities both now and over the long term? Relevant to this point, testimony submitted for the record by Charles Ingoglia, Vice President of Public Policy for the National Council for Community Behavioral Healthcare, suggests that VA hiring is, and I quote, "exacerbating an existing mental health workforce shortage and may not meet the long-term treatment and rehabilitation needs of returning veterans."

Mr. Chairman, I dare say, something we have talked about on this Committee is how we get the right amount of treatment as quickly as we can in the most intense way. In fact, if we have a medical professional shortage, we will be unable to do that and treat veterans at the most important time. Mr. Ingoglia suggests that rather than competing with the community-based mental health organizations for available workers, VA could, and I quote, "pursue a targeted strategy of cooperation and collaboration through service partnerships," unquote. Such partnerships would have the added benefit of making care available for veterans in rural communities.

What all this means is that we need to be prepared to take a comprehensive view of addressing the problems and be prepared to embrace the solutions that are in the best interest of the health care of our veterans, wherever they reside.

Mr. Chairman, this is an extremely important hearing. Many of the decisions that we make from here on out have effects within the VA system on the direct care received by our veterans, but also outside the VA system on the care that this country's other veterans will receive, and the public at large.

I thank the Chair for the time.

Chairman AKAKA. Thank you very much. By arrival time, let me call on Senator Craig for your statement.

STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Senator CRAIG. Chairman Akaka, thank you very much, and Ranking Member Burr, thank you for this hearing today.

I will submit my formal remarks for the record and react to what Senator Burr has just said. Mr. Chairman, because clearly we are headed into a time in health care—both for veterans and non-veteran civilian populations—that is having substantial stress on the resources available for a variety of reasons: from desirability of workplace and conditions to pay to lack of a Medicare system that stays sensitive to the constant needs of the patient—a combination of things.

One of the things, though, that I find most fascinating that you have just mentioned, Senator Burr, is that really—while we may not get there now, we must get there some day, and that is the idea that these are stand-alone systems and not effectively integrated. We are doing a little of that today, a little bit of that.

Senator Murray and I—while I was up in the Lewiston area, and, of course, Lewiston, ID, and Clarkston and Asotin, WA, come together right there at a point in geography and transportation—we are standing up a CBOC that we are going to open up out there in mid-May. I met with the folks from over in Walla Walla and they had come over to walk me through it and show me the work that was being done. But, they are also contracting services with the local health care providers in the community for the things they cannot provide that aren't necessarily needed for travel on into Spokane or over to Walla Walla. And, of course, that CBOC will serve Clarkston and Asotin, WA, and Lewiston, ID.

That is really the kind of integration that we have got to get at, the idea that we create bricks and mortar and walls, but we don't have a payment system that shows some flexibility. I have talked about that over time. Yesterday, I had a group of young veterans in my office. All of them have served in Iraq and Afghanistan and most of them live in rural Idaho. And they said, "Senator Craig, why can't we have a VA health card? Why can't we have a card that allows us to go to our local providers to get the service we need instead of traveling the 200 to 500 miles that you are now requiring us to travel to get the health care that we are entitled to have?"

And again, I understand that, but as you know, as a Member of this Committee longstanding, I have also argued that in the dynamics of health care into the future, that the bricks and mortar and the walls and the structures we have created, while they have served us phenomenally well, may not serve us as well if our focus is service to the veteran, access to health care, period—access to health care—not the health care we define you are eligible for within that structure and that building.

To me, that makes a great deal of sense, and when we talk about the problems that you and Senator Burr have talked about, we have got a marvelous system today. Again, VA gets top ratings. The New England Journal of Medicine has just put us on top

again: access; quality; all of those kinds of things in general. And yet a million nurses are talked about now, a near shortage of a million nurses in the near future, 25,000 physicians by 2020. Why should health care systems be competing? Should they not be complementing? I think that is going to be our greater challenge in the out years as we put money into this system to do so.

And, of course, as you know, I have to get in my traditional punch. If we expand, if we are not focused on the disabled and the poor of the VA system and we go to Priority 8s and we add 1.4 million more to the system, from the standpoint of eligibility, then the numbers we are concerned about today simply go up. The demand goes up. And ought there not be a greater way for us to provide for our veterans in the out years, and looking at it in the modern sense that we may not be looking at it today. We are still dedicated—and I have no criticism of that—but to the bricks and mortar we have built down through the years. But it isn't serving our veterans across America as well as it should.

So, yesterday, I had that reality when that veteran held up his hand and said, "Senator, why can't I have a VA health card that allows me to get my services in Salmon, Idaho, or in Pocatello or somewhere in rural Idaho that provides quality health care that has an association with the VA system?" I said to him, smile, work at it, become an advocate of it. Work with your service organizations, because they, too, are stuck in the tradition of supporting what we have instead of where we ought to go.

Thank you very much.

[The prepared statement of Senator Craig follows:]

PREPARED STATEMENT OF HON. LARRY E. CRAIG, U.S. SENATOR FROM IDAHO

Chairman Akaka, Thank you for calling this hearing today. I just want to make a few comments.

One thing that I cannot do often enough is to commend VA for the excellent health care they provide for our veterans. In studies by various well-respected publications, including the *New England Journal of Medicine*, VA has outperformed Medicare and private insurance in quality of care.

A key component of maintaining the high quality of VA health care is recruiting and retaining a dedicated staff. However, we are also facing a shortage across the country in many health care professions—including physicians, nurses, and a variety of sub-specialties. A July 2007 report from the Health Research Institute of PricewaterhouseCoopers found that the United States will be short nearly one million nurses and 24,000 physicians by 2020. Specifically, in my home State of Idaho we are grappling with a shortage of primary care physicians to treat individuals living in rural areas. In the midst of this nationwide shortage, VA must also continue to raise its profile among potential health care professionals to recruit a quality staff in order to maintain its stellar reputation as a health care system. This is no small challenge.

I want to take this opportunity to point out that this is one of the reasons why I am opposed to allowing Priority 8 veterans into the VA health care system. While I think VA recognizes the need to aggressively recruit health care professionals, we also need to be realistic. We are being confronted with a nationwide shortage and if VA is having recruitment challenges now, adding upwards of 1.4 million individuals to the patient population would only exacerbate this problem.

VA needs to continue to focus its health care delivery on our disabled veterans.

With that being said, I want to commend VA on the excellent workplace environment it has created and I look forward to hearing from our witnesses about how they are addressing recruitment challenges.

Chairman AKAKA. Thank you, Senator Craig.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you, Chairman Akaka, Senator Burr, for holding this hearing on the recruitment and retention of health care professionals in the Veterans Health Administration. I look forward to the testimony from our distinguished members of both panels. I especially want to extend a welcome to Valerie O'Meara. She has traveled here across the country to testify in front of us today as a nurse practitioner from the Seattle VA Center. As I have said many times, Mr. Chairman, our VA staff are some of the most caring and compassionate people I know. They work hard. They are smart and very caring. They understand the needs of the veteran population that they serve; and they are critical as we see so many returning veterans coming home today, as well as veterans of previous wars. I appreciate the great job all of you and your coworkers do.

Mr. Chairman, the doctors and nurses and mental health care providers and many health care professionals who work at the VA are the reason that the VA can stay true to its mission and to provide the best quality of care anywhere. But, as the topic of your hearing suggests today, the VA faces significant hurdles as it tries to recruit and retain the kind of high-quality health care professionals that the Department relies on to serve the veterans today. So, I am very pleased, Mr. Chairman, that we are holding this hearing to explore VA's workforce needs.

I really think we have to get to the heart of this issue and explore our options, not only to improve working conditions for our current VA employees, but to ensure that the VA can compete with the private sector and recruit the best and brightest professionals. In order to do that, we have a lot of work ahead of us because there are a number of challenges to overcome.

The VHA employment process is overly complicated and takes far too long. The VA doesn't pay health professionals as well as the private sector does. Education and training opportunities for workers have to be updated and revamped.

So, Mr. Chairman, I emphasize this hearing is not only about the ways we can become more competitive as we recruit new people into the VHA system, it is about retaining our current employees, as well. And along that line, I am very concerned that a recent study by the Partnership for Public Service found that job satisfaction among VHA employees under the age of 40 is very low. If the VA is going to continue to provide the best quality of care anywhere, that has to change.

So, Mr. Chairman, I look forward to hearing from the witnesses today as we begin to address this issue. I do have another hearing at the same time as this hearing, so I am going to miss the first panel and their testimony, but my staff will be here and I will be back for the second panel. I think this is an extremely important topic, Mr. Chairman, and I thank you for exploring it today.

Chairman AKAKA. Thank you very much, Senator Murray. As you know, Senator Murray plays a huge role on Veterans' Affairs, and, of course, she is on the Appropriations Committee. We work very well together in trying to get things done for veterans. Thank you very much, Senator Murray.

I want to now welcome our witnesses from the Department of Veterans Affairs. I appreciate your being here today and look forward to your testimony. Will you please be seated.

First, I welcome Marisa Palkuti, Director of the VHA Health Care Retention and Recruitment Office. I also welcome Sheila Cullen, Director of the San Francisco VA Medical Center; and I also want to welcome Dr. Wiebe, who I see here in the room. Welcome and aloha, Dr. Wiebe, for being here today. Finally, I welcome Steven Kleinglass, Director of the Minneapolis VA Medical Center.

I want to thank all of you for joining us today. Your full statements will appear in the record of this Committee.

Ms. Palkuti, please begin after I ask Senator Tester whether he has any statement to make at this point in time.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Well, thank you, Mr. Chairman. That is very gracious of you. I am sorry about being late.

I just want to tell you that from a Montana perspective, recruitment and retention of our health care officials and our support staff is really important. I have been around to most of the veterans' facilities in the State of Montana, done some public hearings and heard from veterans throughout the State and I can tell you the one comment that I hear repeatedly is a lack of staff.

I look forward to your statements. I really want to hear what we are doing as far as recruitment and retention bonuses, those kind of things, to get people on board. I have been told by some of the health care professionals that the VA cannot pay what the private sector is paying for health care folks. I don't know what the thought process was there—whoever made that rule—but, it is wrong-headed thinking. I think if we are going to get the best people to take care of our veterans in this country, we have got to be competitive; and if we start out from a standpoint that we cannot meet basic wages, I think it reduces the employment pool right out of the chute. And our potential for keeping these people dwindles pretty quickly, because they see what the opportunities are out in the private sector.

So, your statements today are going to be critically important. I will tell you that most of my questions are going to revolve around recruitment and retention and how we can do a better job and how I can help you do a better job in this process.

So, with that, thank you, Mr. Chairman. I appreciate the opportunity.

Chairman AKAKA. Thank you very much, Senator Tester.

At this time, we will hear from Ms. Palkuti.

STATEMENT OF MARISA W. PALKUTI, M. ED., DIRECTOR, HEALTH CARE RETENTION AND RECRUITMENT OFFICE, VETERANS HEALTH ADMINISTRATION

Ms. PALKUTI. Mr. Chairman and Members of the Committee, thank you for the invitation to appear before you. I am honored to be here today to share VA's ongoing efforts and challenges to develop innovative and aggressive approaches to addressing recruitment and retention of our health care workforce. My full testimony

will be in the record, so I will highlight a few of the things that we are working on.

An informal study conducted of all VA facilities in 2007 revealed that 74 percent of the 800 psychologists hired over the past 3 years received some training in professional psychology at VA. This year, the office's academic affiliation and patient care services have significantly expanded VA's psychology training programs in anticipation of the ongoing need for VA psychologists as well as psychologists to practice in the community.

In an effort to initiate proactive strategies and aid in the shortage of clinical faculty in nursing schools, VA has launched the VA Nursing Academy to address the nationwide shortage of nurses. Four partnerships were established in the 2007–2008 school year and four additional partnerships will be selected each year in 2008 and 2009 for a total of 12 partnerships.

We have launched the VA Travel Nurse Corps, which is an exciting new program establishing an internal pool of registered nurses who can be available for short-term temporary travel assignments in VA and centers throughout the country, including rural care.

We have a multitude of student programs that have been instrumental in helping VA meet its workforce needs. These programs include the VA Learning Opportunities Residency Program for baccalaureate prepared nurses and doctoral prepared pharmacists—student career experience programs. We have established a database for our interns and students so that we can track them and use them as a better applicant pool for our future needs.

We have a Graduate Health Administration training program for practical work experiences for recent graduates of health care administrative master's programs for hospital leadership. We have a Technical Career Field Program. It is an entry-level program designed to fill vacancies in fields such as budget, finance, HR, engineering, and others where VA knows that there is a critical need and VA-specific knowledge is necessary.

And we realize that our hiring process is cumbersome. This spring and summer, we will be training medical center leadership in human resources and systems redesign at a series of human resources cluster meetings around the country.

My office works at the national level to promote recruitment branding and provide tools and resources and other materials to support both national and local recruiting efforts. Some of the features we have recently integrated, our VHA Internet Job Board with USA Jobs. We have done a complete revision of that tool. We use Public Service Announcements, online advertising, print advertising. We have a tool kit for recruiters across the country to tap into our resources. We have established National Recruitment Advisory Groups.

As highlighted already, we developed a very comprehensive recruitment and marketing plan for mental health professionals using the strategies mentioned above as well as a number of financial incentives. Among the financial incentives, our Employee Incentive Scholarship Program will pay up to $35,900 for academic and health care-related degree programs. We currently have authorized over 7,200 scholarships to VA employees and have over 4,000 graduates, closer to 4,300 at this point. It shows through

analysis that we also have positive retention outcomes for that program.

Our Education Debt Reduction Program provides a tax-free reimbursement of educational loans for clinical employees, and as of March 31, we had authorized over 6,400 awards under the Education Debt Reduction Program.

There is routine use of other financial incentives—recruitment incentives, retention incentives, relocation incentives, and special salary rates. And in fiscal year 2007, we spent over $24 million in recruitment incentives nationwide for over 3,150 employees in title 38 and hybrid occupations, and over $34 million in retention incentives to 5,300 of our clinical employees.

Regarding the physician pay bill, we truly believe that this legislation has helped us to recruit and retain physicians.

Our agency has one of the best and most comprehensive workforce strategic plans in government. We have been recognized by the Office of Personnel Management as a Federal best practice. We have a commitment, a strong commitment, to succession planning and ensuring that VA has a comprehensive recruitment, retention, and development strategy for the agency.

I would like to thank the Committee for their interest and support in implementing legislation that allows us to compete in an aggressive health care market, and Mr. Chairman, that concludes my oral statement. I will be pleased to respond to any questions.

[The prepared statement of Ms. Palkuti follows:]

PREPARED STATEMENT OF MARISA W. PALKUTI, M. ED., DIRECTOR, HEALTH CARE RETENTION AND RECRUITMENT OFFICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, Thank you for the invitation to appear before you today to discuss the Department of Veterans Affairs (VA), Veterans Health Administration (VHA) recruitment and retention programs, work schedules, and other issues related to creating a compassionate, qualified and diverse workforce of health care professionals. As the Nation's largest integrated health care delivery system, VHA's workforce challenges mirror those of the health care industry as a whole. This country is in the midst of a workforce crisis in health care and VHA experiences the same pressures as other health care organizations. VHA performs extensive national workforce planning and publishes a VHA Workforce Succession Strategic Plan annually. As part of this process, workforce analysis and planning is conducted in each Veterans Integrated Service Network (VISN) and national program office and then is rolled up to create a national plan. VHA's strategic direction addresses current and emerging initiatives including recruitment and retention, mental health care, polytrauma, Traumatic Brain Injury, and rural health to address workforce efforts. I am honored to be here today to share VHA's ongoing efforts and challenges to develop innovative and aggressive approaches to addressing recruitment and retention of our professional health care workforce.

EFFORTS TO RECRUIT HEALTH CARE PROFESSIONALS

There is a growing realization that the supply of appropriately prepared health care workers in this country is inadequate to meet the needs of a growing and diverse population. This shortfall will grow exponentially over the next 20 years. This situation exists for various reasons. Enrollment in professional schools is not growing fast enough to meet the projected future demand for health care providers. The American Association of Colleges of Nursing has reported that more than 42,000 qualified applicants were turned away from nursing schools in 2006 because of insufficient numbers of faculty, clinical sites, classroom space and clinical mentors. The availability of academic programs to provide employees to meet qualification standards in other health care occupations is being experienced in many other health care occupations.

More than 100,000 health professions 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 that, overall, following completion of VA learning experiences, trainees were twice as likely to consider VA employment as before the experience. This demonstrates that many trainees were not aware of VA employment opportunities or the quality of VA's health care environment prior to VA training but became considerably more interested after VA clinical experiences.

An informal survey conducted of all VA facilities in 2007 revealed that 74 percent of the 800 psychologists hired over the last 3 years received some training in professional psychology through VA. This year, the 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.

HRRO has produced a new recruitment brochure titled "From Classroom to Career" that is targeted at and distributed to VA trainees. The Office of Academic Affiliations in VA Central Office emphasizes recruitment of trainees in interactions with education leaders in the VA facilities. The Human Resource Committee of the VHA National Leadership Board has raised the trainee recruitment issue to a high priority and has included it as an important element of their strategic plan.

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 purpose of the Academy is to expand the number of nursing faculty in the 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.

VA Travel Nurse Corp is an exciting new program establishing an internal pool of registered nurses (RNs) who can be available for temporary, short-term assignments at VA medical centers throughout the country. The VA Travel Nurse Corps meets nurses' needs for travel and flexibility while meeting VA medical center needs for temporary top 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 considering leaving the VA system; and to establish a potential pool of Registered Nurses 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 have been instrumental helping meet VA workforce succession needs. These programs include the VA Learning Opportunities Residency (VALOR) Program, the Student Career Experience Program (SCEP), and the Hispanic Association of Colleges and Universities Internship Program (HACU). VALOR is designed to attract academically successful students of baccalaureate nursing programs and pharmacy doctorate programs to work at VA. 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, the pharmacy component was added in 2007 to address VA's need for pharmacists. 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 Data base for Interns (VANDI) is a newly designed database developed to track students in VA internship/student programs to create a qualified applicant pool.

The Graduate Health Administration Training Program (GHATP) provides practical work experience to students and recent graduates of health care administration masters programs. GHATP residents and fellows are competitively selected and upon successful completion of the programs are eligible for conversion to a VA health system management. The Technical Career Field (TCF) program is an entry level program designed to fill vacancies in technical career fields (Budget, Finance, Human Resources, Engineering, etc) 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 based on the changing needs of the workforce. Annually, the target positions and number of intern slots are determined based on projected workforce needs.

STREAMLINING THE HIRING PROCESS

It is well known that the Government hiring process is cumbersome. Last year, VA's Human Resource Committee chartered a workgroup 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. The recommendations were piloted in Network 4 (Pittsburgh, PA) with the implementation and results of the pilot rolled out nationwide. This spring and summer, training in systems redesign will be offered nationally at Human Resources Cluster meetings. At these sessions, we will focus on new strategies and systems redesign elements that can be used to help meet the daily challenges of attracting and retaining critical health care professionals.

VA has direct appointment authority for several Title 38 occupations, including physical therapists. We recognize that the physical therapist occupation is a key to the rehabilitation of returning veterans and VHA is working with the Office of Human Resources Management (OHRM) in the development of a new qualification standard. The new standard is in the final stages of approval and it is expected it will be implemented later this year.

NATIONAL RECRUITMENT/MEDIA MARKETING STRATEGIES

VHA Health Care Retention & Recruitment Office (HRRO) administers national programs to promote national employment branding with VHA as the health care 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.

Results of recent marketing studies for nursing and pharmacy have been the driving force to implementing many of our successful campaigns as I will discuss. HRRO works at the national level to promote recruitment branding and provide tools, resources, and other materials to support both national branding and local recruiting. Some of these features are:

- The recent integration of VHA recruitment Web site (www.VACareers.va.gov) with USAjobs (www.USAjobs.opm.gov) provides consolidated information on careers in VHA, job search capability, and information on Federal employment pay and benefits information.
- Public Service Announcements (PSA) promote the "preferred health care employer" image of VHA. PSA's emphasize the importance and advantage of careers with VA and focus on the personal and professional rewards of such a career.
- Online advertising through a comprehensive web advertising strategy, VA job postings are promoted on commercial employment sites (CareerBuilder, Healthecareers, Google, etc.) and online health information networks that expand our reach to over 5,000 discrete web sites. The strategy includes banner advertising that drives traffic to the VACareers web site for employment information. This advertising results in over 100,000 visits to the VA recruitment web site each month.
- Print advertising includes both direct classified advertising and national employment branding. The national program provides ongoing exposure of VA messaging to potential hires with the intent to promote VA as a leader in patient care. VHA print advertising reaches over 34 million potential candidates.
- VHA Health Care Recruiters' Toolkit, a unique virtual community internal to VHA is an online management program that coordinates national and local recruitment efforts for health care professionals. The toolkit serves as a resource by providing available recruitment tools, materials, ads, 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 embark address recruitment and retention.
- In fiscal year 2007, HRRO developed a comprehensive recruitment marketing plan for mental health professionals using strategies mentioned above as well as financial recruitment incentives. Funding was earmarked for Mental Health Enhancement Initiative (MHEI) Education Debt Reduction Program (EDRP) positions. As of March 31, 2008, awards were made to over 100 participants. The total payout for these participants is $4,394,671 over the 5-year service obligation period. The average total award is $35,157.

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 health care-related degree programs. Since the program began in 1999, approximately 7,200 VA employees have received

scholarship awards for academic education programs related to title 38 and Hybrid title 38 occupations. Approximately 4,000 employees have graduated from their academic programs. Scholarship recipients include registered nurses (93 percent), pharmacists, and many other allied health professionals. Focus group market research shows that 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 VA's equivalent to the Student Loan Repayment Program (SLRP) sponsored under Office of Personnel Management (OPM) regulations. The maximum award amount is capped at $48,000 due to the budget, but carries an added value because of the tax exempt status of the award. As of March 31, 2008, there were over 6,400 health care professionals participating in EDRP. The average amount authorized per student, for all years, is $18,392. The average award amount per employee has increased over the years from over $13,500 in fiscal year 2002 to over $29,000 in fiscal year 2008 as education costs have increased. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations—registered nurse, pharmacist and physician. Resignation rates of EDRP recipients are significantly less than non-recipients as determined in a 2005 study.

VHA routinely uses hiring and pay incentives established under Title 5, extended by the Secretary to title 38 employees. There is routine use of financial recruitment incentives, retention incentives (both individual and group), special salary rates, relocation incentives and other incentives as documented in VHA's Workforce Succession Strategic Plan. Recruitment and retention incentives are other strategies used to reduce turnover rates and help fill vacancies. In fiscal year 2007, nearly $24 million in recruitment bonuses were given to over 3,150 title 38 and title 38 Hybrid employees. Over $34 million in retention bonuses were given to 5,300 title 38 and title 38 Hybrid employees.

The implementation of the physician pay legislation (Public Law 108–445) has been very successful for VHA. The pay of VHA physicians and dentists consists of three elements: base pay, market pay, and performance pay. Since the implementation of the pay bill and the end of February 2008, we have increased the number of VA physicians by over 1,430 FTEE. We believe the legislation has helped VHA's ability to recruit physicians and dentists. Also as a component of this legislation, the Chief Nurse of VHA has the discretionary ability to set Nurse Executive Pay to ensure we continue to successfully recruit and retain nursing leaders.

VHA's workforce plan is one of the most comprehensive in government and has been recognized by OPM as a Federal best practice. VA presented at other Federal agencies and the OPM Conference, "A Best Practice Leadership Form on Succession Management" as well as being featured on the February 2008 edition of *Government Executive*, in the article "VHA Grooms a Younger Generation to Ride out the Retirement Wave."

This year, VHA will benchmark its succession planning/developmental programs against private industry health care and other organizations. This will ensure that VHA is being as proactive as possible to meet the Administration's future needs and ensure that we have the right people in place at the right time. VHA has made a 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.

We want to thank the Committee for their interest and support in implementing legislation that allows us to compete in the aggressive health care market.

Mr. Chairman, that concludes my statement. I am pleased to respond to any questions you or the Subcommittee members may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO MARISA W. PALKUTI, M. ED., DIRECTOR, HEALTH CARE RETENTION AND RECRUITMENT OFFICE, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Committee oversight activities have made clear the challenges in providing nurses with sufficient pay. How does VA deal with compression of nurse salary grades?

Response. The Department of Veterans Affairs (VA) is experiencing the kinds of workforce challenges every other health care organization faces. VA's Nursing Serv-

ice has implemented a number of provisions to offset the challenges salary compression creates, including the following:

- Nurse locality pay schedules have been adjusted to minimize the impact of salary grade compression by establishing pay schedules with up to 26 steps, instead of the usual 12 steps.
- Special pay bands have been established by facilities for each nursing specialty, including clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and administrative nurses.
- Nurse managers are given two additional pay steps when they assume clinical leadership roles.
- Public Law (Pub. L.) 108–445, Physician Pay, provided VA a comprehensive way to offer flexible compensation packages to nurse executives. VA is authorized to grant special pay rates of $10,000 to $25,000 per year to the nurse executive at each VA medical center, and to nurse executives in VA Central Office Nursing Service based on the scope and complexity of the nurse position; the nurse executive's personal qualifications; the characteristics of the health care facility, and demonstrated recruitment and retention difficulties.
- Facilities have the discretion to use other tools, including recruitment and retention incentives, relocation assistance, educational support, and student loan reimbursement to relieve pay compression.

Question 2. GAO has suggested that VA managers need better training in the conduct of locality pay surveys. VA concurred with this recommendation. What action has VA taken as of this time?

Response. Public Law 106–419 enabled VA facilities to use third party salary surveys rather than VA-conducted surveys whenever practicable. The use of third party survey data is VA's preference in administering the locality pay system.

As a result, VA's Office of Human Resources Management (OHRM) has focused on training managers in accessing the appropriate salary data for a particular situation. When current data is unavailable from the Bureau of Labor Statistics, facilities must use available third-party data. When third party data is not available then VA-conducted surveys are used, but only as a last resort. To assist facilities in conducting surveys, a Web-based training module on VA-conducted surveys is expected to be available by late summer 2008.

On-going training and education on administering the nurse locality pay system includes a monthly national conference call targeted to nurse executives and human resource managers. Topics of discussion included how to obtain salary data; how to expand the local labor market to capture effective survey data; additional pay authorities available to facility directors; and sharing of "best practices" used throughout the country. OHRM worked with the Veterans Health Administration (VHA) to provide nurse locality pay training to more than 80 interns in 2007.

OHRM will conduct a training session at a VA Health care Recruiters Conference, to be held in the summer of 2008. The session will be titled, Obtaining Salary Survey Data to Develop an Effective Recruitment/Retention Program. Participants in the conference include VA human resources management community, nurses, and other health care recruiters. In addition, OHRM conducts technical review of all Locality Pay Schedules (LPS) and special salary rate schedules at the Central Office level, and provides appropriate direction and guidance.

VHA's Workforce Management and Consulting Office and the Department's Strategic Human Resource Advisory Council are holding cluster conferences in the summer of 2008, at which pay, flexibilities, salary data, and special schedules will be discussed.

OHRM is also conducting market research to determine if a contractor could provide a single source of third party salary survey data for each VA facility. A request for information will solicit contractors to submit information regarding their salary survey products, processes and availability; a statement of work will be created and posted for contract bidding if market research reveals a potential salary survey product. If a contractor is available, VA would be able to centrally identify appropriate job matches and ensure consistency in the interpretation of salary data.

Question 3. Which VA medical centers, if any, do not conduct locality pay surveys, and what is the rational for such inaction?

Response. There is a mandatory requirement for VA facilities to collect salary survey data whenever the facility director determines a significant pay-related staffing problem exists or is likely to exist. Only when current Bureau of Labor Statistics or third party data is unavailable may a facility conduct its own salary survey.

Facility directors have the discretion to collect appropriate survey data at any time, and as often as necessary, to maintain competitive rates of pay.

Title 38 U.S.C. 7451(e)(4) requires each facility director to provide the Secretary an annual report on staffing for covered nurse positions. This report is sent to the Senate and House Committees on Veterans' Affairs. OHRM reviews each report to ensure salary survey data is collected when specific criteria indicates that a pay-related staffing problem exists, or is likely to exist. In the most recent report dated October 2, 2007, only 24 (3.3 percent) of VA's 717 locality pay schedules met the criteria for the mandatory collection of survey data. The 24 schedules required mandatory review at 21 different VA facilities. As required by policy, those 21 facilities initiated the appropriate collection of salary survey data within the required 90-day timeframe, and those results were included in our report to Congress.

Question 4. There are over 700 locality pay schedules used by VHA. While locality pay surveys and policies are set at the local level, the VA Central Office is charged with overseeing the system. Do you believe the current system is an efficient and effective method to address geographically-related pay issues?

Response. VA's nurse locality pay system is unique. Unlike other pay systems in the Federal Government, the nurse locality pay system enables VA officials throughout the country to establish and adjust nurse pay rates based on local survey data. This authority enables facility directors to quickly respond to compensation trends within specific local labor markets in order to maintain competitive rates needed to recruit and retain high quality nursing staff. Nurse locality pay continues to be an effective pay system to address geographically-related pay issues.

Question 5. Education incentive programs have the potential to improve recruitment and retention, but current average awards are out of step with the cost of education. Can this program be adjusted to better reflect the cost of education, and to better match the goals of VHA and individual employees?

Response. VHA's educational incentive programs have statutory limitations that are adjusted annually by the amount of the General Schedule pay increase. The newly adjusted statutory award cap for the Education Debt Reduction program (EDRP) is just over $50,000, based on the General Schedule increase in January 2008. While the program is generously funded at $15 million per year, there is not enough funding to provide EDRP awards to every new hire with student loans. Priorities and funding amounts are therefore established to enable VHA to make awards to the largest number of individuals possible given budget constraints and mission requirements. The average award is not entirely reflective of the actual awards authorized to employees. Many participants are authorized to receive reimbursement for their entire loan. If the award is small, it can reduce the average of the total award amounts. From fiscal year 2006 to fiscal year 2008, 40 percent of the participants were authorized the maximum award. For fiscal year 2006 and fiscal year 2007 the maximum award was capped within VHA at $38,000. In fiscal year 2008 the award cap was increased to $48,000. This fiscal year, EDRP awards range from a low of $621 to the VHA budgetary cap of $48,000.

We are seeing increases in the levels of debt new hires have accumulated when they enter on duty. Many of these individuals have educational loans in excess of $100,000. While the EDRP program doesn't retire the complete debt, it makes a substantial contribution to retiring student loans. Because EDRP awards are tax free, the financial benefit to the individual extends beyond the actual value of the award.

In addition to EDRP, employees may participate in an additional Federal program designed to retire student educational debt. Through Section 401 of the College Cost Reduction and Access Act, (Pub. L. 110–84), public service employees are eligible to have their student loans forgiven after 10 years of service. This program can be used in addition to an EDRP award.

Question 6. How are funds distributed for EDRP—at the national level, or through each facility, or by another modality?

Response. Funds for EDRP are established through VHA's National Leadership Board and allocated by the national VHA Health care Retention and Recruitment Office (HRRO) to all Veterans Integrated Service Networks (VISNs). Allocations are made proportionately based on each VISN's total number of title 38 and Hybrid title 38 employees; the previous year's usage, and other special need programs such as the mental health enhancement initiative and the polytrauma rehabilitation center start-up. Funds are allocated at the beginning of the fiscal year to the VISNs. VISNs in turn allocate resources to the facilities in its networks. HRRO staff monitors the funding on a weekly basis to ensure that award funding can be redistributed between VISNs as necessary throughout the year.

Question 7. Almost 4 years ago, Congress enacted sweeping reforms of the physician and dentist pay system. At the time, VA was spending huge sums on high-cost specialty care contracts. How much is VA still spending on specialty care contracts, and have more physicians and dentists been attracted to VA?

Response. The annual report to Congress on the pay of physicians and dentists in VA (Pub. L. 108–445) delivered December 2007, provides an in-depth analysis of VA's reduction in physician and dentist contracts. From fiscal year 2006 to fiscal year 2007, $5.6 million in contract dollars were saved for physician services. Since the new pay system has been implemented, VA has seen a 10 percent increase in the number of physicians it has hired.

Question 8. The quality of workplace facilities plays a significant role in patient and staff satisfaction, from lighting to sound abatement. What steps has VA taken to modify facilities to improve patient and staff quality-of-life?

Response. Transforming Care at the Bedside (TCAB) is a national project designed to transform care processes for ongoing improvement in medical/surgical units. These transformations are accomplished by engaging and empowering nurses and managers to identify needed changes; rapidly conducting small tests of potential solutions or improvements and determining whether changes should be implemented. As a result, nurses on TCAB units report measurable improvements in work unit vitality, patient safety and the efficiency with which the unit delivers care, and the patient centeredness of the care delivered.

Some results of what TCAB has accomplished include:

- Nine TCAB pilots units have gone 5 successive months or more without a need for a full resuscitation code;
- Three TCAB pilot units have gone 6 successive months without patients having moderate or severe harm resulting from falls;
- Average turnover rates for registered nurses on the TCAB pilots units at all TCAB sites dropped from 5.8 percent in 2003 to 3.4 percent in 2006 (58 percent decrease);
- The percentage of time registered nurses spent in direct patient care at TCAB hospitals increased from approximately 40 percent in 2004 to greater than 50 percent in 2006;
- Improved patient satisfaction with nursing care and with all care;
- Increased percentage of licensed nurse time in direct patient care;
- More self-accountability tools for patients to take control of their own health; and,
- More interdisciplinary focus on care planning.

TCAB projects were funded by the Robert Wood Johnson Foundation. The work was initiated by the Institute for Health care Improvement and involved 13 U.S. hospitals, including the Tampa VA Medical Center (VAMC). The project has been expanded by the American Organization of Nurse Executives to work with 68 hospitals nationwide, including Central Arkansas Veterans Health Care System, Greater Los Angeles Health care System, San Francisco VAMC and Zablocki VAMC in Milwaukee.

VA facilities have accomplished ward renovation projects to ensure patient satisfaction. Doors, floors, and ceilings have been replaced as a result of environment of care inspections. Complaints from staff and patients about parking are being addressed at some facilities by leasing additional parking or initiating parking garage projects.

Other strategies for workplace improvement include ongoing supervisory, managerial, and executive training; educational and mentoring programs for staff throughout the system, and initiatives to improve workplace culture.

VHA managers and employees formulate action plans based on information gathered in the annual Patient Survey and the All Employee Survey. This analysis is a proactive approach to improve worker and patient quality-of-life at facility and work unit level.

These projects provide an excellent opportunity for nurses within VA to redesign care processes emphasizing nurse empowerment and process improvement. Information and lessons from these projects can improve the process and outcomes of delivering care for veterans.

Question 9. VA has the authority to assign a range of personnel to alternative work schedules. Alternative work schedules have been demonstrated to improve employee satisfaction. How does VA use these schedules to improve recruitment, retention, and employee satisfaction?

Response. VA encourages facility managers to use alternate work schedules for all eligible employees whenever feasible. This includes compressed and flexible work schedules as well as alternate work schedules that pertain only to registered nurses. As authorized by Pub. L. 108–445, the use of the 36/40 work schedule and the 9-month/3-month work schedule are available for registered nurses when managers determine that such schedules are needed to be competitive in the local markets.

The use of alternate work schedules increases VA's visibility as the employer of choice.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO MS. PALKUTI, MR. KLEINGLASS AND MS. CULLEN

ALTERNATIVE WORK SCHEDULE

Question. Can you all please explain why the VA is not using Alternative Work Schedules more often?

Response from Ms. Palkuti on behalf of all. VA encourages facility managers to use alternate work schedules for all eligible employees whenever feasible. However, this legislation is discretionary; the law provides the direction for establishing alternate work schedules. Facilities are not mandated to use the alternate work schedules. There are multiple types of alternate work schedules and many VA facilities use at least one option of alternate work schedules for nursing staff in order to provide attractive and competitive work hours and, to meet staffing requirements. Individual facilities may choose to offer the alternate work schedules if they believe these schedules would benefit their posture of retaining well-qualified staff as an employer of choice.

Alternate work schedules can be an expensive alternative to staffing challenges, and is implemented judicially as appropriate in a particular competitive marketplace.

Challenges in payroll, timekeeping, and tracking are being addressed through modification of the time and attendance tracking software. The Office of Human Resources Management, Work Life and Benefits Service are currently researching and considering solutions that can be implemented to address these systems issues.

Chairman AKAKA. Thank you very much, Ms. Palkuti.

Ms. Cullen?

STATEMENT OF SHEILA M. CULLEN, DIRECTOR, SAN FRANCISCO VA MEDICAL CENTER

Ms. CULLEN. Mr. Chairman, Mr. Tester, thank you for the invitation to appear before you today to discuss recruitment and retention challenges faced by the San Francisco VA Medical Center. I appreciate the opportunity to discuss our ongoing efforts to recruit some of the finest employees in the VA system and the challenges we face to retain those employees in one of the most expensive areas of the country.

The San Francisco VA Medical Center has an outstanding workforce of more than 1,900 dedicated staff. We are proud that our medical center has had consistently high patient and employee satisfaction scores. In a recent inpatient satisfaction survey, we scored better than the national average in several areas, including the categories of courtesy exhibited by doctors, confidence and trust patients have with their doctor, and the dignity and respect given to patients during their stay.

In the recently conducted all-employee survey, nearly 76 percent of our employees responded and our scores were better than the VHA national average in all areas except for categories related to pay. Last year, our nurses participated in the National R.N. Satisfaction Survey and we rated in the top ten nationally for highest employee satisfaction scores.

We believe employee satisfaction and dedication to the mission of serving veterans leads directly to good patient care. To ensure that we maintain a highly talented and motivated workforce, we have implemented several programs to aid in our retention and recruitment efforts. We have a very successful grow-our-own program for specialized occupations, such as surgical technicians, nuclear medi-

cine technologists, and diagnostic radiology technicians. This program provides educational and career advancement opportunities for staff in specialized fields that are difficult to recruit and retain due to the competitive health care market.

We have a very successful program in place to hire new nurse graduates. Through this program, graduates are hired as temporary nurses without benefits. They are assigned a preceptor and they work 40 hours per week gaining experience in clinical areas. After a 12-week rotation, they can compete for permanent jobs. This program has an 88 percent retention rate. Our overall vacancy rate is 3.5 to 4.5 percent, with a turnover rate of just under 12 percent, and the primary reason for turnover at our medical center is attributed to retirements.

Our success in physician recruitment and retention is directly credited to our strong affiliation with the University of California, San Francisco. In addition, our unique mission of providing health care to veterans as well as our excellent research and teaching programs play key roles. San Francisco does have the largest research program in the VA nationally. The physician pay bill has also clearly been instrumental in helping us to maintain our top-notch medical staff.

We believe much of our success is due to our efforts to provide a good work environment, which includes adequate support staff, educational opportunities, state-of-the-art equipment, and ongoing support of leadership.

Our recruitment and retention efforts are continually challenged as a result of the high cost of living and non-competitive salaries in the Bay area. According to the National Association of Realtors, the median home price in the nine-county Bay area is $720,000. That is three times as expensive as the national average, and that is greatly reduced from what it was last year and the year before that as a result of national declining real estate values.

We fully utilize the authority to offer recruitment and relocation bonuses. Last year, we paid out over $200,000 in recruitment bonuses, $129,000 for relocation bonuses, and over $1.8 million for retention pay.

In an effort to stay competitive, we use the special salary rate authority as much as possible. This has been somewhat successful for clinical support staff. Our medical center has 13.5 percent of our employees on special salary rates. Excluding nurses, the annual additional cost to our medical center budget is $5.7 million. We also have the highest geographical pay in the country, which includes a 33.5 percent locality pay adjustment for those on the General Schedule.

In order to keep our retention rates above the 80th percentile, we have attempted to keep pace with community hospitals by approving salary increases for our registered nurses, which have ranged from five to 8 percent annually. The 2008 annual salary increases for all professional nurses was nearly $3 million.

Another emerging pay situation is with our Certified Registered Nurse Anesthetists, or CRNAs, who are compensated under the Nurse Locality Pay System. Our CRNA pay schedule has reached the statutory pay limit, so staff can only receive the mandated annual cost-of-living increase. What this means is that we cannot

offer a salary any higher than the statutory limit of $139,600, even though our local labor market shows that salaries for a CRNA is at a median salary of over $170,000. If we are unable to recruit or retain CRNAs, we will be forced to use expensive contracts whose annual rate would be approximately $300,000.

VA has many effective training programs that serve to support our recruitment efforts and have proven their efficacy. We are currently exploring possibilities for expanding these programs to other professional areas.

In summary, the San Francisco VA Medical Center has made great efforts to recruit and retain qualified personnel through our innovative training programs, financial incentives, and commitment to the advancement in growth of our staff. We are committed to facing the challenges of the future and will continue to look for innovative ways to enhance our workforce.

Mr. Chairman, this concludes my statement. I have a slightly longer statement that was submitted for the record and I am pleased to answer any questions that you may have.

[The prepared statement of Ms. Cullen follows:]

PREPARED STATEMENT OF SHEILA M. CULLEN, MEDICAL CENTER DIRECTOR, SAN FRANCISCO VA MEDICAL CENTER

Mr. Chairman and Members of the Committee, thank you for the invitation to appear before you today to discuss recruitment and retention challenges faced by the San Francisco VA Medical Center. I appreciate the opportunity to discuss our ongoing efforts to recruit some of the finest employees in the VA system and the challenges we face to retain these employees in one of the most expensive cities in the country.

The San Francisco VA Medical Center provides a full range of primary and tertiary health care services. We are proud to have five National Centers of Excellence, as well as the largest funded research program in VA.

Our Medical Center has had consistently high patient satisfaction scores. In our recent VA Office of the Inspector General (OIG) Combined Assessment Program Review, we were very proud that the patient interviews documented an impressive level of patient satisfaction with care at our facility. In our recent inpatient satisfaction survey, we scored better then the national average in several areas including the categories of "courtesy exhibited by doctors," "confidence and trust patients have with their doctor," and the "dignity and respect given to patients during their stay."

We have also had consistently high employee satisfaction scores. In the recently conducted VHA All Employee Survey, nearly 76 percent of our employees responded to the survey and our scores were better than the VHA national average in all areas except for categories related to pay. In fiscal year 2007, our nurses participated in a national nurse satisfaction survey. Our Medical Center rated in the top ten nationally for highest employee satisfaction scores. Our nurses also had the highest scores for our Network, VISN 21, in quality of care and overall job satisfaction. These high levels of satisfaction are noteworthy given our high cost of living and the challenges we face with recruitment and retention. We believe employee satisfaction and dedication to the mission of serving veterans directly leads to good patient care.

ACCOMPLISHMENTS

In our ongoing efforts to ensure that we maintain a highly talented and motivated workforce, we have implemented several programs to aid in our retention efforts, as well as assist us in meeting the mission and organizational needs of the Medical Center. Our upward mobility program provides employees with an opportunity to obtain career positions through on-the-job and formal training.

We have a very successful "Grow Our Own" program for specialized occupations such as surgical technicians, nuclear medicine technologists, and diagnostic radiology technicians. This program provides educational and career advancement opportunities for staff in specialized fields that are difficult to recruit and retain due to the competitive health care market. Without these efforts, we would have to rely on costly registry or contract staff to fill these vacancies.

We have a very successful program in place to hire new nurse graduates. Through this program, graduates are hired as temporary nurses without benefits. They are assigned a preceptor and work 40 hours per week gaining experience in clinical areas. After they complete a 12-week rotation, they have the opportunity to compete for permanent jobs. This program has an 88 percent retention rate. Our overall vacancy rate for nurses is 3.5–4.5 percent with a turnover rate of 11.95 percent. VA's national turnover rate is 10.55 percent, so we consider this is be excellent, in spite of the high cost of living in our area. The primary reason for turnover is attributed to retirements.

Our success in physician recruitment and retention can be credited to our strong affiliation with the University of California San Francisco. In addition, our unique mission of providing health care to veterans, as well as our excellent research and teaching programs, play key roles. The physician pay bill has also been instrumental in helping us to maintain our top notch medical staff.

We believe much of our success is due to our efforts to provide a good work environment, which includes adequate support staff, educational opportunities, state-of-the-art equipment and ongoing support of leadership.

CHALLENGES

While we have been successful in developing effective and innovative programs to supplement our recruitment and retention efforts, we are continually challenged as a result of the high cost of living and non-competitive salaries in the Bay Area—specifically, we note that Federal salaries across the board in the Bay Area are often not competitive with local providers. According to the National Association of Realtors, the median home price in the 9-county Bay Area is $720,000—three times as expensive as the national average. The median home price in San Francisco has increased by nearly 96 percent since the early 1990's. We fully utilize the authority to offer recruitment and relocation bonuses. Last year we paid out over $200,000 in recruitment bonuses, $129,000 for relocation bonuses and over $1.8 million for retention pay.

A large percentage of employees in many services are approaching retirement age, while other services have a relatively young staff. Both present unique challenges either in recruiting qualified replacements for highly skilled retiring employees or retaining younger staff in highly specialized areas in a very competitive job market. Currently, more than 29 percent of our employees are eligible to retire.

In an effort to stay competitive we use the special salary rate authority, as much as possible. This has been somewhat successful for clinical support staff. Our Medical Center has 13.5 percent of our employees on special salary rates. Excluding nurses, the annual additional cost to our Medical Center budget is $5.7 million. This is on top of the fact that we already have the highest geographical pay in the country which includes a 32.53 percent locality pay adjustment. In order to keep our retention rates above the 80th percentile, we have approved salary increases for our Registered Nurses which have ranged from 5–8 percent annually. The 2008 annual salary increase for all professional nursing categories was nearly $3 million.

Another challenge is the limitation in developing special salary charts for difficult-to-fill occupations. Current law only allows the General Schedule salary chart to be extended out an additional 18 steps. In our high cost economy we have reached our maximum effectiveness with many of our GS direct patient care occupations. Due to the 18-step limitation, our special salary charts for these occupations has become severely compressed. Since most of these employees are hired in difficult to recruit clinical specialties, their salary is often set at the higher end of the pay range. This limits their opportunities for future step increases.

Another emerging pay situation is with our Certified Registered Nurse Anesthetists (CRNA), who are compensated under the Nurse Locality Pay System. Our CRNA pay schedule has reached the statutory pay limit, so staff can only receive the mandated annual cost of living increase. What this means is that we cannot offer a salary any higher than the statutory limit of $139,600 even though our local labor market shows that salaries for a CRNA is at a median salary of $171,334. Therefore, we have had to maximize the 25 percent retention incentive for this occupation.

VA has many effective training programs that serve to support our recruitment efforts and have proven their efficacy. We are currently exploring possibilities for expanding these programs to other professional areas.

The recent mental health initiative has given us the opportunity to increase our mental health capacity. However, since so many facilities nationwide are competing for limited numbers of psychiatrists and psychologists it has been a challenge to fill

all of our positions, particularly in rural areas. In addition, recruitment of primary care providers in rural areas proves to be increasingly difficult.

In summary, the San Francisco VA Medical Center has made great efforts to recruit and retain qualified personnel through our innovative training programs, financial incentives, and commitment to the advancement and growth of our staff. As our work force ages, the recruitment and retention of highly qualified employees will be even more important and our challenges greater. We are committed to facing these challenges head on and will continue to look for new and innovative ways to maintain and enhance our workforce.

Mr. Chairman, this concludes my statement. I am pleased to answer any questions you or the Committee members may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO SHEILA M. CULLEN, MEDICAL CENTER DIRECTOR, SAN FRANCISCO VA MEDICAL CENTER; AND STEVEN P. KLEINGLASS, FACHE, DIRECTOR, VETERANS AFFAIRS MEDICAL CENTER, MINNEAPOLIS, MINNESOTA

Question 1. How many nurses under your direction work an alternative work schedule, and how do you use these schedules to improve recruitment, retention, and employee satisfaction?

Response. At the Minneapolis VAMC there are approximately 424 registered nurses, 79 licensed practical nurses, 46 nurse assistants and 54 health technicians on compressed or non-traditional tours of duty. Alternative work schedules improve recruitment, retention and employee satisfaction. Allowing staff the option to choose non-traditional tours of duty hours gives them the chance to find balance between their work and home lives as they feel best suits their individual needs. Many nurses go to compressed tours to attend school for advanced educational purposes.

In general, alternative schedules are used for staff who work on non-traditional tour hours, 9, 10 or 12 hour tours.

There are 100 San Francisco VAMC staff nurses who work under an alternate work schedule/compressed work tour. In the past year, we have seen considerable improvement in our vacancy rates, particularly in the critical care units, because we offer these alternative tours of duty.

Vacancy Rates	10/1/2007	4/7/2008
Intensive care unit	6.4 percent	3.4 percent
Transitional care unit	8.1 percent	1.0 percent
Hemodialysis unit	14.5 percent	1.2 percent

We have assessed through our new graduate nurse training program that most new hires are highly interested in an alternative work schedule. In addition, critical care unit staff have taken an interest in expanding their nursing leadership roles, including furthering their education. Alternative work schedules are effective in allowing staff this opportunity. We believe that offering an alternative work schedule improves recruitment, retention and employee satisfaction.

Question 2. Please detail each step you take in conducting locality pay surveys.

Response. The local process at the VAMC Minneapolis starts with the establishment of a Committee with representatives from:

Management (deputy nurse executive)
Technical advisor (human resources specialist)
Subject matter experts such as:
  Registered nurse
  Nurse practitioner
  Certified registered nurse anesthetist (CRNA)
  Operative room registered nurse (ORRN)

A survey team that consists of registered nurses, labor representatives, and a technical advisor is formed to collect salary databased on matching job duties with like positions in the private sector. The teams identify local labor market areas and medical facilities to contact that are similar to the VAMC. The team sends out letters to private sector agencies requesting their participation then schedules a time for interview at their location. The team requests information on minimum, midpoint and maximum rates actually paid in a given job category. Copies of job descriptions are requested to ensure job matches and numbers of employees are the

same. Once this process is complete, a statistical analysis of this data is done to create a summary of the results.

The human resources officer and human resources technical advisor present options to the medical center director, nurse executive, fiscal officer and chief nurse anesthetist for review and discussion. After discussion, the medical center director approves pay scales and the information is then sent to VA Central Office for final review, approval, and input into the paid system.

Over the past years the medical center has consistently provided an equitable pay increase to the nursing staff based on the data from the locality pay survey.

The San Francisco VAMC partners with the Allied for Health Survey Program to conduct the annual locality pay surveys. Once the survey results are received, we use this information to set the beginning rate for each grade. In choosing the beginning rate of pay, we consider the geographic relationship of our facility to major establishments in the survey area, the severity of recruitment or retention problems, local non-VA employee benefit packages, and other factors, which affect our ability to recruit and retain nurses. Normally, we set the beginning rate for each grade at, or within 5 percent of, the average beginning rate for comparable non-VA positions in the survey area. By law, we cannot set a beginning rate above the highest beginning rate in the community for corresponding positions. In order to keep our retention rates above the 80th percentile, we have attempted to keep pace with community hospitals by approving salary increases for our registered nurses, which have ranged from 5–8 percent annually.

Question 3. Emergency situations in hospitals often create staffing challenges. Under what emergency circumstances are nurses required to work mandatory overtime?

Response. Since our nursing staff at the Minneapolis VAMC is required to be on duty 24 hours per day, 7 days a week, there are infrequent times when mandated overtime is needed to satisfy patient care demands. It is medical center policy to avoid the use of mandates. If there is a mandated situation, the medical center director is informed of the reason for its occurrence. Some instances in which nurses are required to work mandatory overtime are to cover unplanned leave, sick leave, emergency annual leave, absenteeism, and tardiness for duty by nursing staff.

Patient's safety and staffing levels at the San Francisco VAMC would mandate an emergency situation. In the last 3 years, the San Francisco VA Medical Center has implemented a mandatory overtime on ONE occasion, and it was with the concurrence of the local bargaining union.

Chairman AKAKA. And I repeat that your full statements will be included in the record.

Mr. Kleinglass?

STATEMENT OF STEVEN P. KLEINGLASS, DIRECTOR, MINNEAPOLIS VA MEDICAL CENTER

Mr. KLEINGLASS. Thanks. Mr. Chairman and Mr. Tester, thank you for the invitation to appear before you today to present testimony on recruitment and retention issues at the Minneapolis VA Medical Center. I am honored to be here today to share some thoughts with you on these important issues.

In the greater Twin Cities geographic area, there are numerous highly respected health care systems, hospitals, outpatient clinics, nursing facilities, and pharmaceutical branches that the Minneapolis VA competes with for the health care worker. In the March 20 Sunday edition of the local newspaper, the jobs section had four pages seeking applicants for health care careers and all claimed that they were exceptional places to be employed. So, from the very start, we are competing for a limited number of applicants in a highly competitive environment.

In addition, while pay is not the only driving factor, we are in an area where our locality pay is higher than it is in Washington, DC.

I would like to share with you some of our successes regarding recruitment and retention and how they have impacted our ability to maintain some of our stability within our organization.

Without reservation, the physician and dentist pay legislation is a major factor in our ability to attract providers in our competitive area. Unlike most highly affiliated teaching and research VA medical centers, we at Minneapolis employ more than 160 full-time physicians and dentists. We are able to do this because we have taken full advantage of the pay legislation. While we still struggle to employ physicians in the highly competitive sub-specialty categories, we contract with our local affiliate for these providers.

In the nursing profession, we have taken several proactive measures to both attract and retain these highly-valued employees. Each year, we do a nurse locality pay survey and make necessary adjustments to nurse pay to stay competitive with our community. During fiscal year 2007, 19 registered nurse hires were former student nurse technicians from within our own facility. Also, we use finders fees and other programs and attend various health fairs throughout the State to attract individuals.

In the pharmacy profession, we see keen competition for both pharmacists and pharmacy technicians and the private sector recruitment bonuses and starting salaries are highly attractive to new graduates. Our competitive edge has been starting these individuals above the minimum salary rates. We then involve these individuals on the treatment team so they work directly with physicians in prescribing appropriate drugs for better patient outcomes. In addition, since we believe we operate the largest single pharmacy in the State of Minnesota with more than 5,000 outpatient prescriptions being processed daily through our pharmacy, the volume, pace, and work affords our staff an exciting work environment.

In the areas of other patient care support personnel, such as diagnostic radiology technicians, medical record coders, medical supply technicians, physical therapists, and Certified Registered Nurse Anesthetists, there are numbers of issues that we face both in recruitment and retention. Again, while pay is an issue, the competition for these scarce employees is highly competitive and our community has been willing to offer some very interesting perks to both entice new grads and our current employees. Some of our recruitment successes in these areas have come from our having an onsite radiology technician and CRNA school within the medical center, and this gives us a pool to be able to recruit new graduates to work within our facility.

Let me share some other approaches in general that we have taken at the Minneapolis VA Medical Center in an effort to maintain our workforce. As part of our annual budget process, we have focused on identifying several departments where succession planning would be a benefit for the medical center and then we provide appropriate resources to these departments. As a medical center, we strive to be an employer of choice and we have done several things to reinforce this including the following.

Between fiscal year 2006 and 2007, we have increased the number of employees who receive performance awards by 750. We have two major all-employee recognition functions each year to recognize

and thank our employees for the work they do. We promote wellness in many ways and have a fitness center that is available to our employees at no cost. We have an onsite day care center where many of our employees' children receive their day care each day, and employees can venture there during their lunch hour to be with their children. We have a farmers' market on site in the summer where employees and our patients can buy produce. Finally, we believe that employee engagement is a key to morale and retention. To this end, we have annual employee forums, regular lunch-and-learn sessions with leaders, and ongoing communications with our staff through a daily e-mail message, a monthly newsletter, and walk-arounds from the executive team as they dialog with employees.

In closing, while we do have issues with employee recruitment and retention, I am pleased to report that during fiscal year 2007 our overall employee turnover rate was less than 10 percent. This is amongst the lowest when compared with other similar VA medical centers in our system and lower than a recent health care entity that was a Malcolm Baldridge award winner.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions that you or Mr. Tester may have.

[The prepared statement of Mr. Kleinglass follows:]

PREPARED STATEMENT OF STEVEN P. KLEINGLASS, FACHE, DIRECTOR, VETERANS AFFAIRS MEDICAL CENTER, MINNEAPOLIS, MINNESOTA

Mr. Chairman and Members of the Committee. Thank you for the invitation to appear before you today to present testimony on recruitment and retention efforts at the Minneapolis, Minnesota VA Medical Center. I am honored to be here today and to share with you some thoughts on these important issues.

In the greater Twin Cities geographical area there are numerous highly respected health care systems, hospitals, outpatient clinics, nursing facilities and pharmaceutical branches that the Minneapolis VA competes with for the health care worker. In the March 30th Sunday edition of the local newspaper the "Jobs" section had four pages seeking applicants for health care careers and all claimed that they were exceptional places to be employed. So, from the very start, we are competing for a limited number of applicants in a highly competitive environment. In addition, while pay is not the driving factor, we are in an area where our locality pay is higher than it is in Washington, DC.

I would like to share some of our successes related to recruitment and retention and how they have impacted our ability to maintain some stability within our workforce.

• Without reservation the physician and dentist pay legislation is a major factor in our ability to attract providers in our competitive area with few exceptions. Unlike most highly affiliated, teaching and research VA medical centers, we employ more than 160 full-time physicians and dentists. We are able to do this because we have taken full advantage of the pay legislation. We still struggle to employ physicians in the highly competitive sub-specialty categories and so we contract for those services with our affiliated medical school.

• In the nursing profession we have taken several proactive measures to both attract and retain these highly valued employees. Each year we do a nurse locality pay survey, and make necessary adjustments to nurse pay, to stay competitive within our community. During fiscal year 2007, 19 Registered Nurse hires were former student nurse technicians from our facility. Also, we use a finder's fee program and attend various recruitment fairs.

• In the pharmacy profession we see keen competition for both pharmacists and pharmacy technicians and the private sector recruitment bonuses and starting salary rates are highly attractive to new graduates who are impressionable. Our competitive edge has been starting these individuals above the minimum salary rates. We then involve these skilled individuals on the treatment teams so that they work directly with physicians in prescribing appropriate drugs for better patient outcomes. In addition, since we believe we operate the largest single pharmacy in the

State of Minnesota with more than 5000 outpatient prescriptions being processed daily through our pharmacy the volume and pace of work affords our staff an exciting work environment.

- In the areas of other patient care support personnel such as diagnostic radiology technicians, medical record coders, medical supply technicians, physical therapists and certified registered nurse anesthetists (CRNA) there are a number of issues that we face in both recruitment and retention. Again, while pay is an issue, the competition for these scarce employees is highly competitive and our community has been willing to offer some very interesting "perks" to entice both new grads and our current employees. Some of our recruitment successes in these areas have come from having a radiology technician and CRNA school on-site which provides a pool of new graduates to recruit from every year.

Let me share with you some approaches in general we have taken at the Minneapolis VAMC toward maintaining a workforce that meets our needs.

- As part of our annual budget process we have focused on identifying several departments where succession planning would be a benefit to the Medical Center and we then provide the appropriate resources.
- As a Medical Center we strive to be an employer of choice and we have done several things to reinforce this including:
  - Between fiscal year 2006 and fiscal year 2007, we increased the number of employees who received performance awards by 750.
  - We have two major all-employee recognition functions.
  - We promote wellness in many ways and have a fitness center available to employees without cost.
  - We have an on-site daycare center where many employees' children receive daycare.
  - We have an on-site farmers market during the summer months.
  - Finally, we believe that "employee engagement" is a key to morale and retention. To this end, we have annual employee forums, regular "lunch and learn" sessions with leaders and ongoing communications with our staff through a daily e-mail, a monthly newsletter and "walk-a-rounds" through the medical center by the Executive Team.

In closing, while we do have issues with employee recruitment and retention, I am pleased to report that during fiscal year 2007 our overall employee turnover rate was less than 10 percent. This level is amongst the lowest when compared with other similar VA medical centers and lower than a recent health care entity that was a Malcolm Baldridge winner.

Mr. Chairman, that concludes my statement. Thank you for allowing me to provide these comments and I would be pleased to respond to any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO STEVEN P. KLEINGLASS, FACHE, DIRECTOR, VETERANS AFFAIRS MEDICAL CENTER, MINNEAPOLIS, MINNESOTA

RETENTION BONUS ISSUES

Question 1. Mr. Kleinglass, you mentioned during the hearing that there are problems associated with the use of retention bonuses. Can you please expand on what you mean by that statement?

Response. A recent request to provide retention bonuses across the board to a particular group of nursing staff was not approved. A review of the request found that approving this request would cause disparity among other employees. At the Minneapolis VAMC, our government pay scale falls behind the medical community as a whole, therefore, in theory, we should have most of our employees on a retention bonus. The Minneapolis VAMC has allowed bonuses in a limited fashion and mainly for recruitment purposes with time pay back provisions. The Minneapolis VAMC does have some retention bonuses in place, which are reviewed annually and adjusted appropriately. In an effort to deal with the pay and retention issues for the certified registered nurse anesthetist (CRNA) staff, the Director has requested a site visit by the Chief, Anesthesia and CRNA services within VHA. This site visit is scheduled for June 10, 2008. During this consultative visit pay, performance, scheduling and other associated issues related to CRNA staff will be addressed.

Chairman AKAKA. Thank you very much, Mr. Kleinglass.

Ms. Palkuti, thank you for your statement. You laid out everything that your office is doing and I must tell you it is impressive.

Ms. PALKUTI. Thank you.

Chairman AKAKA. But my simple question to you is, even with that impressive service that you provide, is that enough? Are there some other things that you can suggest?

Ms. PALKUTI. What we do at the central level is to try to help support the local facilities and their individual recruitment needs and implementing the legislation as fully as we can. We realize that continuing to work with individual facilities to help them improve their recruitment planning, to help them improve how they use the scholarships or strategize how they can better use education debt reduction programs is part of our mission and something that we work on consistently. We are a very large system and so we are consistently working in that endeavor.

I think the work that we are doing in expanding our clinical programs and our training programs in psychology, what we are doing with the expansion of the nursing academy, will probably be the strongest direction that we go in in terms of helping not only VA in the future, but communities, as well. We do very closely monitor student satisfaction with their clinical assignments and find that that is a very strong area that helps improve our performance. This year, we are going to be taking additional efforts to focus more intently, both my office and the Office of Academic Affiliations and others, on improving our recruitment from our student corps.

Chairman AKAKA. Ms. Cullen, I would note that nurses at your facilities have told us that they really believe you are using all of the authorities bestowed upon you to ensure that their pay is fair. You mentioned all the good things you have done and did admit that pay was one of the areas that you are looking at. My question to you is, knowing that your area is a high cost-of-living area, what would you tell other directors about how to achieve a similar level of success?

Ms. CULLEN. Thank you, Mr. Chairman. It is all about creating a positive work environment, and I think that that is reflected in the results of the all-employee survey, not only at the San Francisco VA Medical Center, but actually throughout VISN 21, and that is under Dr. Wiebe's leadership. All of the facilities in Northern California, Hawaii, and Northern Nevada have consistently expressed satisfaction at levels higher than the national average.

The strong commitment to veteran patient care and world-class research are a key at San Francisco. The quality of staff who come and stay do that because of the strong demonstrated support for those dual missions. I believe that even non-academicians, nurses included, are positively affected and influenced by that high level of research and academic pride.

We have a viable partnership with our professional union, the NFFE IAM Local 1 and President Patricia La Sala, who is also a registered nurse and who keeps me on my toes and makes sure I utilize every possible authority that can benefit our nursing staff. We have a transparent and cooperative relationship committed to the goals of the organization.

The positive press for VHA and the confidence that VHA employees have that they work for one of the most successful health care systems in the world absolutely helps recruitment and retention.

We certainly try to publicize the positive media acclaim that VA has received wherever possible in employee forums.

Of course, maintaining our success requires supportive budgets, not to mention market-level health care clinical and administrative salaries. I referenced earlier in my testimony that we are absolutely bound to provide our staff with state-of-the-art equipment, adequate support staff, educational opportunities, and ongoing support of leadership.

Chairman AKAKA. Going back to pay, do you feel that in those high cost-of-living areas the pay is fair in your region?

Ms. CULLEN. Well, I feel that we maximally utilize the authorities that we have available to us. I feel that a much broader issue, which is the OPM-set salaries, are woefully inadequate for administrative staff. I think that goes beyond—it is an issue beyond VA—however, despite the 33 and one-half percent geographic COLA. We are able to keep pace with our competitive institutions through special salary rates, and while we are not allowed to be the pay leader, we are allowed to catch up to pay in the surrounding area, and we take advantage of that with annual adjustments for all of our professions that have special salary rates.

Chairman AKAKA. Thank you. Mr. Kleinglass, we will hear from GAO in a bit about how difficult it is to recruit and retain nurse anesthetists. Have you used the retention bonuses for these professionals, and have you used them for temporary hires to fill vacant spots?

Mr. KLEINGLASS. Mr. Chairman, as you state, it is difficult to recruit these individuals. We have not used retention bonuses in this field for our current employees because I believe there are some overall issues with doing that, and I can elaborate on that if you would like me to. When we do recruit new hires, we do use that authority, and just recently I did sign some recruitment bonuses for some new hires. We have on occasion used some locum tenens in this area to be able to maintain the level of staffing that we need for these individuals.

Chairman AKAKA. Thank you. Let me at this time call on Senator Burr for his questions, and that will be followed by Senator Tester.

Senator BURR. Mr. Chairman, I will be very brief. I have only one question and it is to some degree off topic. I want to take the opportunity to ask Ms. Palkuti, Federal Recovery Coordinators were recently put in place to assist severely injured servicemembers and their families in navigating confusing layers of support that exist from rehabilitation and recovery case managers. It took several months to hire eight. One has died. One has quit. How long would it take to fill the vacancies so that we get what I think most Members on this Committee agree is an absolute necessity, and that is these Recovery Coordinators, in place?

Ms. PALKUTI. I am not personally involved with that particular process, with that particular occupation, so I didn't realize that it had—one had passed and one had not. But the general process of recruiting for that occupation would require announcing the position for whatever period of time and then interviewing to find the best candidate. It could take as short a period of time as 30 days. I would be more than happy to take that question for the record

and find out precisely what is going rather than offering you just a theoretical time line.

Senator BURR. I will save you the responsibility, but we will follow through with the VA.

I just want to encourage all of you. There is a system in place. You could tell me better than I could tell you whether the system works as prescribed. It has been very frustrating to me as to how long it is taking to get these Recovery Coordinators in place. Now, if we have a process in place that is cumbersome and duplicative and does not allow us to aggressively go out and surge to an area that there is total agreement we need to do—and this is in the best interest of our veterans coming back—then tell us to change this; and we, collectively, I think, can get our heads together and figure out whether we can provide some legislative remedy to it, or, at least we will review it to determine whether it needs to stay in place.

But, I would say this to all three of you, just because things are in statute certain ways, if they don't work, for God's sake, tell us so that we can change them, so that we can facilitate what it is you need in the positions that you hold to make sure that recruitment and retention are much easier. I think there is a tendency, Mr. Chairman, and I believe it is probably very appropriate, that the pay challenges are probably the number one thing. But if it was pay alone, then I think we would be looking at a different universe of health care professionals within VA.

There is more to it, and I really want you to reach in and share with the Committee at some point those things that really do make a difference in us being able to develop that delivery system that reflects what the private sector does for the 21st century. I dare say I am not sure that there is a private sector entity that goes very long with a space unfilled because that is a service they can't deliver, and it is hard for me to believe how the best health care system in the world with the most vulnerable population could go for so long with positions unfilled. Because the net result to me is somebody is not serviced to the degree that the commitment was made. We are here to try to facilitate that and I encourage you.

I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Tester?

Senator TESTER. Thank you, Mr. Chairman. I want to thank the participants on this panel very much for the work you do. I appreciate the pride that is exhibited by all of you in your specific institutions, or medical facilities, I should say; and I want to thank you for the work that you do. I think that it is very important.

A couple of things. Again, it spins off of what Senator Burr said about more to it than pay and things that make a difference, and I think that the San Francisco VA Center and Minneapolis VA Center did talk about some things—the fitness center, the day care, the farmers' market on site. I applaud that. Those kind of things are important, but then also from a professional standpoint, Ms. Cullen, you talked about a nurse rotation of 12 weeks. Eighty-eight percent of the folks who went through that program that you hired stay on, 88 percent of the time——

Ms. CULLEN. That is correct. Those were new hires, new nursing graduates.

Senator TESTER. How long has that been in place?

Ms. CULLEN. Over the last 2 years.

Senator TESTER. Good.

Ms. CULLEN. We are in our second year.

Senator TESTER. And then, I think, if I recall, you both talked about the physician pay bill and how that was important to your success.

I don't know if you know this because you work in a pretty urban setting, especially if you compare it to a place like Montana—I don't know if any of you have been to Montana——

[Nodding heads.]

Senator TESTER. That is good. You have all been there. Good. Come back again. But it is a very rural State and your boss, Secretary Peake, was out a few months ago and got a sense of it. But some of the issues that bother me about what is going on right now for veteran health care is the fact that veterans who live in rural areas don't live as long, and I don't think it is because the air is dirty or the water is dirty or we get worse food there. I really do think it revolves around health care. And it is not the VA's exclusive problem. I mean, every small hospital in the State of Montana, every big hospital in the State of Montana, has a hard time recruiting and keeping people for a number of reasons.

But, one of the things that I think works pretty darn well is that if you can have people do their intern programs in a VA hospital or in a rural part of America if you are trying to recruit, it really does work. So, the question I have for you, Ms. Palkuti, is the bigger places have it. I mean, there are, what, 100,000 health care professionals that you train at VA facilities every year, and you need to be applauded for that.

Ms. PALKUTI. Thank you.

Senator TESTER. How many of those are in rural areas? How many are trained in rural areas to really meet the needs of veterans living in rural America? And if it is zero, that is fine. We can fix it.

Ms. PALKUTI. You know, personally, I don't have that number for you at this point in time. I know that a number of places—there was someone I was speaking to in Arizona, actually, and they were designing part of their clinical process so that they would have that particular set of residents rotate through their more remote outpatient clinics. It is becoming something that was actually a popular rotation among clinicians in that area. So, they are looking at getting people out to some of those CBOCs that are further out in the country.

Senator TESTER. Good. My daughter happens to be a registered nurse. She graduated from college—a 4-year program in 2002, I believe—and she did do part of her—I forget what the term is, but part of——

Ms. PALKUTI. Clinical rotation?

Senator TESTER. That is it—in a VA hospital in Helena, Montana, and she liked it a lot. I guess I am wondering, does the VA aggressively approach—there are a lot of nursing schools in Montana.

Ms. PALKUTI. Right.

Senator TESTER. Do they aggressively approach these folks to do their—it is not internship, but you know what I mean——

Ms. PALKUTI. Rotation.

Senator TESTER. Yes, rotation—there?

Ms. PALKUTI. VA has academic affiliations with numerous nursing schools around the country and encourages people to do academic rotations. I think, through the project that we have right now with the expanding in the VA nursing academy and because of all the learner surveys that we do with all of the clinicians who come through our organizations, we realize that in-place rotation at a VA facility is critical to improving our chance of hiring those people afterwards.

Senator TESTER. So, what you are saying is they do reach out to the colleges and technical schools to——

Ms. PALKUTI. Yes.

Senator TESTER. Pretty aggressively, in your opinion? I mean——

Ms. PALKUTI. From my knowledge, yes.

Senator TESTER. OK. It needs to be very aggressive, I think, from my perspective. And you have got to know that my focus is on rural. We have got 930,000, 950,000 people in a State that is pretty good-sized, and so it is really important.

You talked about $24 million in recruitment bonuses and you had a figure of people that that impacted, and $34 million in retention bonuses. Can you give me any idea on how much of that money went to rural areas?

Ms. PALKUTI. I can go back and have the data run that way.

Senator TESTER. Could you, I mean, because the issue—could you just run it for Montana? I am not going to pick up the sheet and say, gosh, we are—I am not going to do that. I am just curious, because burn-out is a big problem amongst our professional folks and we have got some great people working in these clinics and these hospitals. I am not kidding you. They are incredibly committed to the health care system and to veterans throughout the State and I am incredibly impressed by them. But, they are burning out and so that is why I wonder, because I think that if there were some dollars for incentives, we could get them in. There might not be a lot of people there, but there is some pretty good fishing and hunting and hiking and those kinds of things.

Ms. PALKUTI. My brother went out there for the antelope.

Senator TESTER. There you go.

Ms. PALKUTI. And never went back to Kentucky.

Senator TESTER. Have him come to my house; I have too many.

At any rate, I wanted to ask—and you guys may or may not know this, Ms. Cullen and Mr. Kleinglass—if a person is sitting in a waiting room, are there limits of time that the doctor spends with a client; and what is that?

Mr. KLEINGLASS. Well, I would like to respond for you.

Senator TESTER. Sure.

Mr. KLEINGLASS. We do have standards that we look at to measure this and I often talk with patients in the morning as I come into the medical center and ask them. And what I am realizing now is that patients are getting upset with us because they are moving through the medical center so quickly, and that is a very

good thing. So, our waiting times now in our primary care areas and our non-specialty areas are really quite good. We have done a lot to help that by putting in more support staff so that our professional staff can have more time to do the professional things that they need to do.

We still have some longer waits in some of the sub-specialties. In our eye clinic, in particular in orthopedics, there are longer waits there and we see times that we don't like and our patients don't like.

Senator TESTER. There are actually two issues here and the first one deals with the time in the waiting room, which I applaud your efforts in minimizing that as much as possible. The other one applies to the amount of time that the person spends with the doctor in the examination room. Are there limits on that time?

Mr. KLEINGLASS. There are set appointment times, but I would hope and I feel fairly confident telling you that the physicians will spend whatever time is necessary if there is an issue with a patient, and that is going to complicate back-up.

Senator TESTER. Yes, exactly; and it will complicate the amount of time you spend in the waiting room. So, if your physicians were told that they needed to funnel these folks through, 15 minutes is the most they can spend with them, would you object vigorously to that? You can answer, too, Ms. Cullen.

Ms. CULLEN. Our appointments are for one-half hour for routine appointments, 1 hour for a first-time appointment in primary care. We do not schedule 15-minute appointments.

Senator TESTER. Good.

Ms. CULLEN. In some areas, there are 20-minute appointments, but no shorter than that.

Senator TESTER. Well, I think the problem is—because I have heard this in Montana—I think the problem is lack of staff. I think that they have to get them through because we have got more people that need help than we have staff to take care of them. I think that contributes, in a great part, to the burn-out. Because there is nothing more frustrating than coming to a Committee meeting and not being able to spend as much time as you want asking you folks questions; and compound that exponentially if you are a doctor or a nurse and you are trying to give health care that you were trained to give and you don't have enough time to give it.

So, I think you get my drift here. Like I said, it is not just VA in rural America, but we are really in crisis when it comes to health care. And I am on this Committee, and I think that we need to do our best to make sure we live up to our obligation to veterans, make no mistake about it.

I would love to work with all three of you individually to figure out ways we can address health care in rural/frontier America. I have got some ideas. I know you guys have more ideas than I have. We have just got to figure out—as Senator Burr said, it isn't all about money. I think a lot of it has to do about training. I think a lot of it has to do about telling folks the opportunities. I think a lot of it has to do about stuff like on-site day care and fitness centers and farmers' markets for availability. I mean, that is good stuff.

Go ahead.

Mr. KLEINGLASS. We will do anything that is innovative and creative to help manage this. These are small things that we do, but I think that when you measure these across, they mean a lot to employees.

Senator TESTER. Yes, in the end. I appreciate you guys' work, but I am telling you, we do have a problem in rural America. Because, number one, it is tough to get them, it is tough to keep them, and we are burning out the ones we are getting. So, it just compounds itself.

So, thank you.

Chairman AKAKA. Thank you, Senator Tester.

Mr. Kleinglass, I understand from my staff that you have been using Maxim Health Care Services to fill some of your vacancies. Why have you resorted to temporary staffing of VA with an outside entity? Have you not been able to recruit professionals through the normal channels?

Mr. KLEINGLASS. Mr. Chairman, I am not familiar with Maxim staffing. Is that an agency?

Chairman AKAKA. Health Care Services, yes.

Mr. KLEINGLASS. There are times where we do use temporary agencies to help supplement some of our staff. I personally don't think that is a bad thing. It gives us some flexibility in some areas where we flex up and flex down according to the needs of what is going on. So, it depends specifically in what area we are using those temporaries. We have used some temporaries in some of our Community-Based Outpatient Clinics because, quite honestly, it is a rural area, and as Senator Tester said, it is sometimes difficult to recruit staff for those areas. So, we do use temporaries—locum tenentes—in those areas.

Chairman AKAKA. Yes. Mr. Kleinglass and Ms. Cullen, could you both please tell us what types of physician specialties you still must contract for despite the success of physician pay reform, and please give us an example of the sub-specialty contract at your facility and how much you are currently paying them. Ms. Cullen?

Ms. CULLEN. We still have anesthesiologists on contract, neuroradiologists, and those are the only two that come to mind. Most of our physician staff are on staff. Neuroradiologists remain out of our price range and anesthesiologists are very difficult to recruit, and we have some salary concerns there, as well. But truly, our affiliation with UC San Francisco has been our strength for recruiting and retaining staff.

Chairman AKAKA. Mr. Kleinglass?

Mr. KLEINGLASS. Mr. Chairman, in our case, the physician and dentist pay bill has been an outstanding tool that we have and we have; used that pay bill to help us in lots of areas. We struggle in the areas of therapeutic radiology, diagnostic radiology, and cardiovascular surgeons, in particular. These sub-specialties are both in high demand in the community and command salaries that would exceed the limitations that we have.

Chairman AKAKA. Ms. Cullen, how much are you paying for your anesthesiologist contract, for example?

Ms. CULLEN. I don't have that dollar amount. I can certainly get you that, specifically. But, we are currently exceeding the amounts

that are identified for anesthesiologists. I will have to follow up and provide that.

[The response from Ms. Cullen follows:]

Response. The cost of an anesthesiologist on contract is $472,160 at VA Medical Center San Francisco.

Chairman AKAKA. My final question is to Mr. Kleinglass and Ms. Cullen. I am aware that some facilities give nurse managers and supervisors greater locality pay than other nurses versus increases for the staff nurses. Based on the results of the locality pay surveys, how do you assign locality pay and how do you justify higher locality pay for nurse managers and supervisors?

Ms. CULLEN. For our nurse managers, and particularly for our nurse managers on inpatient units, we have two additional steps of salary for that additional supervisory role. For the most part, our larger geographic salary is allocated to the nurses who work on inpatient units; and we find that we can adequately recruit nurses in outpatient settings. It remains difficult to recruit them for inpatient settings and for off-hour shifts, as well. So, they are on a higher salary range, not our nurse managers, but the nurses who work on inpatient units.

Chairman AKAKA. Mr. Kleinglass?

Mr. KLEINGLASS. Mr. Chairman, in fiscal year 2006, our annualized RN locality pay survey resulted in an $850,000 annualized cost. In fiscal year 2007, it was $1.1 million in annualized cost. We take the locality pay survey work extremely seriously. We put a lot of effort into doing that and we do want to match up as best we can, albeit staying below the community rates, and over the many, many years that I have been at Minneapolis, each year, we have provided a raise for these individuals.

We do provide some extra money to our nurse managers and we started that several years ago. We did that because of the demands on those individuals, our expectations of them, and the roles they play each day in managing patient care. So, they do get some extra money. It is not a lot, and I don't have the exact figures with me, but, in fact, they do get some extra money.

Chairman AKAKA. We are into our second round. Senator Tester, do you have any questions?

Senator TESTER. I do have just a couple of real quick ones. I talked about the medical professionals in the first round. I want to talk more about administrative folks, folks who answer the phone, folks who do the schedules. A little less pressure on the pool there, but I hear a lot of things about the length of time it takes to hire somebody to answer the phone. Is the bureaucracy that bulky? Do we need to do some things to change it? Tell me the process and why it should take a long time to hire somebody to——

Ms. PALKUTI. Well——

Senator TESTER. No, go ahead.

Ms. PALKUTI. The process, depending on which hiring authority you use, there is something called delegated examining, which is commonly used to bring in people in administrative positions because we don't have a direct hire authority for most of those occupations. And so we are delegated by OPM with the authority to hire and examine for those positions.

Starting actually last summer, we did a total evaluation of delegated hiring within the Veterans Health Administration and we had 19 units around the country. Effective October 1 of 2007, we have completely reorganized that function, centralized it under my office. We now have eight of the most high-performing centers that have now been totally automated and are performing the delegated examining function for the agency.

From the time that a complete package is received in those examining units until a certificate is delivered to an H.R. manager is—our March numbers showed that it was around 14 days. So, it depends on how long the position is open. If it is open for 2 weeks, then—but generally, within 7 days of the position closing, we actually do have the certificate back to the hiring manager. And we have been monitoring our numbers in that regard since the reorganization——

Senator TESTER. And do you track it after the certificate goes? Is there some tracking on that human resource person as to when they hire the person?

Ms. PALKUTI. Yes, we do. We track the process well beyond the date that we produce the certificate——

Senator TESTER. And there isn't a glitch there?

Ms. PALKUTI. There is the timing that it takes a manager to schedule interviews, do interviews, make a selection, check credentials, and those kinds of things——

Senator TESTER. OK. Are we understaffed in the human resource end of things so that is holding up the process?

Ms. PALKUTI. We have identified the human resources occupation as one of our top ten priority occupations for the agency. We have increased the number of folks that we are hiring in new internships for developmental purposes to 42 this year.

Senator TESTER. OK.

Ms. PALKUTI. We are looking at that.

Senator TESTER. I mean, one of the things that really gets the VA off to a bad start is if the first person they talk to is a machine.

Ms. PALKUTI. Correct.

Senator TESTER. With the press the last couple days reporting on credit cards, I'm inclined to ask this question to both Ms. Cullen and Mr. Kleinglass. Are there people that you have oversight over, yourselves included, that have VA credit cards; and are there rules as to how those cards can be used?

Mr. KLEINGLASS. Please.

Ms. CULLEN. Yes, I have a government credit card. Mine is just for travel; and yes, we have a number of government credit cards throughout our organization; and there are, indeed, rules for how they are to be utilized.

Senator TESTER. And I assume it is the same for you, Mr. Kleinglass?

Mr. KLEINGLASS. Yes, Senator Tester. I have a government credit card. We have many staff that have them. There are rules. We have an Ethics Committee at our institution. We talk about this regularly.

Senator TESTER. I am not making any implications on your particular facilities, let the record be clear on that. But do you have

any oversight of those credit cards within your facilities or is it all done from this end?

Mr. KLEINGLASS. In our institution, our Chief Financial Officer and his staff manage that for us and they regularly put out guidance on the use of these cards and I know of no problems at our institution.

Senator TESTER. OK.

Ms. CULLEN. Also, we do internal audits on the use of purchase cards, and we occasionally have the benefit of visits from our colleagues in central office who do the same, and from the IG. They just—within this fiscal year, we had a random audit of credit cards by the IG, as well.

Senator TESTER. Thank you very much. Sorry I had to bring up the messy subject, but I had to do it. Thank you.

Ms. CULLEN. No problem.

Chairman AKAKA. Thank you very much.

Before I dismiss the first panel, I want to call on Senator Wicker for any statement or questions you may have.

STATEMENT OF HON. ROGER F. WICKER, U.S. SENATOR FROM MISSISSIPPI

Senator WICKER. Thank you, and I would ask a few questions. I do want to thank Senator Tester for asking about the credit cards. Some things we sometimes feel go without saying, or some questions go without asking, and then we learn that, lo and behold, the very obvious questions need to be asked. So, I appreciated the question and appreciate the answer.

Let me just follow up, first of all, Mr. Kleinglass, with your testimony about extra pay or incentive pay for nurse managers and certain specialty areas among the nurses. Do you find that your civilian counterparts are doing the same, or are there differences in that particular area? Or do you have conversations with your civilian counterparts?

Mr. KLEINGLASS. I do. I sit on the Minnesota Hospital Association Board and I asked various questions of my colleagues in town. What I would say to you is it is very difficult to match up exactly, for lots of reasons. It is my understanding when our nurse executive at our institution asked me about doing this, she was interested in it because the community in which we reside does this. She felt passionately that in order to maintain the staff that we want, this would be a good incentive for our nurse managers.

I didn't bring the numbers with me, but I am fairly confident when I tell you the amount of money that we have given to these nurse managers is really very small in the realm of what we are asking them to do. They are really the backbone to the nursing units and have responsibilities 24 hours-a-day/7 days-a-week, with a very large responsibility.

Senator WICKER. Well, I think, certainly, we can acknowledge that the shortage across the board affects the government health care providers and private and community-based health care providers.

Let me just back up and see if someone on the panel can give us an overview of the profile of physicians and nurses in the VA. Do you get most of them straight from school, or do they work a

while in the private sector typically? And at what point do we tend to lose them, both the doctors and the nurses, to the private sector? Is there anything that we can learn along those lines that might be helpful to the Committee?

Mr. KLEINGLASS. I would be pleased to answer that for you. In our institution, and I am speaking only for the Minneapolis VA, we have a combination of reasons why physicians come to us and we get a mix from our affiliate through the medical school, through the training programs, and then individuals that are mid-career that have gone out and done some other things come back to us.

When I talk to new physicians that come to work for us, they come because of the affinity for taking care of veterans; for the teaching opportunities; for the research opportunities; and for the way we do our business—particularly with the computerized patient medical record. That is a real bonus. They also like the way we practice medicine within the VA. They are getting very frustrated with what is going on in the private sector—their inability to order tests or inability to really practice—and so, they see the VA as a model of very high level practice availability.

Senator WICKER. And why do you lose them at a certain point?

Mr. KLEINGLASS. Well, I can give you one specific example. We are losing a physician that we value greatly and he was kind enough to tell me he was going to be leaving us. So, I asked him to come up to my office and we spoke quite a bit. His words to me were, “I am leaving because of a family lifestyle change, a location—that is, going back home—and not because I am unhappy here in any way, and it is not because of pay.” So, I think there are those reasons.

Quite honestly, in some of the sub-specialties, particular cardiology, diagnostic radiology, interventional cardiology, we lose some physicians because of pay, and predominately pay. And I have some examples of those that I could share with you where we have tried to entice these people to stay. And it is very, very difficult to compete with the pay that these people are getting. I was successful a couple of years ago convincing one of our valued cardiologists not to leave, and a year and one-half later the offer just was way out of control from the private sector.

Ms. CULLEN. At San Francisco, our situation is similar to what Mr. Kleinglass describes. We hire physicians at all levels. Experienced, tenured physicians from other areas will come to our medical center. The affiliation with our medical school is the primary draw for recruitment and retention of physicians. Our research program, which is the largest in the VA, is an enormous magnet for recruitment and retention. We lose physicians because they can get an academic promotion elsewhere. Infrequently, but it does happen, we lose them due to very attractive salary offers, sometimes outside academia.

Most recently, we have two pending physician losses that will be very painful to us, one, an interventional cardiologist who is leaving for an over $600,000 salary. The second is an anesthesiologist who will be leaving us for a $300,000 sign-on bonus and who will yet get to stay in the area. But, for the most part, our physicians remain in an academic setting.

With nurses, we hire them as new grads and we try to attract new nursing graduates, but the largest number of nurses that we lose are through retirement, so they are people who have had an extensive career with the VA—extensive and successful career with VA. Sometimes we lose people because families move elsewhere, but that is to be expected. Again, as I think I mentioned in my testimony, our largest nursing loss is due to retirements.

Senator WICKER. Well, thank you. And I guess this is a question for the record, but if anyone on the panel could let us know the percentage of people—nurses or doctors—who stick with you the whole time. I realize that is not what we do in society anymore. People have a number of careers nowadays, whereas in my father's day, you picked one and that is what you retired from. But, it would be interesting if you could supply me—if you know off the top of your head or can supply for the record—how many people make a total career out of it.

Thank you; and thank you, Mr. Chairman.

[The response from Ms. Cullen follows:]

Response. VA does not keep data on staff who remain with VA for their entire careers.

Chairman AKAKA. Thank you, Senator Wicker.

Senator Rockefeller, any statement or questions to the first panel?

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, I am just interested in the fact that in this question, and in response to what the Senator previously said, my understanding was that the average VA nurse has been there for 27 years. VA has also hired a lot of people—specialists and general people—in the last 2 years because you have had more money to do so—thanks to Patty Murray—and that you plan on hiring some 500 more this year, if that is correct. So, the question is sort of regarding the people leaving for higher pay versus the 27 years tradition, if that is still correct, and then the hiring on of new people means that they are coming already knowing that there is higher pay elsewhere, and that would make sense to me simply because of the centrality of the veterans. The last several years have really highlighted it. This Congress will never be the same, I hope, as it has been in the past, unfortunately.

One thing that caught my attention was the question of nurses seeking sort of overtime and the 3-day/12-hour-a-day pattern, and that that seemed to make sense to them—and obviously does to you because it probably wouldn't have been suggested if that had not been the case. But then I am confused, because you have the sole authority to decide which workplace disputes can be grieved. Since 2002—I am just saying "you" generically—has ruled in favor of management and against the employees' right to grieve in 100 percent of the cases that have come before him, which couldn't be you, and that interests me.

Ms. PALKUTI. Sir, I am probably not the expert in the employee relations arena. Can I take that question for the record and respond to that?

Senator ROCKEFELLER. Yes, if you could let me know. It is just sort of a phenomenon that doesn't take place if they are satisfied with it; and you are satisfied with it, but then those who don't always lose. So, if you could take that for the record, I would be very grateful.

Ms. PALKUTI. Yes, sir. I would be glad to. Thank you.

Senator ROCKEFELLER. That will be my only question for the moment, Mr. Chairman.

[The response from Ms. Palkuti follows:]

Response. VA provided this information directly to Senator Rockefeller's office.

Chairman AKAKA. Thank you very much, Senator Rockefeller.

Senator Murray?

Senator MURRAY. Mr. Chairman, I had an opportunity to speak earlier and I know the panel has been up here and you have got a second panel. I will pass on my questions and submit them for the record on this panel.

Chairman AKAKA. Thank you very much.

I want to then thank our first panel. The kind of questions we have had really were seeking to find out more of what you are doing. You have been doing an incredible job and we want others to learn from your experiences, as well. So, thank you very much for being here today.

Senator ROCKEFELLER. Can I——

Chairman AKAKA. Just a second. Senator Rockefeller?

Senator ROCKEFELLER. I didn't use all my time, did I? Let me go back to the earlier part of that question. Is the 27-year thing still fundamentally accurate?

Ms. PALKUTI. Are you asking if——

Senator ROCKEFELLER. That the average length of the VA nurse's stay. I have used it all over my State, so I am hoping that it is——

Ms. PALKUTI. You are hoping it is correct.

[Laughter.]

Ms. PALKUTI. I can confirm or determine whether that——

Senator ROCKEFELLER. It is in that area.

Ms. PALKUTI [continuing]. That average is——

Senator ROCKEFELLER. I believe it is in that area, which shows the dedication.

Ms. PALKUTI. Yes.

Senator ROCKEFELLER. But then you use the example of people being attracted by higher salaries elsewhere, and, of course, we all face that, particularly those of us who are surrounded by much richer States. And you have hired a lot of people, which meant they had to go through that calculus in their mind, because they know what is being offered. Is there an explanation for that?

Ms. PALKUTI. Well, I guess we can refer back to some of our workforce planning initiatives. We have turnover because of retirement and other types of attrition, so we are continuously hiring new employees. Many of them are coming from the private sector at mid-career because they appreciate the way VA practices medicine. There is a focus on the patient and less of a focus on just decisions that are bottom-line business decisions. We have a phenomenal health record that draws people. And so, some people do make a decision and calculate the differences in terms of salary to

make a choice to come and work for VA. Many people come to us because of the mission, and some who don't come to us because they are mission-bound become very attached to our mission very shortly after arriving.

We have some very good incentives. We have scholarship incentives that draw people, especially associate and baccalaureate degree nurses. We have a scholarship program which is exceptional across the agency, so we draw them in for their educational benefits. Our Education Debt Reduction Program, which is offered to new hires, gives them an incentive to stay for 5 years to collect all of those funds, and we found very clearly that employees who stay in years three, four, and five remain with the agency when those benefits expire.

So, we have some very good benefits that draw people into the agency and help them see what a fine place it is to practice and serve the country.

Senator ROCKEFELLER. Has the intensity of these two wars that are going on and the trauma of the wounded and injured—physically, psychologically, both—has that, do you think, helped the whole sense of mission?

Ms. PALKUTI. To some degree, I would like to defer to my colleagues who are more on the front lines and may be able to speak to that even more.

Mr. KLEINGLASS. Mr. Rockefeller, the Minneapolis VA Medical Center is one of VHA's five polytrauma centers, and so we have a lot of experience with your question. I would say, undoubtedly, the new staff that is coming in have this notion of serving veterans is just a noble thing. They thoroughly enjoy working with the returning soldiers. We have a tremendously dedicated staff that work day-in and day-out with the returning soldiers and thoroughly, thoroughly enjoy it. And so, I think that in our case, at least, that has contributed to some of our successes with the new people coming in.

Senator ROCKEFELLER. Good. I have over-used my time and I apologize, but I am glad to hear those answers.

Chairman AKAKA. Thank you, Senator Rockefeller.

Let me say that speaking of dedication, there is a nurse at the Albany VA Hospital who has just celebrated her 50th anniversary as a nurse. That is something to shoot for, and I want Senator Rockefeller and Senator Wicker to know that. There is a 50-year-career at the Albany VA Hospital.

With that, again, thank you very much to our first panel for being here and sharing your experiences.

Let me now welcome our second panel. I would like to thank our second panel for being here today.

First, I welcome Marjorie Kanof, Managing Director for Health Care in the Government Accountability Office.

Second, I welcome Dr. John McDonald, Vice President for Health Sciences and Dean of the University of Nevada School of Medicine.

I also welcome Valerie O'Meara, a nurse practitioner in the VA Puget Sound Health Care System and Professional Vice President of the American Federation of Government Employees Local 3197.

Next, I welcome Randy Phelps, Deputy Executive Director of the American Psychological Association Practice Directorate.

Finally, I welcome Dr. Jennifer Strauss, Assistant Professor in the Department of Psychiatry and Behavioral Sciences of Duke University Medical Center.

Again, I want to thank all of you for being here today and let you know that your full statements will appear in the record. We will begin with Dr. Kanof and your testimony.

STATEMENT OF MARJORIE KANOF, M.D., MANAGING DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Dr. KANOF. Mr. Chairman, Mr. Rockefeller, and Ms. Murray, I am pleased to be here today as you discuss personnel issues at the Department of Veterans Affairs.

One such issue VA faces is an increased demand for the services provided by Certified Registered Nurse Anesthetists (CRNAs), who provide the majority of anesthesia care veterans receive in VA medical facilities. The VA employs approximately 500 CRNAs and many of these CRNAs are nearing retirement eligibility age. Given the increased demand for CRNAs, concerns have been raised about the challenges VA may face in making salaries competitive to maintain the CRNA workforce, particularly in the areas where the local market can be highly competitive.

In December 2007, GAO issued a report that examined the challenges VA faces recruiting and retaining CRNAs. Based on this report, I will discuss both the CRNA workforce challenges and the key mechanisms VA facilities have to make CRNA salaries competitive.

We reported that VA medical facilities have challenges both recruiting and retaining CRNAs. Seventy-four percent of the VA chief anesthesiologists that responded to our survey reported that they had difficulty recruiting CRNAs. VA medical facility officials responding to our survey reported that it took VA facilities a long time, on average about 15 months, to fill a CRNA vacancy. Based on fiscal year 2005 data, nationally, VA had a 13 percent CRNA vacancy, or 70 unfilled positions at 43 medical facilities.

According to our survey, the CRNA vacancy impacted the delivery of care to the veterans. For example, 54 percent of our chief anesthesiologists reported that they temporarily closed their operating rooms.

In addition to the challenge of recruiting CRNAs, we also reported that VA medical facilities were likely to face a challenge in retaining CRNAs. On the basis of the response to our survey, we projected a CRNA attrition rate of 26 percent across VA in the next 5 years. Overall, 93 CRNAs at 53 facilities reported that they plan to either leave or retire from the VA in 5 years. VA medical facilities reported in our survey that recruitment and retention challenges were caused primarily by the level of VA's CRNA salaries when compared to salaries in the local market area.

In December 2007, we also reported that VA's Locality Pay System, known as LPS, is a key mechanism that facilities use to determine whether to address salaries. The LPS provides information on salaries paid to CRNAs in the facility's local market area. We reported that the majority of VA facilities use the LPS, but at the eight VA medical facilities we visited, five did not use the LPS in

accordance with VA's LPS policy. At these five facilities, officials with oversight responsibility for the LPS were not knowledgeable about the changes in the policy. For example, one official told us that third-party salary survey data wasn't available, so they used salary data from the Hot Jobs Web site, which doesn't match the data accuracy that is required by the VA protocol.

The problem some VA medical facilities had fully understanding the LPS policy indicated that VA training had been inadequate. Actually, VA had changed its policy in 2001, but it had not conducted nationwide training since 1995. As a result, VA medical facility officials cannot ensure that the CRNA salaries have been adjusted as needed to be competitive in local market areas. Training on the LPS is necessary to help ensure that VA medical facilities are competitive as an employer.

And so, to improve VA's ability to recruit and retain CRNAs, in our December report, we recommended that VA expedite the development and implementation of training; and VA agreed with our recommendation and stated that it had developed a draft action plan and they hope to complete online training by the end of this fiscal year.

Mr. Chairman and Members, this concludes my opening statement.

[The prepared statement of Dr. Kanof follows:]

PREPARED STATEMENT OF MARJORIE KANOR, MANAGING DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony

Before the Committee on Veterans' Affairs, U.S. Senate

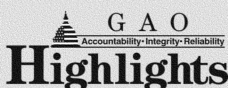
For Release on Delivery
Expected at 9:30 a.m. EDT
Wednesday, April 9, 2008

VA HEALTH CARE

Recruitment and Retention Challenges and Efforts to Make Salaries Competitive for Nurse Anesthetists

Statement of Marjorie Kanof, Managing Director
Health Care

GAO-08-647T



Highlights

Highlights of GAO-08-647T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

Certified registered nurse anesthetists (CRNA), registered nurses who have completed a master's degree program in nurse anesthesia, provide the majority of anesthesia care in the Department of Veterans Affairs (VA) medical facilities. There are approximately 500 VA-employed CRNAs (VA CRNA) who provide care to veterans in VA medical facilities. While the demand for CRNAs has increased, many employed by VA are nearing retirement eligibility age. Concerns have been raised about the challenges VA may face in making VA CRNA salaries competitive in order to maintain its VA CRNA workforce, particularly in local markets that can be highly competitive.

This testimony is based on GAO work reported in *VA Health Care: Many Medical Facilities Have Challenges in Recruiting and Retaining Nurse Anesthetists*, (GAO-08-56, Dec. 13, 2007). This testimony (1) identifies workforce challenges that VA medical facilities experience related to VA CRNAs, and (2) identifies a key mechanism that VA medical facilities have to help make VA CRNA salaries competitive and the extent to which VA facilities use this mechanism.

For the December 2007 report, GAO analyzed surveys sent to VA chief anesthesiologists, VA human resources officers, and VA CRNAs. GAO also visited eight VA medical facilities and interviewed facility officials about efforts to recruit and retain VA CRNAs.

To view the full product, including the scope and methodology, click on GAO-08-647T. For more information, contact Marjorie Kanof, (202) 512-7114 or kanofm@gao.gov.

April 9, 2008

VA HEALTH CARE

Recruitment and Retention Challenges and Efforts to Make Salaries Competitive for Nurse Anesthetists

What GAO Found

GAO reported in December 2007 that VA medical facilities had challenges recruiting and retaining VA CRNAs. In GAO's report, most surveyed officials said that they had difficulty recruiting VA CRNAs at their facilities. The challenge of recruiting VA CRNAs affected the ability of VA officials to reduce existing VA CRNA vacancy rates—the number of unfilled VA CRNA positions—at their medical facilities. Vacancy rates varied across VA and, according to GAO's survey, impacted the delivery of services at VA medical facilities. On the basis of its survey results, GAO also found that in addition to their current recruiting challenges, VA medical facilities would likely face a challenge retaining VA CRNAs in the next 5 years due to the number of VA CRNAs projected to either retire from or leave VA. VA medical facility officials reported in GAO's survey that the recruitment and retention challenges were caused primarily by the low level of VA CRNA salaries when compared with CRNA salaries in local market areas.

GAO also reported that VA's locality pay system (LPS) is a key mechanism VA medical facilities can use to determine whether to adjust VA CRNA salaries to help the facilities remain competitive with CRNA salaries in local market areas. GAO also reported that the majority of VA medical facilities that employ VA CRNAs used LPS. However, at the eight VA medical facilities it visited, GAO found that although the facilities used VA's LPS, the majority of them did not fully follow VA's LPS policy correctly in either 2005 or 2006. The problems some VA medical facilities had fully following VA's LPS policy, along with the explanations of facility officials, indicated that VA had not provided adequate training on its LPS policy. As a result, VA medical facility officials cannot ensure that VA CRNA salaries have been adjusted as needed to be competitive in local market areas. Training on the LPS is necessary to help ensure that VA medical facilities are competitive as an employer. In December 2007, GAO recommended that VA expedite the development and implementation of a training course for VA medical facility officials responsible for compliance with the policy. VA agreed with GAO's recommendation and in comments on GAO's draft report stated that it had developed a draft action plan for training staff on its LPS policy. VA anticipated that the online training course would be available by the end of fiscal year 2008.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss personnel issues in the Department of Veterans Affairs (VA). One such issue VA faces is an increased demand for the services provided by certified registered nurse anesthetists (CRNA), who provide the majority of anesthesia care veterans receive in medical facilities operated by VA. CRNAs are registered nurses who have completed a 2- to 3-year master's degree program in nurse anesthesia and who typically provide anesthesia care in health care settings with anesthesiologists and surgeons. There are approximately 500 VA-employed CRNAs (VA CRNA) who provide anesthesia care to veterans in VA medical facilities. When hiring VA CRNAs, VA places them in one of five pay grades, based on the CRNA's education and experience. The demand for these practitioners in VA medical facilities has continued to increase because CRNAs are no longer used only in the operating room, but are used in other areas of a medical facility, such as administering anesthesia to patients who are undergoing cardiac catheterization and providing airway management to patients during cardiac emergencies.

While the demand for CRNAs has continued to increase, many VA CRNAs are nearing retirement eligibility age. According to VA officials, more than half of VA CRNAs are over the age of 51, and the average VA CRNA is 7 years closer to retirement eligibility than the average CRNA nationally. Given the increased demand for CRNAs and the important role they play in providing anesthesia services in VA medical facilities, concerns have been raised about the challenges VA may face in making VA CRNA salaries competitive in order to maintain its VA CRNA workforce, particularly in some local markets where the labor market for CRNAs can be highly competitive.

In December 2007 we issued a report that examined the challenges VA faces recruiting and retaining VA CRNAs.[1] My remarks today are based on this report. Specifically, I will (1) identify workforce challenges that VA medical facilities experience related to VA CRNAs, and (2) identify a key mechanism that VA medical facilities have to help make VA CRNA salaries competitive for recruitment and retention purposes and the extent to which VA facilities use this mechanism.

[1]GAO, *VA Health Care: Many Medical Facilities Have Challenges in Recruiting and Retaining Nurse Anesthetists*, GAO-08-56 (Washington, D.C.: Dec. 13, 2007).

To do the work for our December 2007 report, we analyzed Web-based surveys we sent to all VA chief anesthesiologists, VA human resources (HR) officers, and VA CRNAs, with survey response rates of 92, 85, and 76 percent, respectively. We also analyzed data on VA CRNA vacancies—the number of unfilled VA CRNA positions at VA medical facilities—obtained from VA headquarters. These data were from 2005, the most recent year for which vacancy data were available at the time of our review. Additionally, we obtained data on VA CRNAs' salaries for 2005, 2006, and 2007 and compared these to national salary data we obtained from the American Association of Nurse Anesthetists (AANA), a professional organization for CRNAs. We visited eight VA medical facilities[2] and interviewed chief anesthesiologists, VA CRNAs, HR officers, and other facility officials about their efforts to recruit and retain VA CRNAs. We also interviewed a representative from Kaiser Permanente, a large health care plan that primarily uses CRNAs to deliver anesthesia services, to identify what steps this plan takes to ensure it has a sufficient number of CRNAs and to determine the indicators this plan uses to identify a CRNA shortage or potential future CRNA shortage. To ensure the reliability of the survey and national salary data we used, we performed a systematic review of the returned questionnaires and interviewed VA and AANA officials about the quality checks and edits they performed on their data. We determined that the data we used were adequate for our purposes. We conducted our work from June 2006 through October 2007 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings based on our audit objectives.

In summary, in December 2007 we reported that VA medical facilities had challenges recruiting and retaining VA CRNAs. Seventy-four percent of the VA chief anesthesiologists who responded to our survey reported that they had difficulty recruiting VA CRNAs in fiscal years 2005 and 2006. The challenge of recruiting VA CRNAs affected the ability of VA officials to reduce existing VA CRNA vacancy rates—the number of unfilled VA CRNA positions—at their medical facilities. In our survey, 54 percent of the VA

[2]The eight VA medical facilities we visited were located in Denver, Colorado; Houston, Texas; Minneapolis, Minnesota; New York, New York; Portland, Oregon; Seattle, Washington; Tampa, Florida; and Togus, Maine. We selected these facilities because they are geographically dispersed across the country and employ VA CRNAs.

chief anesthesiologists with VA CRNA vacancies reported that they temporarily closed operating rooms, and 72 percent reported that they delayed elective surgeries as a result of VA CRNA vacancies in fiscal year 2006. Based on our survey results, we also found that in addition to their current recruiting challenges, VA medical facilities would likely face a challenge retaining VA CRNAs in the next 5 years due to the number of VA CRNAs projected to either retire from or leave VA. VA medical facility officials reported in our survey that the recruitment and retention challenges were caused primarily by the low level of VA CRNA salaries when compared with CRNA salaries in local market areas. In December 2007 we also reported that VA's locality pay system (LPS) is a key mechanism that VA medical facilities can use to determine whether to adjust VA CRNA salaries to help the facilities remain competitive with CRNA salaries in local market areas. We reported that the majority of VA medical facilities that employ VA CRNAs used LPS. However, at the eight VA medical facilities we visited, we found that although the facilities used VA's LPS, five of these facilities did not fully follow VA's LPS policy correctly in either 2005 or 2006. The problems some VA medical facilities had fully following VA's LPS policy, along with the explanations of facility officials, indicated that VA had not provided adequate training on its LPS policy. As a result, VA medical facility officials cannot ensure that VA CRNA salaries have been adjusted as needed to be competitive in local market areas. Training on the LPS is necessary to help ensure that VA medical facilities are competitive as an employer.

To improve VA's ability to recruit and retain VA CRNAs, we recommended that the Secretary of Veterans Affairs direct the Assistant Secretary for Human Resources and Administration to expedite development and implementation of a training course on VA's LPS policy for VA medical facility officials responsible for compliance with the policy. VA generally agreed with our conclusions and recommendation and stated that it had developed a draft action plan for training staff on this policy and anticipated that an on-line training course would be available by the end of fiscal year 2008.

VA Medical Facilities Have VA CRNA Recruitment and Retention Challenges Primarily Because of Noncompetitive Salaries

We reported in December 2007 that VA medical facilities had challenges recruiting and retaining VA CRNAs. On the basis of our survey results, we found that VA medical facilities had challenges in recruiting VA CRNAs at their facilities and will likely face challenges in retaining VA CRNAs in the next 5 years due to the number of VA CRNAs projected to either retire from or leave VA. VA medical facility officials reported in our survey that the recruitment and retention challenges were caused primarily by the low level of VA CRNA salaries when compared with CRNA salaries in local market areas.

VA Officials Reported Challenges Recruiting CRNAs, and Projected VA CRNA Attrition Will Likely Create Retention Challenge in the Next 5 Years

In December 2007 we reported our survey results indicating that VA medical facilities had a challenge recruiting VA CRNAs.[3] Of all VA medical facility chief anesthesiologists who responded to our survey, 74 percent reported that they had difficulty recruiting VA CRNAs in fiscal years 2005 and 2006. The recruiting challenges also affected VA medical facility officials' ability to reduce existing VA CRNA vacancy rates at their medical facilities. Additionally, VA medical facility officials responding to our survey reported that it took VA facilities a long time—on average about 15 months—to fill a VA CRNA vacancy from the time facility management approval is granted to fill the position until the time the VA CRNA actually begins providing services at the facility. In particular, VA chief anesthesiologists at 11 medical facilities reported that their facilities took 2 years or more on average to fill a VA CRNA vacancy. In our survey, the shortest time taken to fill a vacancy, as reported by the chief anesthesiologists, was 2 months, and the longest was 60 months.

The challenge of recruiting CRNAs limited the ability of VA officials to reduce existing vacancy rates at their medical facilities. VA's fiscal year 2005 vacancy data show that VA had about a 13 percent VA CRNA vacancy rate systemwide, or 70 unfilled VA CRNA positions at 43 medical facilities. These rates varied across VA, with 26 medical facilities having vacancy rates of 25 percent or more and 15 of them having vacancy rates of 40 percent or more in fiscal year 2005. According to the director of Kaiser Permanente's school of anesthesia for nurse anesthetists, a vacancy rate of 40 percent or higher is considered indicative of a staffing problem. Like VA's vacancy data, our survey also suggested that VA CRNA vacancies were common across VA medical facilities. Of the chief anesthesiologists

[3] GAO-08-56.

responding to our survey, 54 percent reported that they had VA CRNA vacancies at their VA medical facilities, with the number of VA CRNA vacancies ranging from one to six.

According to our survey, VA CRNA vacancies impacted the delivery of services at VA medical facilities. For example, 54 percent of the VA chief anesthesiologists with VA CRNA vacancies reported that they temporarily closed operating rooms, 72 percent delayed elective surgeries, and 68 percent increased the use of overtime for VA CRNAs, as a result of VA CRNA vacancies in fiscal year 2006. Moreover, 44 percent of chief anesthesiologists that had VA CRNA vacancies reported that contract CRNAs supplied by outside companies were used to supplement the VA facilities' VA CRNA workforce. In addition, almost one-third of the chief anesthesiologists whose vacancies were filled by VA CRNAs reported that they still had a shortage.

In addition to the challenges of recruiting VA CRNAs, we also reported that VA medical facilities were likely to face another workforce challenge in the future. Specifically, we found that in the next 5 years VA medical facilities would likely have difficulty retaining VA CRNAs in their workforce and this trend could increase the number of VA CRNA vacancies across VA. On the basis of VA CRNA responses to our survey, we projected a VA CRNA attrition rate of 26 percent across VA in the next 5 years—that is, 26 percent of VA CRNAs either planned to retire or leave VA's health care system within the next 5 years.[4] Overall, 93 VA CRNAs at 53 of VA's 120 medical facilities that employ VA CRNAs reported that they plan to retire or leave VA's health care system. While the overall projected attrition rate across VA, on the basis of our survey results, will likely be 26 percent, this rate will vary by medical facility. In 27 VA medical facilities, we projected that the attrition rate would likely be 50 percent or higher. According to the director of Kaiser Permanente's school of anesthesia for nurse anesthetists, an attrition rate of 50 percent or higher is considered indicative of a future staffing problem.

[4]While CRNA respondents reported their plans for retirement or departure from VA, some will change their plans. On the basis of our survey of VA CRNAs, about one-third of those eligible to retire were unsure of their retirement plans. However, others who indicated that they plan to stay may change their plans as well and leave VA. Thus, this measure is an approximation of likely attrition.

According to VA Officials and VA CRNAs, Recruitment and Retention Challenges Are Due to Noncompetitive VA CRNA Salaries

Our surveys of VA medical facility chief anesthesiologists and HR officers indicated that medical facilities had trouble recruiting and will have trouble retaining VA CRNAs because salaries for VA CRNAs were low compared to CRNA salaries in local market areas. Specifically, of the 69 chief anesthesiologists who reported having difficulty recruiting VA CRNAs during fiscal years 2005 and 2006, about 60 of them attributed this difficulty primarily to the fact that salaries for VA CRNAs at their medical facilities were not competitive with CRNA salaries in local market areas.[5] Additionally, of the 46 chief anesthesiologists who reported having difficulty retaining VA CRNAs during fiscal years 2005 and 2006, 36 of them attributed this primarily to the fact that salaries for experienced VA CRNAs[6] at their medical facilities were not competitive with CRNA salaries in local market areas. Other reasons most frequently cited by the chief anesthesiologists were indirectly associated with the level of VA CRNA salaries.[7]

Of the chief anesthesiologists we surveyed, 72 percent (67) reported that VA CRNA starting salaries for new graduates at their facility were lower than local market area salaries in fiscal year 2005, and 69 percent (64) reported this in fiscal year 2006. In fiscal years 2005 and 2006, 79 percent (73) of chief anesthesiologists estimated that salaries for experienced VA CRNAs at their medical facility were lower than local market area CRNA salaries. Furthermore, about 40 percent of chief anesthesiologists also reported that salaries for both new graduate and experienced VA CRNAs at their facility were $10,000 to $30,000 lower than CRNAs salaries in local market areas during fiscal years 2005 and 2006. (See table 1 for the differences in VA CRNA salaries and CRNA salaries in local market areas in fiscal years 2005 and 2006, as reported by VA chief anesthesiologists.)

[5]Other reasons that were most frequently cited by chief anesthesiologists were VA's lengthy hiring process and a shortage of CRNAs in the local market area.

[6]Experienced VA CRNAs have 2 or more years of experience.

[7]The reason contributing to the difficulty in recruiting and retaining VA CRNAs most frequently cited by the chief anesthesiologists besides CRNA salary was inadequate retention bonuses, which, according to VA HR officers, are often paid because VA CRNA salaries are lower than the local market area CRNA salaries.

Table 1: Differences in VA CRNA Salaries and CRNA Salaries in Local Market Areas, as Reported by VA Chief Anesthesiologists, Fiscal Years 2005 and 2006

	Percentage of chief anesthesiologists reporting for fiscal year 2005		Percentage of chief anesthesiologists reporting for fiscal year 2006	
	New graduate VA CRNA[a]	Experienced VA CRNA[b]	New graduate VA CRNA[a]	Experienced VA CRNA[b]
VA CRNA salaries lower than CRNA salaries in local market areas by $10,000 or less	12	13	9	12
VA CRNA salaries lower than CRNA salaries in local market areas by $10,001 to $30,000	41	40	42	42
VA CRNA salaries lower than CRNA salaries in local market areas by more than $30,000	19	26	18	23
Not checked[c]	8	3	9	7
Not applicable[d]	20	18	23	17

Source: GAO.

Notes: The data are from a GAO survey of 120 VA medical facility chief anesthesiologists. Column totals may not add to 100 percent due to rounding and not all chief anesthesiologists who reported salaries were lower specified how much lower.

[a]New graduate VA CRNAs have less than 2 years experience.

[b]Experienced VA CRNAs have 2 or more years of experience.

[c]Represents the chief anesthesiologists who did not provide a response to this question.

[d]Represents the chief anesthesiologists who reported that VA CRNA salaries were not lower than the local area market.

In December 2007, we reported that to address recruitment challenges related to VA CRNA salaries, VA CRNAs and the director of VA's anesthesia services told us that they were revising VA's CRNA qualification standards. These standards establish the five pay grades—grade I being the lowest—that VA CRNAs are placed into when hired, based on CRNAs' education and experience. According to the officials, the change to VA's qualification standards will have the effect of increasing starting salaries for new graduate VA CRNAs from grade I to grade II. However, we found that this revision to VA CRNA qualification standards—increase in grade and resulting starting salary—would be unlikely to make most VA CRNA starting salaries competitive with local market area CRNA starting salaries. We compared VA CRNA 2007 salary schedules to projected AANA 2007 salary data to determine whether VA CRNA salaries would be competitive with local market area CRNA salaries if salaries for new graduate VA CRNAs were changed from grade I to grade II. Our analysis showed that this revision to VA CRNA qualification standards would not make most VA CRNA starting salaries competitive with local market area

starting CRNA salaries. Specifically, 75 of 120 VA medical facilities that employ VA CRNAs would have VA CRNA starting salaries below local market area CRNA salaries by $20,000 or more.

We found similar challenges related to the retention of VA CRNAs. At the time of our review, more than half of all VA CRNAs earned the maximum statutory salary cap[8] for a VA CRNA in 2006, which was $133,900. However, at 107 of VA's 120 medical facilities that employ VA CRNAs the 2006 maximum statutory salary cap was at least $20,000 lower than 2006 CRNA salaries in local market areas. The 2007 maximum statutory salary cap increased to $136,200. According to VA officials, VA is developing proposed legislation to increase the maximum statutory salary cap. The proposal would increase the maximum statutory salary cap for VA CRNAs by $9,200. Our analysis comparing AANA 2007 salary data for CRNAs to VA's CRNA 2007 maximum statutory salary cap indicated that increasing the VA CRNA maximum statutory salary cap by $9,200 would not, at a majority of VA medical facilities, make VA CRNA salaries competitive with CRNA salaries in local market areas. Specifically, using 2007 rates, we found that after the proposed change, 70 of the 120 VA medical facilities' VA CRNA salaries would still be at least $20,000 or lower than the local market area CRNA salaries.

VA Medical Facilities Can Use LPS to Help Make VA CRNA Salaries Competitive, and While Majority of Facilities Have Used LPS, Some Have Not Followed VA's LPS Policy

In December 2007, we reported that VA's LPS system is a key mechanism that VA medical facilities can use to determine whether to adjust VA CRNA salaries to help the facilities remain competitive with CRNA salaries in local market areas. We also reported that the majority of VA medical facilities that employ VA CRNA used LPS. However, at the eight VA medical facilities we visited, we found that although the facilities used VA's LPS, the majority of them did not fully follow VA's LPS policy correctly in either 2005 or 2006.

[8]The maximum statutory salary cap is the maximum base salary a VA CRNA can earn.

To Recruit and Retain VA CRNAs, Medical Facilities Can Adjust Salaries Using VA's LPS

In December 2007, we reported that VA CRNA pay grades—and thus salaries—are initially determined by VA's qualification standards for VA CRNAs. Although VA medical facility directors are required to use the LPS to determine if VA CRNA salaries should be adjusted, they have the option of adjusting these salaries to recruit and retain VA CRNAs.[9] When adjusting VA CRNA salaries, VA medical facilities are required to use a process known as LPS.[10] The system is intended to help VA medical facilities determine whether to adjust VA CRNA salaries to be regionally competitive. VA's LPS supports this goal by providing information on salaries paid to CRNAs in a facility's local market area. To collect data for the LPS, medical facility directors, who are responsible for their facility's LPS, can either use a salary survey conducted by another entity or conduct their own survey in order to determine the CRNA salary levels paid by health care establishments in the local market area.

VA has an LPS policy, which requires that a medical facility director initiate an LPS survey if the director determines that a significant pay-related staffing problem exists or is likely to exist for any occupation or specialty. VA's LPS policy instructs medical facilities to use a survey conducted by the Bureau of Labor Statistics (BLS); however, if data from this survey are not available or not current, facilities are to use a third-party locality pay survey. Third-party surveys include those that are purchased from a third-party service that collects compensation data on salaries of health care occupations. These surveys can also include salary data collected by local hospital associations for their member health care establishments. When BLS or other third-party surveys are not available or do not contain sufficient salary data, facilities are to conduct their own locality pay survey.

Under VA's LPS policy, a third-party locality pay survey must include data from at least three non-VA health care establishments, such as hospitals and outpatient clinics. VA's LPS policy requires that a third-party survey cover an appropriate local market area, which is defined by VA as one that includes the county in which the VA medical facility is located and includes health care establishments that compete for the same type of

[9]GAO-08-56. Title 38 U.S.C. §7451(d)(2000). VA medical facilities may not set the minimum rate of basic pay for a grade so that it is greater than the beginning pay rates for comparable positions at health care establishments in local market areas. See 38 U.S.C. §7451(d)(3)(E)(2000).

[10]The LPS is also used for other occupations, such as registered nurses.

clinical employees, such as CRNAs. The health care establishments that participate in a third-party survey should provide job descriptions that include the duties, responsibilities, and education and experience requirements of CRNAs and should be able to be readily job-matched to VA's description of the VA CRNA grade levels.

If a VA medical facility conducts its own LPS survey, VA's LPS policy requires that the geographic area surveyed be defined. In order to be valid, three health care establishments must have job descriptions for CRNAs that can be job-matched to VA CRNA grade levels. A VA medical facility may expand the geographic area surveyed when the surveyed area will not adequately reflect the local market area salaries for CRNAs or there are less than three job matches.

Once the survey is completed, a facility's HR officer reports the results to the medical facility director and on the basis of the survey data, recommends whether to adjust VA CRNA salaries. The facility director makes the final decision on whether to adjust the facility's VA CRNA salaries and, therefore, may choose not to adjust existing salaries regardless of what the survey data show, according to VA's policy. VA medical facility directors consider the competing demands for funding across the facility when making decisions about VA CRNA salary increases.

VA's LPS policy requires VA medical facilities to report annually to VA headquarters on VA CRNA staffing, such as the vacancy and turnover rates for VA CRNAs within the recent fiscal year. VA medical facilities are also required to report whether the facility had a pay-related staffing problem as determined by the medical facility director and whether a medical facility director used a locality pay survey to determine if VA CRNA salaries should be adjusted. VA reported that in 2005 and 2006 all VA medical facility directors who determined that a significant pay-related staffing problem existed or was likely to exist at their facility used a locality pay survey to determine whether VA CRNA salaries should be adjusted.

The Majority of VA Medical Facilities Used LPS, but Instances of Incorrect Use Indicated Inadequate Training on LPS Policy

In December 2007 we reported that according to VA, the majority—86 out of 120—of the VA medical facilities that employ VA CRNAs used VA's LPS to determine whether to adjust salaries of VA CRNAs at their facilities. Of those facilities that used VA's LPS, 63 used a third-party survey to obtain data on local market area salary rates for CRNAs.

We also reported that, while VA facilities that employed VA CRNAs used LPS, five of the eight facilities we visited did not use the LPS in accordance with VA's LPS policy in 2005 or 2006. VA's LPS policy is designed to ensure that facility officials have a mechanism to determine whether their VA CRNA salaries should be adjusted to be competitive in recruiting and retaining VA CRNAs. By not fully following this policy, officials at these five facilities made decisions to adjust or not adjust VA CRNA salaries without sufficient data on the salaries of CRNAs in their local market areas.

At the five VA medical facilities that did not fully follow VA's LPS policy correctly, facility officials with oversight responsibility for the LPS were not knowledgeable about certain aspects of the LPS policy. One facility official told us that the third-party salary survey data were determined to be insufficient, so the facility used salary data from a Hot Jobs Web site to determine whether to adjust VA CRNA salaries. The official was unaware that this data source cannot be considered valid survey data for the purpose of adjusting VA CRNA salaries. At one facility, officials applied an outdated methodology for adjusting VA CRNA salaries and in doing so did not fully follow the most current LPS policy. The outdated policy only permitted VA medical facility officials to adjust salary rates for each VA CRNA grade at 5 percent above or below the beginning CRNA salary rates in local market areas. In contrast, VA's current LPS policy allows facility officials to adjust these salaries in order to be competitive. The remaining three facilities did not have sufficient salary data from their own facility-conducted surveys to determine whether VA CRNA salaries should be adjusted, and officials from these facilities told us they believed they could not use salary data of CRNAs that work for organizations that contract CRNA anesthesia services. These officials were unaware that VA's policy allows them to expand their data collection to include the use of salary data of CRNAs that work for organizations that contract anesthesia services if the data they had previously collected were insufficient.

The problems some VA medical facilities had fully following VA's LPS policy, along with the explanations of facility officials, indicated that VA had not provided adequate training on its LPS policy. VA medical facility officials can refer to VA's LPS policy when they have questions, or they can contact VA headquarters, according to a VA official. VA last changed its LPS policy in 2001, which resulted in a number of changes, such as the use of third-party surveys and the use of salary data of CRNAs that work

for organizations that contract anesthesia services. VA, however, had not conducted nationwide training on its LPS policy since 1995.[11] As a result, VA medical facility officials had not received LPS training that reflected VA's current LPS policy and, accordingly could not ensure that VA CRNA salaries had been adjusted as needed to be competitive.

In our December 2007 report we noted that VA was in the process of developing a Web-based training course for the LPS that VA medical facility officials could complete online. We reported that because VA had not made the training a priority, it had not established a time frame for finalizing the development and implementation of the training course. In our December 2007 report we recommended that VA expedite the development and implementation of the training course for VA medical facility officials responsible for compliance with the policy. VA agreed with our recommendation and in comments on our draft report stated that it had developed a draft action plan for training staff on its LPS policy. VA anticipated that the online training course would be available by the end of fiscal year 2008.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions you or other members of the committee may have.

Contact and Acknowledgments

For more information regarding this testimony, please contact Marjorie Kanof at (202) 512-7114 or kanofm@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. In addition, Marcia Mann, Assistant Director; N. Rotimi Adebonojo; Mary Ann Curran; Melanie Egorin; and Krister Friday made key contributions to this testimony.

[11]VA stated in its comments on our 2007 draft report that a 2-hour conference call in November 2002 provided nationwide training on the new provisions in VA's LPS policy. However, none of the VA medical facility officials we interviewed during our review mentioned this training session.

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Chairman AKAKA. Thank you very much, Dr. Kanof.

Dr. McDonald?

STATEMENT OF JOHN A. McDONALD, M.D., PH.D., VICE PRESIDENT FOR HEALTH SCIENCES AND DEAN, UNIVERSITY OF NEVADA SCHOOL OF MEDICINE, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. MCDONALD. Thank you, Mr. Chairman, Mr. Rockefeller, Ms. Murray. I appreciate the opportunity to speak on behalf of the American Association of Medical Colleges and myself. I bring somewhat a different perspective to this dialog. Prior to assuming my

current position in the State of Nevada, I was the Chief of the Medical Service at the Utah Veterans Administration Medical Center in Salt Lake City and was responsible there for the care of veterans and also practiced as a pulmonary physician and internal medicine specialist. Now, I am seeing this dialog through a different set of eyes and hope to share with you briefly some of my observations and those of the AAMC.

This is about recruiting the very best and brightest to serve those who have served the country, as Abraham Lincoln put it so well. Unfortunately, we are all facing a major workforce shortage in physicians as well as in nurses and other health care professionals. Our workforce is aging, just as America is aging. We also have a smaller pipeline to train health care professionals, specifically with regard to physicians. Medical school has not kept up with the growing population of the United States.

In addition, residency training, and every physician in order to become a licensed practitioner must train a minimum of 3 years and sometimes as many as 7 or 8 in order to practice a specialty or sub-specialty, is capped in existing hospitals, civilian hospitals that already have residency programs. This does not make allowances for rapidly-growing States in the West. One example of that: we are 47th out of 50 States with respect to physicians in the workforce; and 50th out of 50 with respect to nurses, and we have the lowest number of physicians-in-training and residencies of any State in the Union with the medical school. So, we are particularly aware, keenly aware, of these problems with the pipeline.

The VA has taken a leadership role in trying to address these issues. It has increased its residency training, as I note in my written testimony, and has increased each year and is trying to go from 9 percent to 11 percent of the total training opportunities for medical residents in this country.

This is extremely important. Residents who train at the VA are much more likely to have a favorable perception of working in the VA, and I would like to add for the record that my own perception of working in the VA, both in a leadership position and as a practicing physician, was entirely positive. I left the institution with great regard for the staff, the nurses, the physicians, the leadership; particularly high regard for the veterans who served our country; and for many reasons, it can be a very attractive work environment for a physician. But if you are not exposed to that environment, you won't learn the benefits of working in it.

We heard in earlier testimony some of the challenges in obtaining specialists to work in the VA, and I think that there are a number of issues that could help in this regard. The average medical student graduates with a debt of approximately $140,000. That is before they enter their residency training. Loan repayment, we think, and the legislation sponsored by Senator Durbin is an important step forward in this regard—would be a very attractive incentive. It has worked well to recruit physicians to rural locations that are underserved in the National Health Service Corps and I believe it would be a very positive enhancement for the VA.

A robust academic affiliate is absolutely essential. You heard from two of the best Veterans Administration hospitals with respect to their relationships with their peer academic institutions—

from Ms. Cullen, the Director of the San Francisco VA, and Mr. Kleinglass, the Director of the Minneapolis VA. These are paradigms of what can be achieved when there is a successful partnership between academia and a Veterans Administration hospital. This standard is one we all strive for. It is not always met because of challenges within the local environment.

A critical part of this is Veterans Administration research and development. One of the attractive lures for young physicians to join the VA is access to a separate pot of money which is restricted to VA physicians and researchers. Unfortunately, over the past several years, despite this Committee's great efforts in the past year to secure more funding, the VA research infrastructure and the research budget have suffered, and I believe that this is well worth the attention of the Committee in terms of being a very positive incentive for attracting promising young physician scientists into the VA system. It is a crisis nationally.

Our young physicians, physician scientists like myself, are simply not choosing an academic path because of the difficulties in funding. The first independent research award, for example, granted to M.D.s does not occur until the mid-40's, which is an astonishing figure to me, and the VA research environment can do a lot to reverse this trend and to recruit the best and brightest into the VA hospitals.

That concludes my spoken testimony, Mr. Chairman. Thank you.

[The prepared statement of Dr. McDonald follows:]

PREPARED STATEMENT OF JOHN A. MCDONALD, M.D., PH.D., VICE PRESIDENT FOR HEALTH SCIENCES AND DEAN OF THE UNIVERSITY OF NEVADA SCHOOL OF MEDICINE; AND MEMBER OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, VETERANS AFFAIRS-DEANS LIAISON COMMITTEE

Good morning and thank you for this opportunity to testify on the recruitment and retention of health professionals at the Department of Veterans Affairs (VA). I am Dr. John McDonald, Vice President for Health Sciences and Dean of the University of Nevada School of Medicine and a member of the Association of American Medical Colleges (AAMC) VA-Deans Liaison Committee. I also recently served as the Chief of Medicine at the Salt Lake City VA Medical Center. The University of Nevada is affiliated with the Reno and Las Vegas VA medical centers of the Sierra Pacific and Desert Pacific Veterans Integrated Service Networks (VISNs 21 and 22, respectively).

The AAMC is a not-for-profit association representing all 129 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

I would like to thank the committee for your support of the Veterans Health Administration (VHA) in the fiscal year 2009 budget resolution. Your leadership resulted in the Senate's passage of $48.2 billion for fiscal year 2009 discretionary veterans programs, including medical care.

For the Veterans Health Administration programs in fiscal year 2009, the AAMC recommends $42.8 billion for VA medical care, $55 million for VA Medical and Prosthetic Research, and $45 million for VA research facilities improvement. This funding is crucial to the continued success of the primary sources of VA's physician recruitment and retention: academic affiliations, graduate medical education, and research.

PHYSICIAN SHORTAGE

Concerns about physician staffing at the VA come at the same time the Nation faces a pending shortage of physicians. Recent analysis by the AAMC's Center for Workforce Studies indicates the United States will face a serious doctor shortage in the next few decades. Our Nation's rapidly growing population, increasing numbers

of elderly Americans, an aging physician workforce, and a rising demand for health care services all point to this conclusion.

Many areas of the country and a number of medical specialties are already reporting a scarcity of physicians. Approximately 30 million people now live in federally designated physician shortage areas. An acute national physician shortage would have a profound effect on access to VA health care, including longer waits for appointments and the need to travel farther to see a doctor.

Currently, 744,000 doctors practice medicine in the United States. But 250,000—one in three of these doctors—are over age 55 and are likely to retire during the next 20 years, just when the baby boom generation begins to turn 70. The annual number of physician retirees is predicted to increase from more than 9,000 in 2000 to almost 23,000 in 2025. Meanwhile, since 1980, the number of first-year enrollees in U.S. medical schools per 100,000 population has declined annually. Consequently, America is producing fewer and fewer doctors each year relative to our continually growing population.

Because it can take as many as 7 to 10 years after college graduation until new doctors enter practice, the AAMC believes that we must begin to act now to avert a physician shortage. Specifically:

- The AAMC has called for a 30 percent increase in U.S. medical school enrollment by 2015, which will result in an additional 5,000 new M.D.s annually.
- To accommodate more M.D. graduates, the AAMC supports a corresponding increase in the number of federally supported residency training positions in the Nation's teaching hospitals.

RECRUITMENT INCENTIVES

With difficulty recruiting health professions, the VA in some cases has similar characteristics to certain rural and urban areas, population groups, or medical facilities designated as "underserved" by the U.S. Department of Health and Human Services. The National Health Service Corps (NHSC) has a proven track record of expanding access for underserved populations by supplying physicians to federally designated shortage areas. The NHSC provides scholarship and loan forgiveness awards in exchange for service in qualifying "health professions shortage areas" (HPSAs). After 5 years of service, the majority of physicians are able to forgive their entire educational debt.

Similarly, the VA's Education Debt Reduction Program (EDRP) provides newly appointed VA health care professionals with educational loan repayment awards. However, the EDRP is limited to $49,000 spread out over 5 years of service. As the average medical education indebtedness has climbed to over $140,000 in 2007, the limited EDRP awards fail to provide an adequate incentive for most physicians.

The AAMC has had initial discussions with Senator Dick Durbin's office regarding the "Veterans Health Care Quality Improvement Act of 2007" (S. 2377), which has been referred to the Senate Committee on Veterans Affairs for consideration. The AAMC is strongly supportive of the bill's proposed increases for VA physician educational loan repayment in exchange for at least 3 years of service in "hard-to-fill positions," as determined by the VA. Under this program, VA physicians would be eligible for up to $30,000 in loan forgiveness per year until their medical education debt had been repaid.

ACADEMIC AFFILIATIONS

The affiliations between VA medical centers and the Nation's medical schools have provided a critical link that brings expert clinicians and researchers to the VA health system. The affiliations began shortly after World War II when the VA faced the challenge of an unprecedented number of veterans needing medical care and a shortage of qualified VA physicians to provide these services. As stated in seminal VA Policy Memorandum No. 2 published in 1946, the affiliations allow VA to provide veterans "a much higher standard of medical care than could be given [them] with a wholly full-time medical service."

Over six decades, these affiliations have proven to be mutually beneficial by affording each party access to resources that would otherwise be unavailable. It would be difficult for VA to deliver its high quality patient care without the physician faculty and medical residents who are available through these affiliations. In return, the medical schools gain access to invaluable undergraduate and graduate medical education opportunities through medical student rotations and residency positions at the VA hospitals. Faculty with joint VA appointments are also afforded opportunities for research funding that are restricted to individuals designated as VA employees.

These faculty physicians represent the full spectrum of generalists and specialists required to provide high quality medical care to veterans, and, importantly, they include accomplished sub-specialists who would be very difficult and expensive, if not impossible, for the VA to obtain regularly and dependably in the absence of the affiliations. According to a 1996 VA OIG report, about 70 percent of VA physicians hold joint medical school faculty positions. These jointly appointed clinicians are typically attracted to the affiliated VA Medical Center both by the challenges of providing care to the veteran population and by the opportunity to conduct disease-related research under VA auspices.

At present, 130 VA medical centers have affiliations with 107 of the 129 allopathic medical schools. Physician education represents half of the over 100,000 VA health professions trainees. In a 2007 Learners Perceptions Survey, the VA examined the impact of training at the VA on physician recruitment. Before training, 21 percent of medical students and 27 percent of medical residents indicated they were very or somewhat likely to consider VA employment after VA training. After training at the VA, these numbers grew to 57 percent of medical students and 49 percent of medical residents.

VA GRADUATE MEDICAL EDUCATION

Today, the VA manages the largest graduate medical education (GME) training program in the United States. The VA system accounts for approximately 9 percent of all GME positions in the country, supporting more than 2,000 ACGME-accredited programs and 9,000 full-time medical residency training positions. Each year approximately 34,000 medical residents (30 percent of U.S. residents) rotate through the VA and more than half the Nation's physicians receive some part of their medical training in VA hospitals.

As our Nation faces a critical shortage of physicians, the VA has been the first to respond. The VA plans to increase its support for GME training, adding an additional 2,000 positions for residency training over 5 years, restoring VA-funded medical resident positions to 10 to 11 percent of the total GME in the United States. The expansion began in July 2007 when the VA added 342 new positions. These training positions address the VA's critical needs and provide skilled health care professionals for the entire Nation. The additional residency positions also encourage innovation in education that will improve patient care, enable physicians in different disciplines to work together, and incorporate state-of-the-art models of clinical care—including VA's renowned quality and patient safety programs and electronic medical record system. Phase 2 of the GME enhancement initiative has received applications requesting 411 new resident positions to be created in July 2008.

VA-AAMC DEANS LIAISON COMMITTEE

The smooth operation of VA's academic affiliations is crucial to preserving the health professions workforce needed to care for our Nation's veterans. The VA-AAMC Deans Liaison Committee meets regularly to maintain an open dialog between the VA and medical school affiliates and to provide advice on how to better manage their joint affiliations. The committee consists of medical school deans and VA officials, including the VA Chief Academic Affiliations Officer, the VA Chief Research and Development Officer, and three Veterans Integrated Service Network (VISN) directors. The committee's agendas usually cover a variety of issues raised by both parties and range from ensuring information technology security to the integrity of sole-source contracting directives.

Recently, the VA-Deans Liaison Committee has reviewed the remarkable progress being made on several VA initiatives. These include:

Establishment of the Blue-Ribbon Panel on Veterans Affairs Medical School Affiliations—This panel will provide advice and consultation on matters related to the VA's strategic planning initiative to assure equitable, harmonious, and synergistic academic affiliations. During the panel's deliberations, those affiliations will be broadly assessed in light of changes in medical education, research priorities, and the health care needs of veterans.

Survey of Medical School Affiliations—The AAMC has worked with VA staff to develop criteria to evaluate the "health" of individual affiliation relationships. The "Affiliation Governance Survey" will survey the leadership at both the VA medical centers and their affiliated schools of medicine on a range of topics including:

- Overall satisfaction and level of integration;
- Affiliation Effectiveness Factors (such as education, research, VA clinical practice environment, and faculty affairs);
- Overall commitment to the affiliation relationship;
- Academic affiliations partnership councils (Dean's committees); and

- Direction and value of school of medicine-VA medical center affiliations.

Development of VA Handbook on VHA Chief of Staff Academic Appointments— To prevent conflicts of interest or the appearance thereof, the VA has determined that limits on receiving remuneration from affiliated institutions are necessary for VHA chiefs of staff and higher levels. While it is important to ensure that remuneration agreements do not create bias in the actions of VHA staff, prohibition of certain compensation from previous academic appointments (e.g., honoraria, tuition waivers, and contributions to retirement funds) could significantly hinder the VA's ability to recruit staff from their academic affiliates. The AAMC has worked with VA staff to develop a mutually acceptable agreement that considers this balance.

Piloting the VA physician time and attendance/hours bank—Monitoring physician time and attendance for the many medical faculty holding joint appointments with VA medical centers has been complicated and inefficient. The VHA has accepted the "hours bank" concept to improve the tracking of part-time physician attendance. Under the hours bank, participating physicians will be paid a level amount over a time period agreed to in a signed Memorandum of Service Level Expectations (MSLE). This agreement will allow the supervisor and participating physician to negotiate and develop a schedule for the upcoming pay period. A subsidiary record will track the number of hours actually worked, and a reconciliation will be performed at the end of the MLSE period to adjust for any discrepancies. A pilot for this program has been successfully completed and plans for nationwide implementation are underway.

The VA has consistently recognized that there is always room for improvement. As such, the AAMC looks forward to working on other items of concern as the VA continues to evaluate its affiliation policies and processes. As medical care shifts to a more satellite-based outpatient approach, graduate medical education needs to follow suit. This strong shift to ambulatory care at multiple sites requires a similar change in the locus of medical training. A dispersion of patients to multiple sites of care makes more difficult the volume of patient contact that is crucial to medical training. Similarly, faculty diffusion to multiple sites also makes more difficult the development of a culture of education and training. This is not exclusively a VA problem and all of our Nation's medical schools and teaching hospitals are working to cope with this shift.

Another concern at both VA and non-VA teaching hospitals is the growing salary discrepancy between more specialized fields of medicine and the other disciplines. With the "Department of Veterans Affairs Health Care Personnel Enhancement Act of 2003" (Pub. L. 108–445, dubbed the "VA-Pay bill"), the VA made significant strides beyond its private-hospital counterparts. However, this discrepancy continues to be an issue of concern. Once again, this is not exclusively a VA problem, but one faced by all medical schools and teaching hospitals.

VA MEDICAL AND PROSTHETIC RESEARCH PROGRAM

To accomplish its aforementioned mission, VHA acknowledges that it needs to provide "excellence in research," and must be an organization characterized as an "employer of choice." The VA Medical and Prosthetic Research program is one of the Nation's premier research endeavors and attracts high-caliber clinicians to deliver care and conduct research in VA health care facilities. The VA research program is exclusively intramural; that is, only VA employees holding at least a five-eighths salaried appointment are eligible to receive VA awards. Unlike other Federal research agencies, VA does not make grants to any non-VA entities. As such, the program offers a dedicated funding source to attract and retain high-quality physicians and clinical investigators to the VA health care system.

VA currently supports 5,143 researchers, of which nearly 83 percent are practicing physicians who provide direct patient care to veteran patients. As a result, the VHA has a unique ability to translate progress in medical science directly to improvements in clinical care.

The VA Research Career Development Program attracts, develops, and retains talented VA clinician scientists who become leaders in both research and VA health care. For VA clinical investigators, the awards (normally 3–5 years) provide protected time for young investigators to develop their research careers. Awardees are expected to devote 75 percent time to research as well as to apply for additional VA Merit-Reviewed funding and non-VA research support. The remainder of their time is devoted to non-research activities such as VA clinical care or teaching. The program is designed to attract, develop, and retain talented VA researchers in areas of particular importance to VA. The Office of Research and Development supports approximately 458 awardees, at a cost of $55 million in fiscal year 2006, in all areas

of medical research including basic science, clinical medicine, health services and rehabilitation research. The VA retains approximately 56 percent of participants as VA principal investigators. This research program, as well as the opportunity to teach, is a major factor in the ability of VA to attract first class physician talent.

Since 2005, inadequate funding for VA research has forced the Department to cap many VA merit-review awards at a mere $125,000 annually. The current cap fails to keep pace with biomedical inflation and VA's commitment to scientific innovation. The cap—which is significantly lower than the average award at comparable Federal research programs—is a tradeoff that VA leadership has had to make to continue funding the same number of grants it has historically supported. To compete with its private counterparts, funding for VA research must be steady and sustainable while allowing for innovative scientific growth to address critical emerging needs. For fiscal year 2009, the AAMC recommends an appropriation of $555 million for the VA Medical and Prosthetic Research program.

EARMARKS AND DESIGNATION OF VA RESEARCH FUNDS

The AAMC opposes earmarks because they jeopardize the strengths of the VA Research program. VA has well-established and highly refined policies and procedures for peer review and national management of the entire VA research portfolio. Peer review of proposals ensures that VA's limited resources support the most meritorious research. Additionally, centralized VA administration provides coordination of VA's national research priorities, aids in moving new discoveries into clinical practice, and instills confidence in overall oversight of VA research, including human subject protections, while preventing costly duplication of effort and infrastructure.

VA research encompasses a wide range of types of research. Designated amounts for specific areas of research compromise VA's ability to fund ongoing programs in other areas and force VA to delay or even cancel plans for new initiatives. While Congress certainly should provide direction to assist VA in setting its research priorities, earmarked funding exacerbates resource allocation problems. AAMC urges the Committee to continue preserving the integrity of the VA research program as an intramural program firmly grounded in scientific peer review. These are principles under which it has functioned so successfully and with such positive benefits to veterans and the Nation since its inception.

VA RESEARCH INFRASTRUCTURE

State-of-the-art research requires state-of-the-art technology, equipment, and facilities. Such an environment promotes excellence in teaching and patient care as well as research. It also helps VA recruit and retain the best and brightest clinician scientists. In recent years, funding for the VA medical and prosthetics research program has failed to provide the resources needed to maintain, upgrade, and replace aging research facilities. Many VA facilities have run out of adequate research space. Ventilation, electrical supply, and plumbing appear frequently on lists of needed upgrades along with space reconfiguration. Under the current system, research must compete with other facility needs for basic infrastructure and physical plant support that are funded through the minor construction appropriation.

To ensure that funding is adequate to meet both immediate and long term needs, the AAMC recommends an annual appropriation of $45 million in the VA's minor construction budget dedicated to renovating existing research facilities and additional major construction funding sufficient to replace at least one outdated facility per year to address this critical shortage of research space.

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on this important issue. I hope my testimony today has demonstrated that the recruitment and retention of an adequate physician workforce is central to the success of VA's mission. The extraordinary partnership between the VA and its medical school affiliates, coupled with the excellence of the VA Medical and Prosthetics Research program, allows VA to attract the Nation's best physicians. Over the last 60 years, we have made great strides toward preserving the success of our affiliations. With the hard work of VA-AAMC Deans Liaison Committee and the VA's Blue Ribbon Panel on Medical School Affiliations, I am confident that this success will continue.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO JOHN A. MCDONALD, M.D., PH.D., VICE PRESIDENT FOR HEALTH SCIENCES AND DEAN, UNIVERSITY OF NEVADA SCHOOL OF MEDICINE ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, VETERANS AFFAIRS-DEANS LIAISON COMMITTEE

DEAR SENATOR MURRAY: Thank you for your inquiry regarding my testimony before the Senate Committee on Veterans' Affairs. Here are my responses.

INCENTIVES FOR RECRUITMENT

Question 1. Dr. McDonald, I know that many questions have been discussed to deal with the VHA's workforce issues. Things such as signing bonuses, loan repayment, relocation expenses, and retention bonuses for those already employed.

What are some of the other things that we can do to attract people to the VHA, particularly with regard to rural areas?

Response. Several possible strategies are worth considering, including:

- Providing medical student scholarships with forgiveness for service clauses, emphasizing students from rural areas. Our own students who come from rural Nevada are more comfortable there, and more likely to relocate to rural areas upon completion of training.
- Create robust telemedicine links between rural practices and VA medical centers, to create a more supportive virtual environment for the solo or small group clinic.
- Set up a formal mentorship/partnership between rural providers and VA facilities the rural provider will be referring patients to.
- Work with the AAMC, ACGME and schools of medicine to encourage residency training in VA rural sites as part of their outpatient experience. As I noted in my testimony, exposure to the VA medical environment is key in altering perceptions of caregivers.

VA RESEARCH CUTS

Question 2. Dr. McDonald, in your testimony you mentioned that the VA Medical and Prosthetic Research program "attracts high-caliber clinicians to deliver care and conduct research in VA health care facilities." As you know, the President cut funding for this critical program in his fiscal year 2009 budget request.

Can you discuss in more detail what budget cuts to the VA's research budget does to the morale of VA's current workforce and how it impacts the department's ability to recruit high quality health care professionals?

Response. My experience includes serving as chief of medicine in a VA facility, NIH funded investigator within the VA system, brief tenure as ACOS for Research and Development, and meetings with central VA administration. Based on this and discussions with fellow deans of medicine, I believe that the diminishing VA research budget, combined with aging and inadequate research facilities at many stations, has a very deleterious effect upon morale, recruitment and retention. Historically, the VA has been seen as an environment fostering the development of young physician investigators and Ph.D. scientists. It was this atmosphere of inquiry and scholarship that attracted and kept the best and brightest investigators and physicians within the VA. Now, more than ever, the VA and those it serves will benefit from the development and application of new diagnostic and therapeutic modalities, driven by these highly motivated individuals.

DOD AND VA COLLABORATION

Question 3. Over the past couple of years, there has been a lot of attention focused on the seamless transition between the VA and the DOD when it comes to information sharing.

Thinking along those lines, is there any way that the VHA and the DOD could pool together and share some of their resources to fill in some of the gaps in clinical coverage?

Response. I have read the testimony presented for the Record by the Honorable Gordon England, Deputy Secretary of Defense, and the Honorable Gordon Mansfield, Deputy Secretary of Veterans Affairs before the Senate Committee on Armed Services on 13 February 2008. I have little to add to this report, as this specific topic is not one that I have experience in. It would appear as you point out that the move toward seamless sharing of medical information between DOD and VA is of particular benefit in facilitating the care of our wounded veterans. In addition, where possible, sharing physicians and other care givers between VA and DOD facilities could be used to extend services of scarce specialties or ameliorate local shortages in care givers.

Chairman AKAKA. Thank you very much, Dr. McDonald.
Ms. O'Meara?

STATEMENT OF VALERIE O'MEARA, N.P., VA PUGET SOUND HEALTH CARE SYSTEM, PROFESSIONAL VICE PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES LOCAL 3197

Ms. O'MEARA. Chairman Akaka, Mr. Rockefeller, and Ms. Murray, thank you for inviting me here to testify today. My name is Valerie O'Meara. I am from Seattle, Washington. I have worked as a primary care and emergency room nurse practitioner at the VA Puget Sound Health Care System for the past 13 years, which is my entire career as a nurse practitioner. I am also a union representative for the nurses, physicians, and other health care professionals at my facility.

In 1993, the VA paid all of my tuition plus a stipend so I could attend the University of Pennsylvania to pursue my master's degree in nursing. In exchange, I had to work at the VA for 2 years. Obviously, I am still there, and why is that? It is because I love working with the veterans and taking care of the veterans. I get so much professional fulfillment from helping them and knowing that they really need the care that we provide. My own father is a Korean War veteran, and I can think of no better place to gain valuable experience than as a front-line health care provider in the VA. We get exposed to such a wide range of medical issues. The VA is a terrific learning environment, as has been attested to, as well.

At Puget Sound, we get to consult often with the medical faculty of the University of Washington. We have regular in-services where we discuss ongoing research and how to apply it to our practice. The VA is a true culture of learning.

So, why am I seeing so many nurses quit the VA after a few years, especially ward nurses or staff nurses? First, it is so difficult for them to get the type of pay they see nurses getting in private hospitals right nearby. Our nurses are not getting the flexible work schedules that are so popular in nursing today. And with too little staff to care for the veterans, the work environment becomes highly stressful and low on respect for the employees' ability to make good decisions.

When it comes to getting educational help, not everyone has had as good of an experience as I had. For example, right now, I am battling a case for a nurse practitioner in which the VA is trying to withhold the remaining 3 years of her promised EDRP, or Education Debt Reduction Program payments, because they are insisting—incorrectly, we believe—that she transferred to an ineligible nursing position. Management is not only reading the law wrong, they are letting this drag on for over 3 years. Both the local and the central office EDRP managers, each are denying that they have authority for declaring that nurse ineligible.

We fought another battle over educational assistance that shows how often management doesn't understand these programs. An R.N. at Puget Sound got her master's degree to become a nurse practitioner with the help from the NNEI Program, but human resources and nursing refused to hire her when an NP vacancy came

up in the area she was already working in as a nurse, claiming she didn't have enough experience as a nurse practitioner. In the meantime, we had to fight just to get her enough hours to maintain her new license, because you do have to practice in the State of Washington to maintain your licensure. She finally quit out of frustration and got hired immediately as a nurse practitioner at the University of Washington.

EDRP and other education assistance programs are clearly a win-win for management, veterans, and employees carrying large school debts. But, managers need to understand them and facilities need enough sense so applicants are no longer turned away, especially when funds are lying around unused in other VA facilities.

We all know how expensive education is these days, and as a parent, I certainly worry about it. It would also be helpful to increase the amount of assistance that can be given to each employee in the program to keep up with today's tuition costs.

A few years ago, we learned that the VA was no longer offering EDRP for continuous open announcements. Instead, rather, it was linking EDRP offers to specific position announcements and I think this is short-sighted. EDRP should be offered throughout nursing and throughout other professional jobs. I also think it could be a great retention tool if it were offered not to just new employees, because it would help hold on to the nurses the VA has already invested in.

I also don't understand why management is so resistant to conducting nurse locality pay surveys to keep us competitive—and we have to stay competitive. In Seattle, the private sector lures our nurses away with huge pay increases all the time. When management does these surveys, we, as employees and union, are kept in the dark. They don't tell us when they conduct third-party surveys at my facility, for example; and when we tried to access the survey data—data that we need to be sure that our pay is being correctly set—we are turned down and told we can't challenge it through the grievance process.

We recently had to go through a long and difficult process to get more pay for advanced practice nurses. First, we asked for a one-time retention pay increase from our nurse executive. And the reason we did that is because she had declared us officially "difficult to recruit and retain" about 6 months prior. She insisted on tying the retention bonus or pay to a performance standard, even though that is not what the law says. We submitted a petition with approximately 20 signatures of advance practice nurses, and only after the new director had recently arrived, he saw the petition and that is when we learned that, in fact, a locality pay survey had recently been done. He looked at it again and decided to give us a raise, and we do want to give him kudos for that. He acted very quickly and we got a substantial raise.

The Locality Pay System definitely needs to be more transparent and conducted with a better understanding of the survey process. so nurses don't have to go through such frustration and delays.

I am fortunate that the VA lets me work part-time so I can spend more time with my 4- and 6-year-old boys. But I only learned recently, after the fact, that there is a real cost to being a part-time nurse at the VA. I worked full-time for approximately

5 years before switching to part-time, and as a full-time nurse, I went through my two-year probationary period and became a permanent employee with grievance rights, reduction-in-force rights, and other appeal rights. No one ever explained to me that I would lose all of these rights and essentially had become an "employee at will" when I became part-time.

And parents are not the only ones who may need to work part-time. Since I started at Puget Sound, the nursing workforce has gotten noticeably older. There are nurses who have worked at the VA for a very long time who want to switch to part-time because, out of many reasons, one is that they are caregivers for their elderly parents or they need to reduce the stress of this very demanding job.

It seems only fair that full-time nurses become permanent employees with appeal rights and job security after 2 years, that part-timers should earn the same rights when they work the equivalent of 2 years. And for nurses like me who already went through a 2-year probationary period, we should not have to go through it again just because we now fall under a different section of the law. One thing is certain. I am going to make top priority to educate our nurses about the tradeoffs of part-time employment.

I want to close by expressing my hope that we can go back to the labor-management partnerships that used to be in place at the VA, to work together to improve patient care and working conditions. Nurses at Puget Sound who are part of these partnerships tell me how great it was to have their opinions valued and to feel like they had an equal voice in making VA health care even better for the veterans. Isn't it easier to work together than to be at odds, after all?

Thank you again for the great honor of testifying before this Committee.

[The prepared statement of Ms. O'Meara follows:]

PREPARED STATEMENT OF VALERIE O'MEARA, N.P., PROFESSIONAL VICE PRESIDENT, AFGE LOCAL 3197, VA PUGET SOUND HEALTH CARE SYSTEM, SEATTLE, WASHINGTON, ON BEHALF OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Dear Chairman and Members of the Committee: On behalf of the American Federation of Government Employees (AFGE), I thank you for the opportunity to testify regarding recruitment and retention of Department of Veterans' Affairs (VA) health care professionals.

Throughout my thirteen-year career as a Nurse Practitioner (NP), I have worked at the VA Puget Sound Health care System in Seattle, Washington. As the Professional Vice President of AFGE Local 3197 at Puget Sound, I am also in regular communication with other nurses and health care professionals at my facility. Through my participation in the VISN 20 Advanced Practice Nurse (APN) Advisory Group to the Office of Nursing Service and AFGE National VA Council discussion forums, I also hear a great deal about what health professionals at other facilities are experiencing.

We feel as if we have to fight harder each year for the pay and working conditions that we should be entitled to by law. The VA is losing nurses to private sector jobs where the pay is more competitive, shifts are more flexible and their input into hospital matters are more valued. In my facility, I see many RNs and NPs leave in frustration after only a few years with the VA. This turnover is very expensive. As I recently pointed out to management in an effort to secure APN retention pay, nursing research shows that the replacement cost of a nurse in an acute care facility is at least twice that nurse's regular salary. By the VA's own estimates, it costs $100,000 to bring on a new nurse.

At the same time, our older nurses retire as soon as they can, and many go on to work in the private sector. Nationwide, nearly two-thirds of VA's registered nurses will be eligible to retire in 2010. Since I have gotten there, the average age of nurses at Puget Sound has increased noticeably.

It is especially frustrating for us to see Congress take steps to address this impending crisis with good pay and scheduling laws, only to have VA management undermine Congress' intent through loopholes, delay, and inaction.

Our facility is less short staffed than some others, but we have still seen an impact on veterans' care. Whenever our ICU is full, we cannot take ambulance calls and veterans must be diverted elsewhere. This seems to happen each winter, especially. As a result of huge backlogs for outpatient care in urology, podiatry, and other subspecialty clinics, patients with chronic illnesses such as diabetes are not getting monitored as frequently as they should. Puget Sound has massively increased its use of fee basis, non-VA providers to address these backlogs. Better recruitment and retention policies would be a preferable and less expensive alternative in the long run.

NURSE LOCALITY PAY

Nurse locality pay is a big source of frustration for VA nurses. In my facility, we were facing a serious recruitment and retention problem for APNs. We asked for retention bonuses and the Chief Nurse did declare us "hard to recruit." But instead of just giving us the bonuses, she wanted to tie our bonuses to our performance and require us to "highly perform" based on new criteria. We tried to explain to her and Human Resources what the law said and submitted a petition signed by almost 20 people. When the director arrived, he looked at a locality pay survey (LPS) that we did not even know existed, and decided to give us additional pay instead to address recruitment and retention.

I believe that if management received more training on LPS, there were be fewer problems across the country. Locality pay should be provided based on local labor market conditions, and be paid according to consistent rules, not on how hard employees fight for it or whether a particular manager decides to pay it.

I hear many stories from other facilities about delays in conducting surveys and management's unwillingness to share survey information. It is also very troubling that in many facilities, nurse managers receive their locality pay through separate, more favorable survey data.

The 2000 law also requires the VA to report annually on turnover rates, vacancies, staffing problems, and survey information from each facility. I have never seen this data and would find it very valuable. Therefore, I urge the Committee to strengthen these reporting requirements.

Nurse Premium and Overtime Pay

RNs have expressed frustration at the inconsistent application of premium pay (weekend pay and night shift differential pay) and overtime pay. At Puget Sound, management attempted to deny overtime pay for work above 8 hours because it involved charting, which management contended was not direct patient care. Here, too, it was only after the union contested this policy did they pay overtime according to the law. Perhaps additional training on these pay provisions would also be helpful.

Another problem is that nurses working on a part-time schedule are not consistently receiving overtime pay for shifts longer than 8 hours when the shift spans two calendar days.

More generally, we believe that the VA's premium and overtime pay policies must be competitive with those of other workplaces. We urge the Committee to take steps to ensure that premium pay is available to all RNs who perform services on weekends or off shifts, work overtime on a voluntary or mandatory basis, or work during on call duty, and that overtime rules are applied properly.

Other Needed Pay Adjustments

CRNA Pay: Facilities around the country are finding it increasingly difficult to recruit CRNAs. To ensure that VA's CRNAs can receive locality pay increases needed to keep the VA competitive with local market conditions, AFGE recommends lifting the current statutory pay cap that prohibits any RN pay to exceed that of the facility's chief nurse.

LPN Pay: Under current law (39 U.S.C. 7455), VA health care personnel who are not covered by specific pay legislation can receive special pay increases at the discretion of their directors to achieve competitive pay levels. This provision sets a cap on the size of this increase. Congress has exempted other professions (CRNAs, physical therapists, and pharmacists) from this in order to keep their pay competitive.

LPNs are now facing similar problems receiving needed special pay. Therefore, we urge this Committee to add LPNs to the exempted group.

I. COMPETITIVE NURSE WORK SCHEDULE POLICIES

In 2004, Congress provided VHA with two additional tools for recruitment and retention of RNs: alternative work schedules (AWS) and restrictions on mandatory overtime. As a result of delay and resistance by the VA at the national and local levels, both tools have failed to meet their potential for addressing VA nurse recruitment and retention problems.

Currently, local directors have complete discretion as to whether to offer AWS In my facility. The AWS schedule (either three 12-hour days or 9 month schedules) are not offered, even though they are available to nurses at other Seattle hospitals. Other VA nurses around the country report the same problem. If we attempt to challenge this, management says AWS is a nongrievable patient care issue under 39 U.S.C. 7422 (to be discussed.) It seems as if the law was never passed.

AFGE urges this Committee to hold the VA more accountable for proper implementation of the AWS law. An important first step would be to require the VA to provide data to Congress comparing the prevalence of AWS in the VA as compared to private employers, by each local labor market, in order to determine whether and to what extent the VA needs to offer AWS to its nurses to remain a competitive nurse employer.

Restrictions on Mandatory Overtime

We are fortunate at Puget Sound that voluntary nurse overtime meets the current need. However, I am aware of widespread problems in other facilities, where nurses are forced to work overtime on a frequent basis.

Once again, Congress' attempt to make VA hospitals safer and lessen nurse burnout has been thwarted. The law permits the VA to require overtime in cases of emergency. AFGE filed a national grievance to require the VA apply a nationally uniform definition of emergency consistent with common usage even though nine States (including Washington) have passed such laws, VA successfully blocked our challenge to the policy on emergencies based on "7422." As a result, facility directors continue to invoke the emergency exception when staffing shortages are the result of easily anticipated scheduling and hiring problems. AFGE urges the Committee to protect VA nurses and the safety of their patients by enacting a statutory, workable definition of emergency.

AFGE also supports expansion of overtime protections to LPNs and Nursing Assistants.

Finally, AFGE urges the Committee to strengthen the requirement in the overtime provision that VHA provide a report to Congress certifying that facilities have implemented nurse overtime policies. Reports issued to date appear to grant, without explanation, a large number of waivers to facilities that have not developed overtime policies.

II. PART-TIME NURSES

During my first 5 years at Puget Sound, I was full-time which meant I had job security in the event of a RIF and grievance and arbitration rights. When I switched to part-time to raise a family, I lost these rights—but no one made me aware of this at the time. I have seen the same thing happen to older nurses who have worked a decade or more for the VA who switch to part-time because of the stress of their job or to care for their aging parents. Now that I understand this two-tier system, it is a top priority for me as a union representative to educate our nurses about the tradeoffs of becoming part-time.

Part-time RNs represent a valuable resource for the VA. They should be able to accrue the rights of permanent employees after they work the equivalent of 2 years, just like their full-time colleagues. This will be a valuable recruitment and retention tool for the VA. We urge the Committee to take action to address this inequity.

III. EDUCATIONAL PROGRAMS

The VA has excellent educational programs to use as recruitment and retention tools, including the Education Debt Reduction Program (EDRP) and National Nursing Education Initiative (NNEI). With adequate funding, better resource allocation, and more national direction, these programs could be even more effective. VA has a long tradition of "growing its own", i.e., training employees in lower level positions to become registered nurses, and training RNs to become NPs.

One of the problems we are seeing is that once the employee completes his or her training, the VA does not provide a suitable position. At Puget Sound, one of our

RNs got assistance through the NNEI program to become an NP but management refused to hire her when an opening came up so she quit.

Nurses at other facilities report problems with EDRP, a highly effective program that ties tuition loan repayment to a commitment to work at the VA. Applicants are being turned away at some facilities because EDRP funds have been exhausted, while EDRP funds in other facilities remain unused. In addition, the EDRP grant amounts need to be raised to better match current educational costs.

IV. NURSES NEED TO BE HEARD

I am proud that VA nurses have played such an essential role in the past in transforming its health care system into a world leader in health care quality and cost effectiveness.

According to a January 2008 VA national RN satisfaction survey, for the past 2 years, "Participation in Hospital Affairs" was one of two areas (along with staffing) where RNs were the least satisfied. Yet, VA increasingly deprives front line nurses of meaningful opportunities for input into groups shaping policies on key issues such as patient safety and qualification standards. This hurts the veteran and the taxpayer as well.

The VA keeps saying that magnet status is its most effective nurse recruitment and retention tool because it is said to offer nurses a voice in organizational decisionmaking. I hear reports from nurses in a number of facilities that patient care dollars and substantial staff time are being diverted to the process of preparing magnet applications and paying large certification fees.

I find this very troubling and wasteful. VA has a long and successful track record in soliciting and using input from front-line nurses. The Department simply needs to return to a more collaborative approach and bring the nurses back into policy setting groups where they were once welcome, not use an expensive third party to hear from its nurses.

V. RECRUITMENT AND RETENTION CHALLENGES IN OTHER VA HEALTH CARE PROFESSIONS

AFGE also urges the Committee to examine obstacles to VA's ability to recruit and retain physicians and other professionals. In a health care system of this magnitude that encompasses three different personnel systems (Title 38, Title 5, and Hybrid Title 38) and hundreds of local labor markets, one size will surely not fit all, but swift action is needed nonetheless.

Physicians

VA physicians are facing great pressures to meet current patient demand without additional resources. In my facility, management wants to require physicians who take sick leave or vacation leave to make up the clinics they canceled, either on the weekends, evenings or during their administrative days that they need for other duties. If there were enough physicians in the VA workforce, others could cover when someone takes leave he or she has earned and needs.

At Puget Sound, we just lost our ER Director who was growing more and more frustrated at management for refusing to provide extra staff. Instead, ER doctors are required to work longer shifts. The ER has to draw from other pools on an ad hoc basis to find physicians to fill the gap. Clearly, a longer range staffing plan would be preferable.

Here too, the VA is undermining a valuable retention tool: the 2004 physician pay law (Pub. L. 108–445). Reduced reliance on contract physician services was at the top of Congress' agenda when this legislation. Based on our members' very mixed experiences with market pay and performance pay awarded under the new law, we are very doubtful that Congressional intent has been well served to date.

Unfortunately, the VA has not been forthcoming with its own data on recruitment, retention, and contract care. Although the pay bill has been in effect for 27 months, we have still not seen the 18 month report that Congress required the VA to provide. We believe veterans and the taxpayers deserve to see the evidence of whether contract care is the best solution to current VA physician shortages. More transparency in the pay process is greatly needed. In the market pay process that was first conducted 2 years ago, management excluded employee representatives from national groups that set pay ranges and selected survey. Front line practitioners were largely excluded at the local level from compensation panels setting individual pay, despite requirements in the law to include them. AFGE's own attempts to obtain information through the Freedom of Information Act were denied.

Annual physician performance pay awards under this law have been inconsistent and unjustifiably lower than the maximum amounts set by Congress. At many fa-

cilities, management has imposed improper performance criteria that determine bonuses based on factors beyond the practitioner's control, such as missed appointments. In very rare instances have front line physicians been allowed to have input in the selection of these critical criteria.

Unreasonable panel sizes are also causing severe morale problems among VA physicians, particularly in primary care and psychiatry. Many facilities keep raising their panel sizes, while others have simply lifted the ceiling altogether! As a result, practitioners do not have adequate time to assess the medical needs of new patients (e.g., no additional time is allowed for a first time exam of veterans with Traumatic Brain Injury) or enough patient openings to schedule needed follow up for veterans with chronic illnesses that require frequent monitoring. Management is also requiring them to work more weekend and evening hours without compensation to meet growing demand.

Other VA Health Care Professionals

AFGE members report significant recruitment retention problems in other VA professions due to pay policies and other factors. For example:

Physician Assistants: Like physicians, physician assistants (PAs) are also trying to deliver care in the face of unreasonable panel sizes. In addition, PAs lack an effective voice for their profession at the facility and national levels because the PA Advisor is only a part-time position. AFGE supports pending House legislation (H.R. 2790) to establish a full-time PA Advisor. AFGE also urges legislative action to more closely align PA pay and benefits, including professional education assistance, with the private sector.

Podiatrists: The demand for podiatry services is rising among elderly veterans with chronic illnesses and injured OEF/OIF veterans. Unfortunately, the VA's compensation package for podiatrists has been largely unchanged since 1976. As a result, the pay gap between the VA and private sector is widening, causing severe recruitment and retention problems.

Psychologists and the Hybrid Boarding Process: As part of the "hybrid Title 38" group of VA health care professionals, psychologists are required to go through a one-time boarding process to secure hybrid status and obtain promotions. Delays in the boarding process have been especially long and demoralizing: some psychologists have still not received their promotions 2 years after issuance of the board's recommendation. At a time when the VA is significantly increasing its mental health capacity, it is especially important that oversight from Congress and VA Central Office is increased to ensure that local facilities are carrying out the hybrid boarding process properly. More generally, AFGE is concerned about widespread delays in the hybrid boarding process that in some cases, are greater than hiring under Title 5. As a result, applicants awaiting credentialing and salary offers end up leaving for other positions because of long delays.

VI. OTHER RECRUITMENT AND RETENTION ISSUES

FERS Sick Leave: Currently, most Federal employees covered by the FERS retirement system cannot apply unused sick leave toward retirement, while their counterparts under the older CSRS system can. Congress carved out an exception under Title 38 for RNs several years ago. We urge that this benefit be extended to all VHA personnel as an added incentive for staying with the VA.

Disincentives in the Current Funding Process: Recruitment and retention strategies depend on a workable funding process. So long as VA health care relies on discretionary dollars, the system will suffer from unpredictable and inadequate funding. In turn, facility directors will continue to be rewarded for keeping a lid on their spending through fewer pay increases, promotions, and less hiring.

Title 38 Collective Bargaining Rights: As noted, VA's health care professionals are unable to challenge workplace policies on pay, scheduling, and other policies that hurt recruitment and retention, even when these policies are directly inconsistent with Congressional intent. Management asserts "nongrievability" under 38 USC 7422 in more and more instances. We greatly appreciate the important step that Senator Rockefeller and cosponsors Senators Webb, Brown, and Mikulski have taken by introducing S. 2824 to restore these critical rights.

Thank you.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO VALERIE O'MEARA, N.P., VA PUGET SOUND HEALTH CARE SYSTEM, PROFESSIONAL VICE PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES LOCAL 3197

Question 1. How effective is the locality pay system at your facility? Does your facility employ temporary health workers, particularly in the area of nursing?

Response. The locality pay system could be improved at our facility. There is no transparency so it is impossible for me to state how effective it is. The most disturbing example of this occurred in the summer of 2007. Several of my Nurse Practitioner (NP) colleagues had commented to me that they felt they were not being competitively paid. In response, as the unit professional vice president, I drafted a memo to this effect to management that was signed by many of the NP staff. At this time the facility had a relatively new Director. Within approximately 2 weeks the Chief Nurse Executive and the Director met with the NPs and told them they had decided to take another look at a recent salary survey and in doing so had decided that an approximately 13% salary raise was in order. Staff believed this confirmed that salary survey data was only acted upon via staff complaints and has led to mistrust of the locality pay system.

My facility does employ temporary health workers. For example, there is only one staff emergency room physician. All the rest are fee basis or locum tenens. There are temporary nursing staff throughout the hospital.

Question 2. Multiple alternative work schedules are available at facilities around the country, from condensed work weeks to intensive 9 month schedules. How prevalent is use of the various alternative work schedules at your facility, and how could VA make better use of these schedules while maintaining quality of care for veterans?

Response. The use of alternate work schedules is concentrated in the areas of intensive care and emergency room, where compressed schedules are used. However, there is no use of the schedules authorized by Public Law 108–445. One reason given by Management why these alternate work schedules are not used is that there is no patch in the pay system to allow them. The other reason that the alternate schedules cannot be used is because there are not enough nursing staff overall to fill the staffing need created by the schedules. The reason given for not enough staff is that nurses are not applying for the jobs. VA needs to create an attractive work environment to compete for nursing personnel, which may mean spending a little more money.

Question 3. What role have VA education incentive programs played in your careers, and how do you think these programs could be improved to encourage further education and improve recruitment and retention?

Response. VA education incentive programs have been very popular at my medical center. I am a good example. I received a Health Professional Scholarship which paid for my Master's Degree in Nursing that included tuition, books, and a stipend.

The program required a 2-year work commitment and I have been with VA for 14 years. The Health Professional Scholarship program should be re-instated. It was a very simple process, with tuition paid directly to the school. This is a powerful incentive to recruitment and retention. There also needs to be a guarantee that the participant will be offered an appropriate assignment upon graduation that is the responsibility of management rather than the participant. One problem currently is that Nurse Practitioners are graduated but then not offered an assignment as a NP, so are forced to leave VA in order to be able to maintain their state licensure and board certification. This defeats the purpose of the programs.

Chairman AKAKA. Thank you, Ms. O'Meara.

Dr. Phelps?

STATEMENT OF RANDY PHELPS, PH.D., DEPUTY EXECUTIVE DIRECTOR, AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE DIRECTORATE

Mr. PHELPS. Thank you, Mr. Chairman. Chairman Akaka, Senator Murray, and Senator Rockefeller, I am Randy Phelps, Deputy Executive Director for Professional Practice at the American Psychological Association. We are the largest association of psychologists, with approximately 90,000 doctoral members and another 50,000 graduate student members in the pipeline to become psychologists, 75 percent of whom will become practitioners and a

great number of whom we hope will serve this Nation's veterans. I am also a licensed clinical psychologist and former practitioner, but for the past 15 years, on APA's executive staff. I have also served as APA's liaison to professional psychology in the Department of Veterans Affairs.

We at APA appreciate the opportunity to testify on making VA the workplace of choice for psychologists. I should note, unlike some of the other testimony today, bring to your attention that VA is already the workplace of choice for many psychologists. There are about 2,400 psychologists in the system currently and, in fact, VA is the single largest employer of psychologists in the Nation. We at APA applaud VA's recent and very aggressive attempts, successful attempts, to recruit new psychologists, but we have many concerns, less so on the recruitment side and more so on the retention side, and I will skip most of this oral statement in the interest of time and focus in on those retention issues.

With regard to the current staffing pattern, however, this is a very recent development. It was only until about 2006, mid-2006 that VA began hiring additional psychologists as a result of influx and needs, mental health needs and TBI needs and so forth due to the War on Terror. In 2006, we finally achieved the psychology, doctoral psychology staffing levels that we had in 1995, so it was on the decline. Again, most recently, VA has been very aggressive to bring new psychologists into the system.

You should be aware that the vast majority of those new psychologists hired, and new FTEs hired, in the last year and one-half are functioning as GS–11 and 13 levels. With regard to leadership of psychology across the system nationally, we are still at essentially the 1995 levels in GS–14s. There are approximately 130 GS–14s in the Nation, psychologists; and only approximately 50 GS–15 leaders nationally currently, which is actually below the level in 1995.

We think that VA's success in recruiting new psychologists has to do in many cases with the outstanding efforts to bring its own trainees into the system, and as you have heard, VA has increased the psychology training slots. Seventy-five percent of all new psychologist hires in the system have been prior VA trainees. So, we applaud those efforts.

With regard to retention, however, the VA needs to not only recruit new and young staffers for careers at VA, but to retain those existing staff who have many years, as we have heard with regard to other disciplines, of dedication to service to this Nation's veterans. Like the other staff in VA, psychologists are not drawn to the money. They are drawn to the work and to the honor in providing care for the heroes of this country.

There are three basic issues that are covered in great detail in our extended remarks for the record with regard to processes that we feel are working against retention of psychologists. One is, there is a lack of uniform psychology leadership positions in the VA system. Senior psychologists—20, 30 years' experience—range from, in some cases, chief psychologist designations to, in most others, lead psychologists, manager psychologists, and so forth.

There is also inequitable access across the VHA system for psychologists to achieve the highest levels of leadership positions in

the VA. The under secretary—two under secretaries now—have reaffirmed a VHA directive that states that it is important that the most qualified individuals be selected for leadership positions in mental health programs regardless of their professional discipline. That directive has had very little practical impact in terms of the appointment of highly-qualified psychologists to VA senior leadership positions.

Most recently, and of great concern to us currently at the VA is the Congress's and the VA's attempt to address recruitment and retention problems through the inclusion of an expansion of the Hybrid 38 program. It has led to very variable and chaotic processes across the system. Many, many psychologist leaders from facilities throughout the country report to us that in their facilities and in their Veterans Integrated Service Networks, that psychologists who have been qualified by the National Professional Standards Boards to advance to GS–14s and 15 levels, for example, and have been recommended to do so, have been stopped at the local level. There are also tremendous informational missteps and technical problems that have plagued the National Psychology Boarding process in this system.

I will just give but two examples that are not in the written testimony—they just crossed my desk, literally, in the last 48 hours—of how problems affect not only the retention of senior psychologists and journey psychologists in the system, but also the new psychologists coming into the system.

One regards a new hire. I just spoke with him this weekend at our board meeting. He happens to be a former—young but very bright star—State Psychological Association president and he happens to be a representative to APA's National Committee on Early Career Psychologists. He told me a story of being dismissed a few months ago in his probationary year after he was unable to effectively discharge what ended up being a dual leadership position thrust upon him in the medical center as the Local Recovery Coordinator, as was discussed earlier, and also in the role of Acting Supervisory Psychologist. This kind of thing has a very chilling effect on our young psychologists' interests.

In another facility, a psychologist who was approved by the National Standards Boards as qualifying for a GS upgrade was denied locally her position as Psychology Program Manager in her facility, and as a result, she tendered her resignation on April 1.

APA considers these problems the most serious obstacle 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 our psychologists come to believe that there is little possibility for advancement in the system regardless of the level or the complexity of their responsibilities, fewer VA psychologists will be willing to accept those positions of greater responsibility; and in addition, high-potential trainees whom the VA would like to attract will increasingly see VA as dead ends—the VA as a dead end for their careers—and will certainly be attracted to other career options that offer more potential for advancement outside the system.

I thank you very much for the opportunity today.

[The prepared statement of Mr. Phelps follows:]

PREPARED STATEMENT OF RANDY PHELPS, PH.D., DEPUTY EXECUTIVE DIRECTOR FOR PROFESSIONAL PRACTICE, AMERICAN PSYCHOLOGICAL ASSOCIATION

Chairman Akaka and distinguished Members of the Committee, I am Dr. Randy Phelps, Deputy Director for Professional Practice of the American Psychological Association ("APA"), the largest association of psychologists, with more than 148,000 members and affiliates engaged in the study, research, and practice of psychology. The APA appreciates the opportunity of testifying before you today on behalf of our member psychologists who are dedicated to serving the very pressing needs of our country's veterans. VA's need for the health and mental health, primary care, research, and other, often unique, services that psychologists provide has perhaps never been greater.

GROWING NEEDS

Over 200,000 homeless veterans will be sleeping on America's streets tonight. Worse yet, Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans are becoming homeless faster than their predecessors. After Vietnam, it took 9 to 12 years for veterans' circumstances to deteriorate to the point of homelessness. Today, the high incidence of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) will contribute to increased homelessness unless dramatic measures are taken to mitigate this trend. Other issues for servicemembers and their families are repeated deployment, National Guard and Reserve deployment, women in combat and the extended duration of the Global War on Terrorism (GWOT).

More than one million servicemembers in the Active and Reserve components of the military have been deployed in OEF/OIF; more than 449,000 of those have been deployed more than once. Of the troops returning from deployment, 31% of Marines, 38% of Soldiers, and 49% of National Guardsmen report psychological symptoms. This doesn't take into account those making multiple deployments or the psychological needs of their families.

There were 686,306 OIF and OEF veterans who separated from active duty service between 2002 and December 2006 who were eligible for Department of Veterans Affairs (DVA) care; 229,015 (33%) of those accessed care at a DVA facility. Of those 229,015 veterans who accessed care since 2002, 83,889 (37%) received a diagnosis of or were evaluated for a mental disorder, including PTSD (39,243 or 17%), non-dependent abuse of drugs (33,099 or 14%), and depressive disorder (27,023 or 12%).

PSYCHOLOGISTS' ROLES WITHIN HEALTH CARE SYSTEMS

Psychologists are unique professionals in terms of their training and skill sets. No other mental health profession requires as high a degree of education and training in mental health as psychology. Accredited doctoral programs in clinical, counseling and other health services psychology involve a median of 7 years of training beyond an undergraduate degree. Psychologists are licensed, independent practitioners with specialized clinical and research skills.

Psychologists provide a holistic approach to mental health care with their keen understanding of how the mind and the body interact. Our members include the specially trained neuropsychologists who understand those disorders of perception, memory, language, and behavior that result from brain injury, an essential skill in dealing with the new generation of veterans returning from theater in large numbers with Traumatic Brain Injuries (TBI).

Psychologists' skills in program development, team building, research/outcome and program evaluation, and in assessment and treatment interventions equip psychologists to be leaders in planning and providing a coordinated service approach. This includes models and practices of care that encompass inpatient, partial hospitalization and outpatient services including Community Based Outpatient Clinics (CBOC), psychosocial rehabilitation programs, homeless programs, geriatric services in the community, residencies and the home.

Psychologists initiate and evaluate innovative programs, such as tele-mental health services. They go beyond the provision of service to initiate, plan and evaluate the efficacy of such services and their clinical and cost benefits.

RECRUITMENT OF PSYCHOLOGISTS IN VHA

It is critical to note that VA is already the single largest employer of psychologists in the Nation, and has been for many years. However, VA continues to recognize the need to increase its psychology staffing numbers in response to ever-increasing needs for services to veterans. For example, the Veterans Health Administration's (VHA) provision of mental health services to veterans has skyrocketed from 1996

to 2006, going from 565,529 veterans served to 934,925 and rising. In response, VHA has hired more than 800 new psychologists since 2005; thereby, increasing the number of GS–11 through 15 psychologists and surpassing its 1995 high of approximately 1,800 psychologists.

The APA applauds VA for its tremendous and serious recent efforts to increase psychology staffing levels, such that there are now approximately 2,400 psychologists employed by VA nationwide across the GS–11 to GS–15 levels. However, that is a very recent accomplishment. It was not until 2006 that psychology staffing levels exceeded those of 1995 levels. Moreover, the vast majority on new psychologist hires in VHA are younger, lesser experienced psychologists who have come into the system at the GS–13 level or below. In contrast, as of the end of 2007, the number of GS–14s in the entire system nationally was essentially the same as it was in 1995, at approximately 130 GS–14 psychologists. Of additional concern to the APA is that the number of GS–15 psychologists nationally as of the end of 2007 (approximately 50) was still considerably lower than the number of GS–15s in 1995.

VA has also recognized and capitalized on the fact that the best source of recruiting new psychologists has been the Department's own training system. Over the past 2 years, approximately 75% 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

Here is the dilemma: while the VA is employing more psychologists than ever, 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 are already institutionalized within the system. These psychologists are vital to service provision because of their professional expertise and knowledge of the system and its resources. However, there are several glaring obstacles to retention, covered in some detail below.

LACK OF UNIFORM 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. Interdisciplinary management within mental health services can have advantages in terms of cross-discipline coordination of care and clearer accountability at the individual program level. However, 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. For Psychology, this problem is further complicated by the fact that the lack of recognized psychology discipline leadership at many facilities translates into a significant lack of oversight, structure and support for the growing number of psychologists working in non-mental health areas such as primary care, geriatrics, and Home & Community Based Care (HBPC), among others.

In 2002, the VA remedied this situation for Social Work with the appointment of a Social Work Executive at each facility that lacked an independent Social Work Service (VHA Directive 2002–029). The creation of the Social Work Executive position has been highly effective in ensuring the integrity of Social Work practice and training within an inter-disciplinary management structure. Since 2003 there have been efforts to create an analogous Psychologist Executive role. However, at present, Psychology remains the only major mental health discipline without an officially designated leader in every medical center. While the number of "Chief Psychologists" is now increasing, a far more prevalent position is the "Lead Psychologist," a position which is all too frequently unrecognized at the level of additional pay for additional responsibilities.

INEQUITABLE ACCESS TO KEY LEADERSHIP POSITIONS

Nor are psychologists represented equitably in the all levels of leadership in the VA's health care 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.

IMPLEMENTATION PROBLEMS IN HYBRID 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 Title 38 Hybrid is a combination of Title 38 and Title 5 provisions for non-physician health care professionals at the VA.

Historically, Title 38 was created to alleviate severe shortages of health care personnel, especially for physicians in VA, by reducing the bureaucratic red tape of the civil service recruiting and hiring system and the restrictive compensation practices inherent in Title 5.

Psychologists remain the only health care providers requiring the doctorate who are not included in Title 38. The Title 38 Hybrid was created to provide a middle ground solution for health care professionals that needed some of the same 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 on the number of GS–14 and 15 psychologists is currently very mixed. Many Psychologist leaders from facilities throughout the country have reported that their facilities and Veterans Integrated Service Networks (VISN) 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. This leaves the psychologists in question with considerable leadership responsibilities, but with little or no recourse regarding their boarding status and consequent grade level.

Informational missteps and technical problems have also plagued the national psychology boarding process. An unknown, but apparently significant, number of boarding packets have been adversely affected by incorrect information provided by local human resource (HR) officials regarding the required format and content of the packets. This has resulted in the submission of a number of packets that may have described GS–14 or above responsibilities, but that were unable to be boarded at that level due to packet content errors.

Of particular concern are reports that a number of psychologists throughout the country were instructed by their facilities to only submit special achievements occurring during the previous 3 years, despite the fact that Psychology Boards were authorized to consider achievements throughout the psychologists' VA careers for the one-time Special Advancement for Achievement. This meant that significant and creditable achievements occurring earlier in the psychologists' VA careers would never have an opportunity to be considered for a Special Advancement for Achievement (SAA).

On March 7, 2007, instructions were sent from the VA Central Office (VACO) to the field that eliminated the national cap on GS–14 psychologists. This was a beneficial step that has removed one of the reasons often cited by local and VISN management for failure to approve justified grade increases to the GS–14 level.

However, the same set of instructions tied the award of GS–15 psychology positions to the facility's level of complexity. Per these instructions, only psychologists at complexity level 1A facilities are eligible for promotion to GS–15. Senior psychologist leaders at non–1A facilities, regardless of the scope and complexity of their actual duties and regardless of the question of whether they meet the VA's own qualification standards for GS–15 would be ineligible for promotion to that grade level. In addition, complexity 1A facilities without current GS–15 psychologists would need to petition VACO for an increase in their GS–15 ceiling should the boarding process recommend, and the facility management concur, in moving a psychologist manager to the GS–15 level.

These new field instructions will accelerate the already steep decline in the number of GS–15 level psychologists. They will also create equity problems in that psy-

chologists from non–1a facilities who supervise many programs and individuals will be ineligible for a GS–15, whereas facility complexity 1a psychologists with more limited supervisory responsibility will be eligible for the grade as long as they meet the minimum GS–15 requirements of the VA's Qualification Standard.

Part of the difficulty with these new instructions is that they treat psychologist promotion in a manner that is characteristic of Title 5. Dissimilar positions are compared against one another according to some overarching standard of complexity. Typically, in the case of psychologists, the comparison is made to the grade level of the Associate Director.

As doctoral level Title 38 Hybrid clinicians, it would be more appropriate to treat the issue of psychologist promotion as being similar to the Title 38 process. In this approach, the full performance level (GS–13) is defined by the journeyperson clinical responsibilities. Additional administrative and program management responsibilities warrant higher grade levels, provided that these additional responsibilities meet established scope and complexity requirements for those levels. This is essentially the approach that was taken in the VA's own Qualification Standard for Psychology.

The decline in the availability of upper grade level positions presents VA with a serious recruitment and retention issue. As psychologists come to believe that there is little possibility for advancement, regardless of the level or complexity of responsibilities, fewer high potential 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.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DR. RANDY PHELPS, DEPUTY EXECUTIVE DIRECTOR, AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE DIRECTORATE

Question 1. The number of veterans rolling into the VA mental health care system is significantly growing each year of the Global War on Terror. The VA system is already stretched with a need for trained mental health professionals to deal with the unique needs of the veteran population and their families. Additionally, veterans in rural areas remain underserved due to the lack of VA access in non-metropolitan areas. The Committee is aware that the Department of Defense successfully conducted a demo project giving prescribing authority to psychologists. In your opinion, would giving VA psychologists the authority to prescribe psychotropic drugs ease the strain on the system; especially in rural areas?

Response. APA continues to look for ways to extend services to veterans in rural areas where existing VA and DOD facilities are simply beyond the reach of patients. We continue to advocate for prescriptive authority for appropriately trained doctoral psychologists, particularly in those rural areas where providers are few and far between.

For Americans living in rural areas, the problem of access to care is particularly acute. The Final Report of the President's New Freedom Commission on Mental Health states that the "vast majority of all Americans living in underserved, rural, and remote areas also experience disparities in mental health services . . . . In rural and other geographically remote areas, many people with mental illnesses have inadequate access to care, limited availability of skilled care providers, lower family incomes, and greater social stigma for seeking mental health treatment than their urban counterparts" which is compounded by "the fact that rural Americans have lower family incomes and are less likely to have private health insurance benefits for mental health care than their urban counterparts."

VA data shows that 19% of the Nation lives in rural America, and that 44% of U.S. military recruits come from those rural areas. This disproportionate number of OEF/OIF rural veterans has created a crisis in which they do not have sufficient access to VA healthcare. Having psychologists ready to accept the challenge of serving these rural veterans, including through psychotherapy, prescribing or unprescribing medication as needed, carrying out medication management and compliance tasks, and any combination of these services, via telehealth or through placement in a Community-Based Outpatient Clinic or satellite clinic in a rural or remote area, would serve well our Nation's veterans from rural and frontier areas.

With a focus on psychologist prescription privileges, the private healthcare sector and states are also grappling with how to ensure access to health and mental health services in rural areas. To address pressing mental health needs, 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, allow appropriately trained and certified psychologists 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) 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 its report on the PDP. Both reports repeatedly stressed how well the PDP psychologists had performed. According to the 1999 GAO report, "an outside panel of psychiatrists and psychologists who evaluated each of the graduates rated the graduates' quality of care as good to excellent." The 1998 ACNP review stated that "they had performed safely and effectively as prescribing psychologists, and that no adverse outcomes had been associated with their performance."

Psychologists are highly trained mental health specialists, many of whom have acquired this additional post-doctoral training in psychopharmacology in order to collaborate with physicians about their patients' medications. With prescriptive authority, they can offer a holistic, integrative model of 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 PDP. 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.

Question 2. In written testimony, APA discussed the challenges of recruiting psychologists in light of a growing national shortage. How can VA recruit more mental health providers to work in rural locations in particular? Could partnerships with community providers be effective, without compromising quality of care?

Response. As the Committee is aware, the VA is not alone in the need to recruit psychologists and other practitioners to provide services in the rural areas of our country. Many private and public employers are working to ensure services in these areas as well. The issue of psychologist recruitment has its own unique aspect, since psychologists are far more numerous than psychiatrists and therefore available to provide services in rural areas, while at the same time, social workers, though relatively more numerous and available, simply do not have the training to deliver the range of psychotherapeutic and testing services that psychologists provide to patients.

The testimony provided by various panelists during the hearing demonstrate that the VA is finding innovative ways to recruit health care professionals into VA service, including in rural areas. The APA would return to our testimony, however, in emphasizing the need to hire and promote psychologists beyond the GS–13 level, particularly through a more effective use of the Title 38 Hybrid process. Pay and promotion must be competitive for psychologists in the VA if the department hopes to be effective in recruiting and retaining psychologists for service in rural areas.

Beyond the fundamental issue of pay and promotion, the APA strongly suggests that the VA look to its current authority to provide mental health services to veterans outside of the VA system. It is now clearly apparent that with the influx of returning OEF/OIF veterans on top of the current mental health needs of the aging veteran population, that the need for mental health services has reached a crisis situation. The recent RAND Corporation study is telling:

• 300,000 returning U.S. troops are suffering symptoms of PTSD or depression but only about half are receiving care. We cannot emphasize strongly enough, the importance of treating these conditions early for effective treatment.

• 320,000 returning troops have suffered possible TBI during deployment. Psychologists are key providers in treating TBI.

• 18.5% of the more than 1.5 million deployed troops in the two war zones are suffering stress disorder and depression. Undoubtedly, many of these soldiers will need psychological care when they separate from service.

As our answer to the first question indicates, a relatively large proportion of veterans are from rural areas, therefore the need for mental health services in rural areas is going to tremendously increase, considering the mental health needs indicated in the RAND study. The VA has authority to contract with non-VA facilities and individual providers, including community providers, for the provision of mental health services. Some of this authority is specific to the provision of mental health services in current statute, such as for the provision of readjustment counseling and related mental health services by a physician or psychologist (see 38 U.S.C. § 1712A(b)(1)).

While we do not have sufficient knowledge or information on how the VA has used this contracting authority for fee-basis care to ensure adequate mental health services in rural areas in the past, we would assume that given the current situation, the VA should utilize its authority more expansively in this time of crisis. Therefore, the APA respectfully suggests that the Committee strongly urge the VA to use this authority now.

The Committee could also approve S. 38, a bill that would establish a program for the provision of readjustment counseling and other mental health services for OEF/OIF veterans. The House already has passed a measure, the Veterans' Health Care Improvement Act, H.R. 2874, which has similar provisions. Certainly, enactment of S. 38 would help address the Committee's query concerning partnering with community providers for care, since the bill would promote these services through "qualified entities," including community mental health providers. We would further suggest that the term "qualified entity" be made more clear so as to include psychologists and other mental health providers whether in facilities or in private or group practice.

Beyond encouraging the VA to use its current authority to contract with psychologists for fee-basis care, the Committee should commend and encourage the VA to continue its efforts to recruit more psychologists into service and urge the VA to contract with psychologists to provide services within VA facilities as needed, particularly for VISNs with large rural populations. All of these initiatives should go a long way in addressing the tremendous need for mental health services for veterans at this time.

Question 3. What effect do VA's hiring processes have on recruitment, and how do you believe it can be improved and accelerated while still ensuring quality care for veterans?

Response. VA is already the single largest employer of psychologists in the Nation, and has been for many years. VA continues to acknowledge the need to increase its psychology staffing numbers in response to ever-increasing needs for services to veterans.

VA has capitalized on the fact that the best source of recruiting new psychologists has been the Department's own training system. Over the past 2 years, approximately 75% 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 post-doctoral fellowship positions, spending approximately $5 million to do so. This will bring the total psychology training positions to approximately 620 per year nationwide.

VA has also recently made tremendous efforts to increase psychology staffing levels, so that there are now approximately 2,400 psychologists employed by VA nationwide across the GS–11 to GS–15 levels. However, that is a very recent accomplishment. It was not until 2006 that psychology staffing levels exceeded those of 1995 levels. Moreover, the vast majority of new psychologist hires in VHA are younger, lesser experienced psychologists who have come into the system at the GS–13 level or below.

In contrast, at the end of 2007, the number of GS–14s in the entire system nationally was essentially the same as it was in 1995, at approximately 130 GS–14 psychologists. Of additional concern to the APA is that the number of GS–15 psychologists nationally at the end of 2007 (approximately 50) was still considerably lower than the number of GS–15s in 1995.

In 2007 a VA instruction lifted the cap on GS–14 psychologists. The numbers are slowly increasing, but not enough to keep up with the growing demand on the system. On the other hand, promotions of GS–15 psychologists remain incredibly low with the cap remaining firmly in place. In fact, the same VA instruction that lifted the cap on GS–14's also tied the promotion to GS–15 for psychologists to the facility's level of complexity. In short, a psychologist must work at a level 1A facility to have a serious chance at promotion to GS–15.

The new promotion process created as a result of the Title 38 Hybrid legislation has been chaotically and unevenly implemented across facilities. There are common reports of medical centers sitting on promotion packages, denying promotion after the national board's review and approval, or misinformation regarding what is to be submitted as part of a board package resulting in the denial of a submitter's package.

Also, there remains a lack of uniform psychology leadership positions in the VA. Psychology is the only major mental health discipline without an officially designated leader in every medical center. Such a position is critical for purposes of professional practice within a facility and as a representative of the facility without. In addition, psychologists are not represented equitably at all levels of leadership in the VA healthcare delivery system. There have been some attempts by the VA to address this but with little practical impact at this time.

In sum, the VA has been making progress in its psychologist recruitment efforts, partly by taking advantage of recruitment from its own psychology training structure. Psychology staffing levels are improving but promotions to the GS–14 and GS–15 levels must be accelerated. Serious implementation problems with the Hybrid Title 38 system should be addressed, as well as the lack of uniform psychology leadership positions and the current inequitable access to key leadership positions within the VA in general that psychologists face.

RESPONSE TO WRITTEN QUESTIONS FOR THE RECORD SUBMITTED BY HON. PATTY MURRAY TO DR. RANDY PHELPS, DEPUTY EXECUTIVE DIRECTOR, AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE DIRECTORATE

Question 1. Over the past couple of years, there has been a lot of attention focused on the seamless transition between the VA and the DOD when it comes to information sharing.

Thinking along those lines, is there any way that the VHA and the DOD could pool together and share some of their resources to fill in some of the gaps in clinical coverage?

Response. The APA greatly appreciates the Committee's active interest and work toward addressing mental health issues as they relate to efforts for a seamless transition between VA and DOD, particularly at a time when so many returning OEF/OIF soldiers are returning with PTSD, TBI, and many other mental health and substance use issues. We further appreciate that the VA and DOD have made concerted efforts to address mental health issues through the work of the Senior Oversight Committee, as reflected in the April 23rd joint testimony before the Committee by The Honorable Gordon England, Deputy Secretary of Defense and The Honorable Gordon Mansfield, Deputy Secretary for Veterans Affairs.

We believe that the Committee should continue to oversee and encourage the current DOD and VA transition activities with regard to mental health and substance use services. These activities and initiatives include: the improvement to the Disability Evaluation System, the DOD Center of Excellence for Psychological Health and Traumatic Brain Injury, and the widespread dissemination and implementation of standard clinical practice guidelines for PTSD and other serious mental and substance use disorders. In addition, the departments should be further encouraged in improving TBI screening and health information sharing, as well as collaborative efforts to address PTSD and PTSD research.

In addition, the APA urges the Committee to encourage the DOD and VA to fully implement the Wounded Warrior title in the recently enacted National Defense Authorization Act, particularly those that relate to the mental health needs of returning soldiers. We share the belief with the Committee and the departments that these needs are extremely pressing at this time, and full and timely implementation is critical to ensure that services are fully available now.

Chairman AKAKA. Thank you, Dr. Phelps.

Dr. Strauss?

STATEMENT OF JENNIFER L. STRAUSS, PH.D., HEALTH SCIENTIST, CENTER FOR HEALTH SERVICES RESEARCH IN PRIMARY CARE, DURHAM VA MEDICAL CENTER, AND ASSISTANT PROFESSOR, DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES, DUKE UNIVERSITY MEDICAL CENTER, ON BEHALF OF THE FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH

Ms. STRAUSS. Hello, Chairman Akaka, Ranking Member Burr, Members of the Committee. On behalf of the Friends of Medical Care and Health Research, I thank you very much for this opportunity to testify.

I am a clinical psychologist and a health scientist at the Durham VA Medical Center and a recipient of a VA Research Career Development Award. The primary focus of my research is the treatment of Post Traumatic Stress Disorder in women survivors of military sexual trauma. Today, I have been asked to share my reasons for choosing a career as a VA clinician researcher and specifically how research opportunities impact the Department of Veterans Affairs's ability to recruit and retain clinicians.

Let me say at the outset that I love my job. The opportunity to conduct research greatly enhances my job satisfaction and has played a large role in my decision to remain at VA.

VA is not the only venue in which a clinician can conduct research, but understand that I have come of age professionally in the post-9/11 era. The opportunity to apply my clinical and research training in support of veterans traumatized by their war experiences continues to resonate very strongly with me.

This war has presented numerous clinical challenges, and in many ways, we are still learning as we go. To make progress, VA must foster partnerships between research and clinical services and must recruit clinician investigators to guide these efforts.

Towards this end, VA offers exceptional research and training opportunities for clinicians like me who are interested in research careers. Among these is the Research Career Development Program. This is a highly competitive mentored award that typically provides 3 to 5 years of structured research training. Clinicians who receive these awards are relieved of 75 percent of their clinical duties, allowing for dedicated time to focus on training and developing an individual program of research.

Despite the many advantages VA offers, it is not necessarily easy to build a career as a clinician investigator at VA and I would like to highlight several ways in which I believe VA can improve recruitment and retention of clinicians such as me, who are interested in integrating research into their careers.

To date, the VA has invested in 5 years of my research training. Yet what happens when my Career Development Award, and the dedicated research time it affords, expires in 2 years is an open question. Unlike clinicians at most academic medical centers, VA clinicians may not fund a portion of their salaries through research grant support. If a non-clinician VA researcher is awarded research funds, those funds can be used to pay salary for time devoted to the research project. But VA clinicians often perform research duties early in the morning or very late into the night after a long day of seeing patients.

I recommend that VA consider a model that is more in line with what is available to clinician researchers working in other academic medical settings, namely to foster recruitment of the best care providers and to encourage clinicians to conduct research by ensuring dedicated research time.

Current space constraints are an additional obstacle to the clinician researcher career path. Space is at such a premium at our facility that some of our researchers may soon be moving offsite. A geographic divide between research labs and clinics will do little to enhance the type of collaborations that I believe are essential to move VA research forward in a manner that will best inform the clinical care of veterans. Continued investment in the Durham research infrastructure and similar investments at other VA facilities are imperative.

The last obstacle I want to mention is data security in the context of research. Absolutely, veterans' privacy and research data must be safeguarded. That is paramount. However, while I know it is not intentional, it has become extremely difficult to share data even among VA facilities, and collaborating with non-VA organizations can be even more problematic. I urge VA to ensure that its security policies guarantee the safety of data but still allow shared research to continue. With improvements in security technology, I hope the current situation will get better. But right now, managing research data in compliance with VA policies is a significant challenge.

Serving veterans is what I do, and I am filled with pride by the opportunity to do so. That feeling is considerably deepened by the opportunity to combine clinical care with research, to compete for Career Development Awards, and to be linked with mentors willing to nurture my research interests. These are significant factors in why I came to and remain at VA; and apparently many of my colleagues also feel this way. When surveyed by VA in 2002, 61 percent of clinician respondents indicated that they would not work at VA without research opportunities.

Mr. Chairman, thank you again for inviting me today and I am happy to answer any questions. Thank you.

[The prepared statement of Ms. Strauss follows:]

PREPARED STATEMENT OF THE FRIENDS OF VA MEDICAL CARE AND HEALTH RESEARCH (FOVA) PRESENTED BY JENNIFER L. STRAUSS, PH.D., HEALTH SCIENTIST, CENTER FOR HEALTH SERVICES RESEARCH IN PRIMARY CARE, DURHAM VA MEDICAL CENTER AND ASSISTANT PROFESSOR IN PSYCHIATRY AND BEHAVIORAL SCIENCES, DUKE UNIVERSITY MEDICAL CENTER

Chairman Akaka, Ranking Member Burr, and Members of the Committee, on behalf of the Friends of VA Medical Care and Health Research, thank you for the opportunity to testify. FOVA is a coalition of over 90 national academic, medical and scientific societies; voluntary health and patient advocacy groups; and veteran service organizations committed to ensuring high-quality health care for our Nation's veterans.

I am a clinical psychologist and health scientist at the Durham VA Medical Center and a recipient of a VA Research Career Development Award. The primary focus of my research is the treatment of Post Traumatic Stress Disorder in women survivors of military sexual trauma. Today I have been asked to share my reasons for choosing a career as a VA clinician-researcher, and specifically, how VA research opportunities impact the Department of Veteran Affairs' ability to recruit and retain talented clinicians.

Let me say at the outset that I love my job. The opportunity to conduct research greatly enhances my job satisfaction and has played a large role in my decision to

remain at the VA for 7 years. From the time I applied to graduate school, my goal was to pursue training and professional opportunities that would allow me to blend my clinical and research interests. And VA provides an environment to do just that.

VA is not the only venue in which a clinician can conduct research. Academic medical centers are frequently the landing pad for individuals like me. But understand that I have come of age professionally in the post-9/11 era. I earned my doctorate in June of 2001. Shortly thereafter we were at war. I wanted to help and I had a specific skill set that could allow me to do so quite directly. The opportunity to apply my clinical and research training in support of veterans traumatized by their war experiences continues to resonate very strongly with me, as I believe it does with many of my VA colleagues.

I treat women survivors of military sexual trauma while also conducting research to make those treatments more effective. I am a small piece of a shared vision to provide the best possible care to our Nation's veterans. And I am well aware of how lucky I am to be able to say that. This war has presented numerous clinical challenges and, in many ways, we are still learning as we go. To make progress, VA must foster partnerships between research and clinical services, and must recruit clinician investigators to guide these efforts.

Towards this end, VA offers exceptional research and training opportunities for clinicians like me who are interested in research careers. Among these is the Research Career Development Program. This is a highly competitive mentored award that typically provides 3–5 years of structured research training. Clinicians who receive these awards are relieved of 75% of their clinical duties, allowing for protected time to focus on training and developing an individual program of research.

This award is specifically designed to attract, develop, and retain talented researchers in areas of particular importance to VA, and it is a powerful recruitment tool. I am currently in the second year of my Research Career Development award. For this privileged opportunity, I aim to repay VA and our Nation's veterans hefty dividends on their investment in me, in the currency of high quality care and clinically-informed research to improve the care of veterans.

As a VA research career development awardee, I am in a unique and fortunate position. I benefit from truly exceptional research mentoring and training, and I have the luxury of devoting a substantial portion of my time to developing a research program at VA. At the Durham VA's Center for Health Services Research in Primary Care, I am one of 31 core investigators, half of whom are clinicians and many of whom are young investigators, who jointly attract over $10 million of research grant support annually. The Center's success is a reflection of exceptional leadership, a sophisticated research infrastructure, and a talented, collegial, multidisciplinary faculty who are unusually invested in fostering the careers of junior faculty. The common thread is a deep respect for our nations' veterans and a drive to provide them with the highest quality care and to constantly seek improved treatments. I believe my success to date is largely a reflection of the exceptional opportunities afforded to me in this environment and it is these opportunities that give me such professional satisfaction and keep me at the VA.

Despite the many advantages VA offers, it is not necessarily easy to build a career as a clinician investigator at VA. I would like to highlight several ways in which I believe VA can improve recruitment and retention of clinicians such as myself, who are interested in integrating research into their careers. I offer what follows from the perspective of a field worker. I know there are numerous constraints on implementing the ideal in the short run. But I also firmly believe that longer-term goals should be kept in mind for the good of the veterans we are all committed to serve.

To date, VA has invested in 7 years of my research training. Yet what happens when my Career Development award, and the protected research time it affords, expires in 2 years is an open question. Unlike clinicians at most academic medical centers, VA clinicians may not fund a portion of their salaries through research grant support. If a non-clinician VA researcher is awarded research funds, those funds can be used to pay salary for time devoted to the research project. But VA clinicians cannot do this and typically must donate their time, often performing research duties early in the morning or very late into the night after a long day of seeing patients. I do not think this is in the best interest of VA or the veterans we serve. I strongly recommend that VA adopt a model that is more in line with what is available to clinician researchers working in academic medical settings. Namely, to foster recruitment of the best care providers and to encourage clinicians to conduct research by providing protected research time. The objective, of course, is to hasten development of the new and more effective treatments that are urgently needed.

There are several other ways in which I believe VA could better facilitate clinicians' involvement in research. Currently, the primary research funding mechanism

for VA investigators is a merit review award. For health services researchers like myself, these are typically 3–5 year studies with relatively large budgets. Understandably, these studies are generally awarded to mature investigators who have already completed a substantial body of work in the research area. Currently missing from the VA research funding portfolio in my area of health services research is a grant mechanism that would allow individuals to conduct research on a smaller scale. I believe this type of funding mechanism, akin to the R03 program offered by the National Institutes of Health, would be particularly attractive to VA clinicians interested in taking on research without the commitment of time and resources that large scale studies demand.

Current space constraints are an additional obstacle to the clinician-researcher career path. Space is at such a premium at our facility that some of our researchers may soon be moving off-site. A geographic divide between research labs and clinics will do little to enhance the type of collaborations that I believe are essential to move VA research forward in a manner that will best inform the clinical care of veterans. Continued investment by VA in the Durham research infrastructure and a similar investment at other facilities are imperative.

The last obstacle I want to mention is data security in the context of research. Absolutely, veterans' privacy and research data must be safeguarded; that is paramount. However, while I know it is not intentional, it has become extremely difficult to share data even among VA facilities, and collaborating with non-VA organizations can be even more problematic. I urge VA to ensure that its security policies guarantee the safety of data, but still allow shared research to continue. With improvements in security technology I hope the current situation will get better. But right now, managing research data in compliance with VA policies is a significant challenge. The reasoning behind some of the obstacles is understandable; the consequences can be severe.

Finally, I think the career opportunities available at VA remain a too well-kept secret. A VA career never occurred to me until a trusted graduate school mentor encouraged me to take a closer look. Coming from a traditional academic training environment, VA simply wasn't on my radar. It is time to let this secret out of the bag. For the reasons I have described, VA is an elite venue for clinicians and researchers alike and should recruit accordingly.

Serving those who have served our country is what my colleagues and I do. And we are filled with pride by the opportunity to do so. That feeling—that attachment—is considerably deepened because of the opportunity to combine clinical care with research, to compete for Career Development awards, and to be linked with mentors willing to nurture our research interests. These are significant factors in why I came to and remain at the VA. And apparently many of my colleagues feel similarly. When surveyed by VA in 2002, 79% judged that research opportunities and support were very or extremely important for recruiting and retaining high quality clinicians in VA, and 61% of clinician respondents indicated that they would not work in VA without research opportunities.

Mr. Chairman, thank you again for inviting me today. I am happy to answer any questions that you or the other committee members may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO JENNIFER L. STRAUSS, PH.D., HEALTH SCIENTIST, CENTER FOR HEALTH SERVICES RESEARCH IN PRIMARY CARE, DURHAM VA MEDICAL CENTER AND ASSISTANT PROFESSOR IN PSYCHIATRY AND BEHAVIORAL SCIENCES, DUKE UNIVERSITY MEDICAL CENTER

BALANCE BETWEEN RESEARCH AND CLINICAL DUTIES

Question 1. Given the need for the VA to do research in areas critical to the health and well being of our veterans, how do we strike a balance between protecting research time for present and prospective VA employees, while still keeping enough clinicians on the "front line" to meet the acute needs of our veterans, given an urgent shortage in this area?

Response. This is a very good question and I think the concept of "balance" between front line clinical care and investment in research is a critical point. In my opinion, one step in this direction would be to allow clinicians to fund a portion of their salary (e.g., 1/8th–2/8th) through VA funding and to allow the medical center to use the salary support offset to backfill the clinicians' time. This would be analogous to the NIH model which provides salary support commensurate with the investigator's level of effort on the project, in addition to the amounts provided for the direct and indirect costs of the grant. This approach would allow clinician research-

ers to devote a specific portion of their time to research without disrupting the availability of clinical care to veterans.

In contrast, the current method of providing "protected" time for researchers is to use VERA dollars to backfill clinical positions. The concern, which I have heard voiced loudly and repeatedly at the annual VA HSR&D meeting, is that VERA dollars are used by medical center directors to fund many competing demands. Additionally, the VERA research allocation is based on prior year funds and the amounts provided to each medical center are not tied to specific projects. With the caveat that I am not a subject matter expert on VA budgets, VERA or the allocation process, what I am suggesting is a more direct means of ensuring the support of clinicians conducting research and the continued provision of front line clinical care to veterans.

Bear in mind that the vast majority of clinicians do not want to conduct research. But I think those who do will play a critical role in improving VHA's ability to provide the best possible care to our veterans, for decades to come. It is arguably shortsighted to not invest in both our ability to provide timely, high quality care today, and to advance the standard and improve the quality of care provided by tomorrow's VHA. In other words, we must strike a balance between VHA's investment in front line clinical care and research.

DOD AND VA COLLABORATION

Question 2. Over the past couple of years, there has been a lot of attention focused on the seamless transition between the VA and the DOD when it comes to information sharing.

Thinking along those lines, is there any way that the VHA and the DOD could pool together and share some of their resources to fill in some of the gaps in clinical coverage?

Response. Broadly speaking, I am certainly in favor of greater collaboration between these agencies, but it is not within my scope of expertise to suggest how best to achieve this goal. That said, one promising idea that has been suggested by others is a common electronic medical record, accessible by both DOD and VHA personnel. If tenable, I believe a shared medical record system would help to smooth transitions between DOD and VA care. From a health services research perspective, a shared electronic medical record would also foster our ability to conduct research on veterans' functioning before and after active duty and deployments, as well as after their transition to veteran status. An additional means of strengthening ties between agencies may be to assign some VHA staff to DOD, to facilitate transitions and access.

Chairman AKAKA. Thank you very much, Dr. Strauss.

I understand that the opportunity to conduct research at VA has influenced the course of your career.

Ms. STRAUSS. Yes, it has.

Chairman AKAKA. In your view, how could the hiring system be modified to attract and retain more researchers like yourself? What was it about VA research that made it an attractive option to you as a clinician? I would just like to note per Dr. McDonald's comments that Congress provided the VA research program with a $69 million increase this year and we are pushing for yet another substantial increase.

Ms. STRAUSS. Which is much appreciated. You know, there are several factors that I think brought me to this career. One really is a specific interest in serving veterans and in conducting the type of research that I think is necessary to increase the quality of care that we are providing over time. So, the mission of that resonates very strongly with me.

I am very fortunate to be at a facility, the Durham VA, that has a very strong research infrastructure and is highly supportive of research and of young clinical investigators like myself, and I am also really blessed with tremendous mentorship.

Looking forward, I think a concern that is on everybody's minds who is in a position like myself, or certainly on my own mind, is

some assurance that we will be allowed to continue to conduct research while also providing patient care. What that means is some mechanism, and I am not the individual, I don't think, to speak to what that mechanism should be or how it should be organized, but some allowance that there can be some dedicated time for us to continue research activities while also taking care of patients.

Chairman AKAKA. Thank you, Dr. Strauss.

Dr. McDonald, over the course of your career, you have both hired contractors in your capacity as a VA administrator and clinician and you have been hired to work in VA as a contractor, so you have been through both of those systems. Does VA have the authority and resources to fully staff its facilities on its own, or do you believe VA will be required to expand contractor agreements?

Dr. MCDONALD. Chairman Akaka, I believe that the answer to that is a qualified yes, and it really depends upon the size of the station or the VA hospital and the relationship with the affiliate medical school. In the case of Durham, San Francisco, Minneapolis, these are tight affiliations. I trained as a medical student at Duke, in fact, in the old Durham VA, and so that relationship goes back many, many years. So, except for some very highly remunerated specialties, such as neuroradiology, interventional radiology, interventional cardiology, for the most part, I believe that the VA will be able to.

I think the current pay scale, although it is a great improvement, is still not adequate to recruit scarce specialties to a VA hospital. It takes—and it is not money, it is really the other elements of working in the VA system. It is the integrated medical record, it is caring for veterans, it is the team approach to health care, it is being in a vertically-integrated health care system. If these appeal to physicians and we expose our medical students and our residents to these environments, then I believe the VA will be successful if it can offer a career path for investigation and scholarship as well as simply seeing patients. If you are simply doing the same thing as a VA physician that all other physicians in the community are doing and getting paid half as much, then it is going to be very difficult to rationalize on pure economic means why you should work at the VA.

Where I believe the Veterans Administration faces particular challenges is in marketplaces like the one in which I serve. Our school has the largest group practice in the State of Nevada. We run two campuses 450 miles apart. For Easterners, that is the distance between Boston and Washington, DC. It is a very competitive health care market. So, our Reno VA, which is not a tertiary care referral VA, often has to refer patients, as we say, across the hill, across the Sierra Nevada to San Francisco, and similarly, Las Vegas is the largest metropolitan area without a dedicated VA hospital. There is an integrated VA-DOD facility, but as you are keenly aware, they are building a new VA hospital.

In those circumstances, it is imperative, I believe, for the VA to really reach out to the academic affiliates to build these strong lasting ties so that there is a mutual interdependence, because I believe that our missions and vision and values are really very similar to the VA. In fact, most of those, particularly those who

have served within the VA, hold it up as a paradigm of health care for this country. Thank you.

Chairman AKAKA. Thank you so much, Dr. McDonald.

This question is for the entire panel. What effect does VA's hiring process have on recruitment, and how do you believe it can be improved and accelerated while still ensuring quality care for veterans? This is for the GAO as well as the providers. Dr. Kanof?

Dr. KANOF. I don't have the answer, but at least I can give you some data. I mean, when we did our surveys—and, granted, this was in 2005 and 2006—we surveyed VA officials that were responsible for H.R. activity and the average took 15 months. In one case, it was as short as 3 months, and this is for the CRNAs. But in another case, it was as long as 60 months. So, clearly, wherever you are, either 15 months or 60 months, that is too long.

The previous panel went through some of the steps, but it really takes a concerted effort to, as soon as you have made the decision to hire someone, to the posting, to the interviewing, to the job offering, to knowing are you going to be offering retentions? Are you going to be doing relocation bonuses? All that needs to be known from step one so that the timeframe could be significantly shortened.

Chairman AKAKA. Dr. McDonald?

Dr. MCDONALD. Yes, sir, Chairman Akaka. There is one piece of the VA hiring puzzle which is not broken and I would urge the Committee to consider this when thinking about changes. That is that currently the VA—and I don't know the situation with nursing, I am sure we can hear about that—but currently, the VA is allowed to hire an employee, a physician, who is licensed in any State in the Union to practice exclusively in a VA facility. That is extremely important, because it may take—in our case, in Nevada—it takes a minimum of 6 months to obtain a medical license and an additional 3 to 6 months before a physician in the civilian sector is fully credentialed with payers. So, essentially, the VA is treating licensure in any State as a national medical license, which I think that is a piece that works very well.

I used to think, until I joined the State of Nevada, that the VA had a cumbersome bureaucracy. I am now disillusioned. I think that we can probably match the Federal system for hiring any day, and I think there probably are some streamlining steps we can take. But, on the other hand, I also realize, as a leader who recruits a lot of other leaders, that it is very important to cast a broad net when you are looking for the most qualified individual. And so, some of the things that seem to be ponderous and slow, hopefully, as long as we get rid of the unnecessary steps, are, I think, very important parts of ensuring a quality workforce. Thank you.

Chairman AKAKA. Thank you, Dr. McDonald.

Ms. O'Meara?

Ms. O'MEARA. Thank you, Chairman Akaka. From what I have seen, one thing, I keep track of the newspaper ads for the VA and they are pretty few and far between. I always wonder why they don't advertise more just in the Sunday paper, which a lot of people get the Sunday paper.

Another issue, from experience, I think that H.R. needs to be fully staffed at my facility and better trained in the process, especially for title 38, because it seems there are many, many people with roles to play in hiring the title 38 professional staff—from the nurse recruiter to the chief nurse executive, then to HR, then to the staffing director. It appeared to me that there wasn't a whole lot of working together. It is like they are working separately and have their own piece. But, if no one is really overseeing the whole process, it can just be slow. Personal experience.

Chairman AKAKA. Thank you. Dr. Phelps?

Mr. PHELPS. I would echo what is being said about human resources policies and procedures, but I wonder if I could also add—and it is on the recruitment side but it is also the retention side—about research. Psychologists are kind of a unique discipline. We are trained at the doctoral level to not only be service delivery providers, but also as researchers, and so Dr. Strauss is a great example of our best and brightest. If we are recruiting psychologists to one or the other role in the system, we are missing the skills and the expertise that psychologists like Dr. Strauss bring to the system.

So, the point that she made about release time to do research—because psychologists, again, are not bench researchers as you see in medicine and other places. We research clinical processes, the delivery of service and how best to do that. For example, the two evidence-based practices that VA cites for the treatment of PTSD, those were developed by clinical researchers in VA, those are people who live in the delivery system as well as do research.

The way the system is configured currently, and this is my experience at a number of facilities around the country, is in many cases, psychologists have 5 percent release time to do research. What they do is get together and pool their 5 percent time across eight people and hand it to somebody in the psychology staff to do research. That is a very foolish waste of research and clinical activity, in my opinion. So, a system that recruits people at their skill level and expertise to fill real needs in the system, I think would go a long way.

Chairman AKAKA. Thank you very much, Dr. Phelps.

Dr. Strauss?

Ms. STRAUSS. Let me see. What can I add to this? Probably distinct from other members of the panel, I am on the early side of my career and I have a very fortunate position in VA right now. My hiring was not through the normal course, because I was able to pursue a research path through a grant award early on.

It is not that long ago, though, that I graduated, and I have to say that if I were on the market looking for a job and I understood that it might take 6 months or so for a position at VA to become available or for the offer to come through, I don't know that I would have been able to afford to wait that long. I don't know if I would have felt terribly welcome or wanted.

Because I haven't been in this position, I am not sure if such things are clarified up front. But, I think it would be really important to express clearly up front to new hires what the package is. So, obviously, for a psychologist like myself interested in research, that would be a piece of the puzzle. The potential for other benefits,

like loan repayment programs, would also factor in, and I think would actually be crucially important for people just coming out of school. I think that that is a real factor.

I guess the upshot is, when one graduates, one knows one needs to get a job and wants to land someplace where they are going to feel welcome and really want to build a career. And some of the timelines that I am hearing about, I think could be problematic in recruiting people at the highest level, because hopefully you are talking about people who also have options elsewhere.

Chairman AKAKA. Thank you all so much. Let me call on Senator Burr for his questions.

Senator BURR. Thank you, Mr. Chairman, and I would appreciate it if nobody would take it personally that I missed the first four and got back for Dr. Strauss. It is a scheduling problem.

Dr. McDonald, let me assure you, coming from a guy that represents a State that is over 600-plus miles from one end to the other, I understand what 450 can be and how challenging it can be.

I wanted to just make an observation on your remark about the national licensure process. It does make it easier for the VA to access, in a timely fashion, health professionals. It comes with a tremendous amount of responsibility on the part of VA to make sure that we have gone through the review of these individuals thoroughly. So, I just caution us that speed is not the lone objective, it is the quality of the individuals, and we have had incidences of late where we have gone back and realized that we had a breakdown in our system. I don't think there are any of us that are proponents that we change something in that national licensure, but I think we constantly are reminded that we need to remind the entire system of the responsibility to proceed with caution as we go through it.

Ms. O'Meara, your statement mentioned several bills signed into law that have failed to be fully implemented by the VA through either inaction or delay. Specifically, you mentioned provisions involving contract physicians, provisions to enhance recruitment, retention, and pay improvements. Would you just briefly tell me where you think this disconnect is occurring?

Ms. O'MEARA. Well, the first area is with alternative work schedules for nurses. I do not know of any facility where the 36-hour week paid as full-time 40-hour week has actually been implemented. Neither has a 9-month work year been offered. So, it was as if the bill was never written, the law was never passed. That is the first area.

I think the EDRP program is not fully—the amounts that are even authorized now are not being fully given to individuals and the amounts could be higher, given the cost of education. Those are the two areas I have the most familiarity with.

Senator BURR. Great. Thank you very much.

Dr. Phelps, you highlighted several problems, as well, that are obstacles to retention of VA psychologists. Let me ask you what the normal turnover rate among VA psychologists is and if you have identified any problems that contributed directly to an accelerated departure by psychologists.

Mr. PHELPS. Senator Burr, I do not have the data on turnover rate for psychologists in VA. Anecdotally, having worked with psychologists for a long time in the system, psychologists tend to stay for a long time. We just have had retirement parties for at least four senior psychologists there 30 years, and I am sure those data would be available from the VA system.

My experience, though, is once you are in, you are in. That has changed of late, though, with the promise of advancement through the Hybrid 38 system for many psychologists who have operated—I know many psychologists who have been in senior leadership positions across the country for 20 years who are still at a GS–13 level, which is the journeyman level in the system. The statute was passed to expand that system in 2003. Here we are 5 years later with what we consider very complicated red tape, bureaucratic systems, that essentially are holding our psychologists at bay, continuing to ask them to perform far above the duties of just service delivery or research but rather leadership position of teams, treatment units, whole components of VA and not being able to advance in the system despite qualifying for advancement through the new National Professional Standards——

Senator BURR. If I made the statement that I personally don't think that the VA delivery system responds the same way that the private delivery system does to technology, to research and the findings from that research, would you agree with that?

Mr. PHELPS. I would agree with it mostly, Senator. The issue of the electronic medical record, however, in the VA is one at least we at the APA—we are studying and participating in national efforts for a national medical record—we see that as a world-class system. Now, this is not to say there are not problems with the system, but with regard to personnel and staffing patterns—and I am really not attempting to introduce turf into this hearing, because I have great respect for our physician colleagues, our nurse colleagues, our occupational therapist colleagues, and so forth—but VA, to simplify, VA's hiring procedures and personnel procedures, at least with regard to health care delivery professionals, are ones that were born out of the days when health care in this country was really driven by what we call the doctors' workshop.

And sir, what that means, the doctors' workshop is the hospital. People don't talk about that much anymore. We have seen radical improvements, and I think this Committee has a large responsibility here; over the last 10 years in a great deal of new and modern thinking in the VA's delivery system so that it has moved out of the hospital, into the community. It still needs to go further. The real frontier is the rural frontier, as we heard earlier. But many, many, the development of the electronic record and so forth. But the personnel system is one that was rooted about 40 years ago, back to the doctors' workshop.

Senator BURR. Let me add to something that you said and that is that we might agree that it doesn't happen naturally within the VA and there is a progression that happens naturally in the private health system.

Mr. PHELPS. Yes.

Senator BURR. You are right. It has been prodded by Congress. It has been prodded by you. It has been prodded by associations

that might represent veterans. I think it is safe to say that with the exponential change that health care is seeing in the future, we can't wait for the VA to be prodded to do something if we expect it to be on the cutting edge of research and development. And I think most of us on the Committee believe that as it relates to Traumatic Brain Injury, PTSD, to other mental health challenges, that the data is sufficient in the system to say the faster you can get people in, the more intense the treatment and the rehabilitation can be, the more you can affect the outcome on the other end.

I am sure at some point we will prod to a point that we will actually believe that not only do we have a system that is conducive to that, but we also have the right incentives on the patient side to make sure that, in fact, they are accessing that treatment at an early point in an intense way with their expectations being, "I am going to get better."

I have got to move to Jennifer just real quick, if I can, because you talked about a number of things. You talked about the need to have the right type of facilities. Here is the challenge for this Committee and for the VA as a whole. If you look at the veterans' population, it continues to age, though we have an infusion now, the result of the War on Terror. How much of our responsibility is it to make sure that our investment in facilities reflects where our veterans are living?

It is pretty easy to look at Nevada and see the growth numbers and say, this is a good place to put a VA facility. It is easy to look at North Carolina and the growth projections, but more importantly, the retiring military families and say, gee, we could start building today and we probably couldn't meet the need.

I think we have to go further, and I believe that we have got to get it even closer than just a couple places in a State, and I think Senator Tester said this. Even though you are not going to look at Montana and find a growth pattern that would say, this requires a tremendous investment right now, it still requires us to look at where the population is and decide whether we can restructure the delivery system in a way that we can provide the services in a fashion that more people take advantage of it.

The Chairman and I have exchanged thoughts as it relates to our ability to not dislocate a veteran from his family, not dislocate a veteran and his family from his community to access care. That is how the private system begins to set up. So, I think we have got to think of new efforts in the future.

I am curious to know how much of the research that is done at the Duke VA is driven based upon the tightness of the affiliation with Duke University and the understanding of today's academic institutions about the need to perfect and to focus on research?

Ms. STRAUSS. Let me make sure I am understanding your question. How much of——

Senator BURR. If Duke University wasn't next door and had the tight affiliation with the Durham VA, do you believe the Durham VA would be involved in the degree of research that they are currently involved in?

Ms. STRAUSS. I am actually not sure, but I think that the Duke academic community is a tremendous resource.

Senator BURR. I agree with you totally. My answer would be, probably not. It would probably not be involved in research to the degree that they are, and I think somebody alluded to it earlier—Dr. McDonald or Dr. Phelps—that it really is leveraging knowledge learned from a standpoint of research from the academic world into the clinical world, and understanding where it is appropriate within the Veterans Administration for us to really drive research that, quite frankly, we can't get anywhere else. This is a gold mine if you pick the right types of things.

In Wilmington, North Carolina, we have one of the largest diabetes research studies being done in a community health center. Now, most people around the world would never believe that that would be a beneficial pool to do a study on diabetes. In fact, it is probably the richest pool, and outside of a community health center, I am not sure that you could find the cross-section like you could there.

I think we are going to be challenged in the future as to how we take more of the VA facilities and have that tight relationship with an academic institution, even if it is not right there on the same footprint like Durham exists. I don't think there is any question that we will continue to be challenged to find new ways to market the VA, and this is my last question.

You made a statement that if it hadn't have been for an academic mentor, you might not have gone to the VA and worked. Let me just say——

Ms. STRAUSS. I think my statement was the quality of mentorship available at my facility——

Senator BURR. OK.

Ms. STRAUSS [continuing]. Was a very strong attraction to me.

Senator BURR. My question is, how does the VA change its marketing strategy to market itself to these unbelievable academic institutions and begin to cultivate in these medical students a desire to work at the VA? Is that something we should be doing that we are not doing today?

Ms. STRAUSS. Probably. In my written testimony, one of the things I mentioned is that I was coming from a very traditional academic medical environment, and honestly, VA wasn't on my radar when I first started looking for positions. It was a very trusted graduate school mentor to whom I am quite grateful who suggested to me that given my research interests, this would be a really good fit. On my own, I am not sure I would have considered it, just because in the ivory tower that is academic research, it wasn't on my radar.

Senator BURR. I look at a nurse with a 4-year degree who is being recruited by people from six different States 6 months before she graduates based upon the market today and the need for nurses. The same is true for every health care professional, and I guess the point I was beginning to make is that VA can no longer silently sit by, waiting until people graduate, and hope that VA is in the mix of consideration.

Do we not have to reprogram to where we proactively go out into the community and begin to pull students in; because there is a story to tell, and the story, as Dr. McDonald said, it is not always the highest pay. It is not always the most responsive system. But

the mission that they carry out is a mission that is more fulfilling than anywhere else somebody in the health profession can work.

Listen, we have gone well over the time that I know the Chairman allotted and asked you to be here. And again, I apologize that I have been out and in. I can't thank all of you enough for the value of the information. And Mr. Chairman, I look forward to trying to figure out exactly how we use this in a very positive way with you.

Chairman AKAKA. Thank you. Thank you very much, Senator Burr.

As you know, this hearing is focusing on making VA the workplace of choice and what we are finding out are many facts here, directly from you, the providers. Before we adjourn, I want to ask the panel on your own to say a few last words about making VA the workplace of choice for health care providers. Thinking about that, thinking about what Senator Burr has asked, what can you add to this about making VA the workplace of choice?

Dr. KANOF. Well, I will start. I am going to echo some of the comments that other members have said, and it is not in our statement, but it goes back to our report. Interesting enough, when we did a survey—and again, this was just the CRNAs—salary, while important, was not one of the drivers for what the CRNAs were looking for in terms of improvement. I mean, they really did want the flexibility in their work schedule. We didn't know to ask them about a market as they do in San Francisco, but they wanted flexibility. They wanted child care. They wanted those elements of quality-of-life that actually the Federal Government and many private sector hospitals are providing.

Chairman AKAKA. Dr. McDonald?

Dr. MCDONALD. Thank you, Mr. Chairman. From the AAMC's perspective and from my own personal perspective, I would say that it is to continue to grow graduate medical education, to carefully consider more robust loan repayment schedules for VA physicians, and to ensure that the tradition and importance of a strong affiliate relationship with the VA is true not just at the large premier institutions, but at some of the smaller institutions, such as the two that I am responsible for affiliates with. Thank you.

Chairman AKAKA. Ms. O'Meara?

Ms. O'MEARA. Thank you, Chairman. I think there are several convergence areas for this to make it the workplace of choice. The pay issues, we have discussed all of those and all of them are important, retention pay, recruitment incentives. I think the VA could definitely start a marketing campaign. I don't think I really see that, you know, what Mr. Burr was talking about, to attract people to the mission. I think that sounds wonderful.

One other area that shows up in nursing research a lot is the workplace environment is very important to nurses particularly, and I am sure other health care professionals. The work environment, which has to do with collegiality, with being treated with respect, having a say in your workplace, things like staffing, things like flexible work schedules, if those things aren't implemented, they will be going other places, and for the newer generation coming in, the Gen X-ers, VA has been shown that they will move along. They will not stay in an environment that they don't enjoy.

And so, as opposed to the older generation where we have the 27-year tenures, I don't think we will see that, unless the VA changes. Thank you.

Chairman AKAKA. Thank you. Dr. Phelps?

Mr. PHELPS. Yes. I think the VA's—this is a little beyond the personnel systems—the VA's continued innovation and modernization of the health care system toward more integrated care models, team-based care, all of these are the modern approach to treatment; world class electronic recordkeeping; and that sort of thing; continued innovation in VA so that it is truly seen as the world class health care delivery system that it can be is probably the strongest marketing point, shall we say, not only for veterans seeking care in the system but for health care professionals to come in. And finally, of course, fair pay for a fair day's work for health care professionals.

Chairman AKAKA. Thank you. Dr. Strauss?

Ms. STRAUSS. Thank you. I guess what I can add or at least reiterate from what already has been said, salary, of course, is an issue—fair pay for what we are doing. I will also say that if salary were the driving issue, I wouldn't be here because I could be paid better elsewhere. And so that is not the thing that keeps me here, although I certainly appreciate the opportunity to be paid fairly.

One of the big driving things that attracted me and keeps me here is truly the mission of what we do and how it makes me feel about myself and the time that I am spending doing it, which is quite a bit of time. And I think that once people enter the system, their commitment and attachment to what we are doing only grows.

I think VA could do a better job, potentially, of marketing the quality of training that is offered in this environment. As I mentioned, when I was in graduate school, it really wasn't on my radar. I had no idea, truly, what the resources were and what a tremendous environment this is to grow a career. So, it is a bit of a kept secret and I wish that weren't the case.

And for the record, I plan to be here for many years to come, so I have every intention and very much hope to continue to build a career at VA.

Chairman AKAKA. Thank you very much, Dr. Strauss.

In closing, I again want to thank this panel for appearing today. Your input on these issues is valuable to this Committee as we work to make VA the employer of choice in our country, and especially for health care professionals in the years to come.

I want you to know that we will be submitting additional questions to you for the record, and again, I want to say thanks so much for your responses today.

This hearing is adjourned.

[Whereupon, at 12:20 p.m., the Committee was adjourned.]

A P P E N D I X

DUKE UNIVERSITY MEDICAL CENTER,
Durham, NC, April 7, 2008.

Hon. DANIEL K. AKAKA,
Chairman,
Senate Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR CHAIRMAN AKAKA: My name is Harvey Jay Cohen, MD. I am the Professor and Chairman of Department of Medicine at Duke University Medical Center, having recently retired from the Department of Veterans Affairs after 35 years of service. I am extremely sorry that I cannot accept the invitation to appear in person before your Committee to offer testimony regarding the VA Research Service. Unfortunately, unavoidable prior scheduling conflicts preclude my doing so. However, I am delighted to respond to the opportunity to write today to express my strongest support for the VA Research Service. I do so because it is my belief that my own career mirrors many others in the VA, and can offer an example of how the VA can be a pivotal driving force in the recruitment and retention of physicians for the Department of Veterans Affairs. In many respects I owe the greatest debt of gratitude to the VA Research Service for offering me the opportunity to initiate and develop essentially my whole career within the VA and in affiliation with Duke University. I believe this a model replicated many times over across this country.

Let me illustrate. In 1971 I was a young faculty member, just having joined the faculty at Duke University one year before. As you may know, our institution is closely affiliated with the VA Medical Center in Durham, located just across the street. I had done part of my residency training and fellowship training at the VA, and had an excellent experience. When asked if I would consider spending my clinical time in hematology and oncology at the VA, I initially hesitated because in addition to my commitment to clinical and educational activities, I was interested in developing my research career as well. When I learned that I could compete for an opportunity to receive a Research Career Development Award, I seized that opportunity immediately. I was fortunate enough to compete successfully and became a VA Research Clinical Investigator the following year. I set up my laboratory at the VA, and became a full time VA investigator and clinician. In ensuing years, I became the Chief of the Hematology/Oncology section at the VA, and then Chief of the Medical Service from 1976 through 1982. Throughout that period I remained funded by competitive grants under the VA merit review program. I also held funding through the NIH, but based that entire activity at the VA.

In subsequent years I became interested in the new discipline of geriatrics and led the effort at our institution to secure a Geriatric Research Education and Clinical Center in the early 1980's, and from that point forward concentrated my efforts on geriatrics with an emphasis on cancer in the older individual. This further cemented my ties with the VA as we continued to expand and develop our programs. Those programs became the basis for the development of the entire geriatrics program at Duke University as well as the VA, a program that has for the last several years been consistently ranked in the top five in the country. Over those years, as my research interests evolved, the VA Research Service offered me the opportunity not only to compete for more basic research, but subsequently for more health services-oriented research and cooperative studies. Each of these, I hope, made contributions to our ability to care for our patients better, but also offered me wonderful opportunities which further cemented my relationship with the VA. This is just one example of how the broad spectrum of the portfolio of VA research can accommodate and encourage physicians with many different interests to serve within the VA system. Personally the VA Research Service allowed me the opportunity to take on clinical and administrative roles which kept me within the system for virtually my en-

tire career. I could not be more enthusiastic about the potential of the VA Research Service.

However, currently there are great challenges despite the tremendous opportunities that continue to exist. Among these challenges is that over the years, the clinical load has increased for many of the physicians within the VA, and this has had consequences in the ability to devote time to research. This is not a problem for people in the career development program. However, for those who are in the clinical service, despite having funding for merit review grants, the time to do the research is difficult to carve out. While it is my understanding that accommodations have been made for this through the VERA modeling, and funding is supposed to be provided to support these investigators' research time, it would appear that because of tight budgetary constraints and other priorities, these dollars do not end up supporting that time directly. It seems to me that the VA might consider an option somewhat like one that the NIH uses when money is awarded to the VA Research Service, such that when physician investigators apply for research grants a portion of their time and FTE could be budgeted directly on the grant, and thus will directly protect that time for the research activity. A second challenge is that science has evolved. In past years, when I was beginning my career the individual investigator working in his laboratory, perhaps with some collaborations, could be successful. Currently, however, with the evolution of scientific technology, it is rare that this situation occurs. Rather, science has become a team game. One needs an environment that is supportive both in terms of infrastructure and in terms of colleagues with complementary scientific expertise. This is sometimes difficult to achieve within a given VA institution's walls, although at some of the more complex tertiary care medical centers with substantial affiliations this can be done. However, even in those circumstances, a flexible and fluid approach to location and activities for any budding investigator must be encouraged, to allow the best of translational science to bring the best of care for the future, to the VA.

Despite these challenges I believe that the VA research system still has great potential. In particular, it has substantial advantages related to the patient population. This is a national system with national databases and the potential to provide accurate patient descriptions (sometimes referred to as the phenotype) which can inform research in many different areas, in particular genomics research. This would allow the VA to participate actively in the coming revolution in the approach to personalized medicine. The databases within the VA are a natural for large-scale epidemiologic work, and the patient population is a natural for cooperative studies. Moreover, as the proportion of women now being cared for by the VA has increased, the patient population becomes even more representative for such studies.

Finally, let me say a bit about the critical role that VA research has played in supporting the growth of certain areas and disciplines. Perhaps the best example of this is geriatrics. My own career parallels the growth of geriatrics in this country, a growth largely initiated and sustained by funding of centers such as the Geriatrics Research Education and Clinical Centers, and subsequently MIRECs and others. These have been able to focus activity through groups of investigators with similar interests to work together and have made great advances, both for the VA and the country at large. Such centers, especially the GRECCS, are under substantial budgetary threats. I would urge the Committee, as it looks at VA research, to find ways to protect these jewels in the VA's crown.

As you can tell, I am most enthusiastic about the VA and its research. Why should I not be? It has afforded me the ability to grow my career while being able to be of service to the veterans in this country to whom we owe so much. Thank you for the opportunity to provide this testimony.

Sincerely,

HARVEY JAY COHEN, M.D.,
Walter Kempner Professor and Chair, Department of Medicine,
Director, Center for the Study of Aging and Human Development,
Duke University Medical Center.

PREPARED STATEMENT BY ANN CONVERSO, RN, PRESIDENT, UNITED AMERICAN NURSES, AFL–CIO

I would like to thank the Chairman, Ranking Republican Member, and Members of the Committee for the opportunity to provide testimony for the hearing on "Making the VA the Workplace of Choice for Health Care Providers." My name is Ann Converso and I have been a registered nurse in acute medical/surgical units and later I.V. therapy at the VA Western New York Health Care in New York's VISN 2 region for more than 30 years. I have also been an active member of my union,

the United American Nurses (UAN), AFL–CIO, during that time. I am testifying today as the President of the United American Nurses, a union representing registered nurses—6,000 of whom are VA nurses.

There exists a health care crisis in our country regarding the shortage of registered nurses. A 2002 report by the Health Resources and Services Administration states that by 2020, hospitals will be short 808,416 RNs. In a 2002 survey by the United American Nurses, three out of every ten nurses said it was unlikely they would be a hospital staff nurse in 5 years. The VA health care system has by no means been immune to the shortage.

As nurses leave the VA system, new nurses are not joining the VA at comparable rates, and patient load is increasing. In its own report, "A Call to Action," the VA states that it must replace up to 5.3 percent of its RN workforce per year to keep up with RNs retiring. By all accounts, that is not happening. In its Web site documentation of system-wide capacities, VA statistics show that between 1996 and 2002 the number of full-time-equivalent RNs went down by 8.4 percent. During that same time period, the number of "unique patients" treated at the VA went up by 55 percent.

In my years as a VA nurse, I have experienced several nursing shortages firsthand. I believe I speak for other VA nurses when I say that we love our jobs and the important work we do in caring for our Nation's veterans. With that said, registered nurses are leaving the bedside in favor of the many other job options now available to us, from clinic jobs, outpatient jobs, computer jobs, quality management, doctors' offices, pharmaceutical jobs or leaving nursing entirely. A contributing factor causing registered nurse to leave the VA is problems they are experiencing with section 7422 of title 38.

Congress amended Title 38 to provide medical professionals who work at VA facilities with collective bargaining rights, which include the rights to use the negotiated grievance procedure and arbitration. Under 38 U.S.C., section 7422, covered employees can negotiate, file grievances and arbitrate disputes over working conditions except "any matter or question concerning or arising out of:"

- professional conduct or competence (defined as direct patient care or clinical competence;
- peer review; or
- the establishment, determination, or adjustment of employee compensation.

Increasingly, VA management has interpreted these exceptions very broadly, and has refused to bargain over significant workplace issues affecting medical professionals. Recent court decisions are upholding VA's broad reading of Section 7422, even when management raises it after completion of the arbitration process.

Congress passed this law in 1991 to strengthen the bargaining rights of VA medical professionals. By its own admission, the VA recognizes the critical role that health care professionals play in improving quality of care. According to the VA Office of Nursing, "VA nurses have been widely recognized for their instrumental work in initiating, developing, implementing, and monitoring the practices and policies that made VHA one of the world's foremost authorities in patient safety and quality outcomes evidenced by performance measures—an exceptional achievement by any assessment." (DVA Web site, April 30, 2007)

In practice, VA health care professionals have a shrinking role in quality assurance and patient safety. Too often, the Human Resource staff is making health care decisions instead. The VA's current 7422 policy goes directly against good medicine and Congressional intent. Employees leave the VA for other public and private health care systems where they have more rights, which in turn pose's a threat on recruitment and retention at the VA. Congress needs to amend section 7422 of Title 38 to ensure that the VA complies with Congressional intent and that registered nurses are able to care for veterans with dignity, respect and the basic bargaining rights they were intended to have.

To address this problem, Senator Rockefeller, along with Senators Webb, Brown, and Mikulski introduced S. 2824, a bill that would improve collective bargaining rights of registered nurses in the Department of Veterans Affairs. The UAN is pleased by the introduction of this legislation and strongly endorses it. The UAN strongly urges Members of the Committee to support and work for the passage of this important legislation.

Thank you again for opportunity to provide testimony regarding this important issue. The UAN looks forward to working with the Committee to protect registered nurses and the veterans they take care of.

PREPARED STATEMENT SUBMITTED BY CHARLES INGOGLIA, VICE PRESIDENT OF PUBLIC POLICY ON BEHALF OF THE NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

The National Council for Community Behavioral Healthcare appreciates the opportunity to submit testimony on behalf of its 1,400 member agencies who provide medical and rehabilitative treatment and support services to nearly six million adults, children, and families with mental and addiction disorders in every community across America.

We appreciate the Committee's interest in meeting the physical and behavioral health needs of our Nation's veterans. Since the initiation of OEF and OIF, nearly 800,000 servicemembers have been discharged and are eligible for VA care. Of those, more than one-third sought medical care within the VA. The Department has also acknowledged that mental disorders are the second most commonly reported health concern by veterans seeking care.

A June 2007 Army study found that 49% of Army National Guard soldiers and 43% of Marine reservists reported symptoms of PTSD, anxiety and depression. At the end of their tours of duty, these citizen soldiers return to their families and communities, oftentimes miles away from a VA facility.

To meet this need, the VA has hired nearly 3,800 mental health workers, including physicians, nurses, pharmacists, social workers, and clinical psychologists, since 2005. Most of these professionals have been hired in the past 18 months. The Department has expressed interest in hiring at least an additional 500 mental health workers in the near future.

The VA's interest in hiring permanent full time staff to meet this need is based on a stated desire to assure sustainable, evidence-based programs. This approach, however, is exacerbating an existing mental health workforce shortage, and may not meet the long-term treatment and rehabilitation needs of returning veterans.

Most Americans with serious mental illnesses receive their treatment from government sponsored or not-for-profit community-based mental health organizations. From California to Maine, and in every State in between, there is currently a shortage of qualified mental health workers. While the shortage of psychiatrists and nurses is the most severe, there are shortages in all areas, including social workers, mental health counselors, and psychologists.

The VA's recent efforts to increase its mental health workforce have exacerbated this shortage. Community-based mental health organizations around the country report that staff are being recruited away by the VA, leaving them unable to serve current clients and looking once again for qualified replacements in a market with few to choose from. This situation is even more acute in rural areas of the country.

While it is clear that many returning servicemembers are currently seeking care for mental disorders, it is less than clear what their long-term treatment needs will be. Instead of providing for a "surge capacity" to meet the current need, the VA is hiring permanent, full time staff in a system where the average employee remains until retirement. Such as approach would also provide the Department, and Congress, time to understand the long-term treatment needs of Veterans and to develop effective programs to meet them, as opposed to building a system that may not be relevant to what veterans need or want.

In our view, rather than competing with, or recruiting from, existing community-based mental organizations, the VA could pursue a targeted strategy of cooperation and collaboration through service partnerships. Such a course of action would provide immediate treatment capacity, as well as ameliorate the ongoing damage to the private sector inflicted by VA recruitment of mental health professionals.

Further, the establishment of service partnerships with existing community-based organizations would also extend the ability of the VA to provide needed treatment services in rural areas of the country where many returning National Guard and Reserve component veterans live. The stigma associated with mental illnesses already serves as a barrier to care, veterans do not need the further barrier of long travel times to access care.

Effective service partnership would be characterized by VA control of the referral process, as well as minimum standards for clinical training. Community organizations participating in such arrangements would be required to hire veterans as peer outreach workers, and to be competent in understanding the military culture and mindset. Additionally, all treatment records would be transmitted to the VA for inclusion in the veteran's electronic medical record to assure continuity of care.

Such models of cooperation exist, albeit in short supply. It is recognized that any such arrangements would be in existence only as long as the need existed and are not intended to replace the existing network of VA controlled care.

We would welcome the opportunity to work with the Committee to further develop these issues in support of our troops, and I would be pleased to answer any questions you might have. Please feel free to contact me by telephone at 301.984.6200, ext. 249, or via email—chucki@thenationalcouncil.org.

PREPARED STATEMENT OF SARA MARBERRY, EXECUTIVE VICE PRESIDENT, AND ANJALI JOSEPH, PH.D., DIRECTOR OF RESEARCH AT THE CENTER FOR HEALTH DESIGN

Chairman Akaka and distinguished Members of the Committee, I am Sara Marberry with The Center for Health Design, along with my colleague Anjali Joseph. Thank you for the opportunity to present our thoughts on how the design of the physical environment of health care can help increase patient and staff safety and satisfaction, and worker efficiency.

The Center for Health Design, which was founded in 1993, is a nonprofit research, education, and advocacy organization of forward-thinking health care, elder care, design, and construction professionals who are leading the quest to improve the quality of health care facilities and create new environments for healthy aging. Our mission is to transform health care settings into healing environments that improve outcomes through the creative use of evidence-based design.

Traditionally, health care environments have been organized to support the individual work efforts of practitioners in various roles and disciplines (doctors, nurses, therapists, dieticians, and many others) who work primarily in their areas of expertise and attempt to coordinate with others by orders, notes, phone calls, pages and other methods of individual communication. Patients and families have traditionally been viewed as passive recipients of care rather than as active experts in their own life and health conditions.

In contrast, a growing body of evidence compiled by The Center for Health Design and others demonstrates that health care work happens most effectively when practitioners work highly interdependently in well-functioning teams, with active participation by patients and families (McCarthy & Blumenthal, 2006; Uhlig, Brown, Nason, Camelio, & Kendall, 2002). As care moves from simply "treating disease" to healing the individual in a holistic sense—physically, emotionally and psychologically—health care teams must increasingly work seamlessly together and include the patient and family as integral team members.

A disconnect has arisen between the traditional, individual-centric health care organizational and physical infrastructure of the workplace and the way that health care practitioners, patients, and families optimally must work together. This manifests itself in the form of inefficiencies, communication breakdowns, occupational stress, medical errors, and other operational failures that are alarmingly common in health care today.

Further, the physical environment of the health care workplace, along with other factors such as culture and work processes, also impacts the health and safety of the health care workforce. According to the Peter D. Hart Research Associates' (2001) survey of registered nurses (RN), the primary reason why nurses leave health care other than for retirement reasons is to find a job that is less stressful and physically demanding. In a survey of nurses conducted by the American Nurses Association (2001), 76% of the nurses stated that unsafe working conditions interfered with their ability to provide quality care.

In order to understand and address these problems, it is necessary to consider the health care workplace as an interdependent system comprised of the physical environment, work processes, organizational culture (e.g. formal and informal values, norms, expectations and policies, etc.), workforce demographics, and information technology (Becker, 2006). It is important to consider the interdependencies and patterns of interaction between these elements, rather than focusing on individual elements alone.

While several studies indicate that the physical environment impacts staff outcomes in health care settings, it is clear that a well-designed environment alone is unlikely to achieve its intent without a supportive work culture and the technology in place. Likewise, a supportive work culture such as one that promotes family and patient participation in care processes is unlikely to function successfully without the presence of design features (such as space for families in patient rooms) that make this possible.

Hospital redesign and renovation projects provide the opportunity to consider how these different elements might interact. The challenge is to create settings where the physical environment, technology and organizational culture together support ways of working that ensure health, safety and effectiveness for all in health care.

HOSPITALS ARE DANGEROUS PLACES TO WORK

Of the 14 industries with the highest numbers of occupational injuries and illnesses, three are in health care, with the top two being hospitals and nursing and residential care facilities. Health care workers are exposed to various occupational hazards on a daily basis. They are exposed to airborne infections in the hospital as well as those acquired through direct contact with patients. Taking care of patients in the hospital is often back breaking work with nurses required to manually lift heavy patient loads. This is an issue of great concern today with the increasing bariatric population in US hospitals.

For night shift nurses, poorly entrained circadian rhythms and lack of sleep contribute to stress, fatigue and health deterioration. In addition, other environmental stressors such as high noise levels, inadequate light and poorly designed workspaces impact staff health and safety. Proper design of health care settings along with a culture that prioritizes the health and safety of the care team through its policies and values can reduce the risk of disease and injury to hospital staff and provide the necessary support needed to perform critical tasks.

Health care employees are at serious risk of contracting infectious diseases from patients due to airborne and surface contamination (Clarke, Sloane, & Aiken, 2002; Jiang et al., 2003; Kromhout et al., 2000; Kumari et al., 1998; Smedbold et al., 2002). Factors such as poor ventilation and fungal contamination of the ventilation system that have been linked to the spread of nosocomial infections among patients may also impact staff. For example, one study that examined the relationship between indoor environmental factors and nasal inflammation among nursing personnel found the contamination of air ducts with Aspergillus fumigatus to be the source of infection (Smedbold et al., 2002). A recent study conducted in the wake of the SARS epidemic in China found that isolating SARS cases in wards with good ventilation could reduce the viral load of the ward and might be the key to preventing outbreaks of SARS among health care workers, along with strict personal protection measures in isolation units (Jiang et al., 2003).

While ventilation system design and maintenance is critical to controlling the spread of airborne infections, infections are often spread through direct and indirect contact with patients. Ulrich and colleagues (2004) in their extensive literature review concluded that poor handwashing compliance among staff is the primary cause of contact transmission of infections. They suggest that providing environmental supports to increase handwashing including visible, conveniently placed sinks, handwashing liquid dispensers, and alcohol rubs might be more successful in improving and sustaining handwashing compliance than education programs alone (Ulrich, Zimring, Joseph, Quan, & Choudhary, 2004). They also document several studies that clearly show that nosocomial infection rates are lower in single patient rooms as compared to semiprivate rooms (Ulrich, Zimring, Joseph, Quan, & Choudhary, 2004). These environmental measures that are linked to increased patient safety are also likely to protect staff from infection.

44% of injuries to staff are strains & sprains

Nursing work has become increasingly complex with changing technology, changing work practices, and increasing documentation requirements. Further, nurses are growing older and the patient demographics are changing as well. Lower back pain is a pervasive problem among nursing staff and is a result of poor fitness, long periods of standing and efforts far exceeding workers' strengths (Brophy, Achimore, & Moore-Dawson, 2001; Camerino et al., 2001; Miller, Engst, Tate, & Yassi, 2006). Patient lifting in particular is a major cause of injury to health care workers. According to Fragala and Bailey (2003), 44% of injuries to nursing staff in hospitals that result in lost workdays are strains and sprains (mostly of the back), and 10.5% of back injuries in the United States are associated with moving and assisting patients. Reducing injuries that result from patient-lifting tasks cannot only result in significant economic benefit (reduced cost of claims, staff lost workdays), but also reduce pain and suffering among workers.

Ergonomic programs, staff education, a no-manual lift policy, and use of mechanical lifts have been successful in reducing back injuries that result from patient-handling tasks (Engst, Chhokar, Miller, Tate, & Yassi, 2005; Garg & Owen, 1992; Garg, Owen, Beller, & Banaag, 1991; Joseph & Fritz, 2006; Miller, Engst, Tate, & Yassi, 2006). When PeaceHealth in Oregon installed ceiling lifts in most patient rooms in their intensive care unit and neurology unit, they found that the number of staff injuries related to patient handling came down from 10 in the 2 years preceding lift installation to two in the 3 years after lift installation (Joseph & Fritz, 2006). The annual cost of patient handling injuries in these units reduced by 83% after the lifts were installed (Joseph & Fritz, 2006).

This study, as well as others, has emphasized the importance of instituting a no-manual lift policy (along with the installation of mechanical lifts) in hospitals to prevent such injuries from occurring. Another environmental design feature that has been linked to reduced discomfort (particularly for the lower extremities and lower back) for workers who spend large amounts of time on their feet, is using softer floors (such as rubber floors) (Redfern & Cham, 2000).

Ergonomic evaluations of the work area of different types of nursing staff might provide solutions to problems that are specific to different groups. For example, based on an ergonomic evaluation of the work area of scrub nurses in the operating room, Gerbrands and colleagues (2004) provided short term solutions for reducing the neck and back problems experienced by this group as well as suggested guidelines for operating room design.

Noise levels in hospitals are louder than a jackhammer

The effects of noise on patients are well known. However, few studies have examined the impact of noise on health care staff. Ulrich and colleagues (2004) analyzed several studies that measured noise levels in hospitals and found that background noise levels in hospitals were typically in the range of 45 dB to 68 dB, with peaks frequently exceeding 85 dB to 90 dB, which is as loud as a jackhammer. This is well above the values (35 dB) recommended by the World Health Organization guidelines (Berglund, Lindvall, & Schwela, 1999).

Staff perceive higher sounds levels as interfering with their work (Bayo, Garcia, & Garcia, 1995) and higher sounds levels are also related to greater stress and annoyance among nursing staff (Morrison, Haas, Shaffner, Garrett, & Fackler, 2003). Importantly, noise-induced stress in nurses correlates with reported emotional exhaustion or burnout (Topf & Dillon, 1988). Blomkvist and colleagues (2005) examined the effects of changing the acoustic conditions on a coronary intensive-care unit (using sound absorbing versus sound reflecting ceiling tiles) on the same group of nurses over a period of months. During the periods of lower noise, many positive outcomes were observed among staff including improved speech intelligibility, reduced perceived work demands and perceived pressure and strain (Blomkvist, Eriksen, Theorell, Ulrich, & Rasmanis, 2005).

DESIGNING BETTER WORKPLACES CAN REDUCE ERRORS & INCREASE EFFICIENCY

The tasks performed by the health care team involve a complex choreography of multiple activities including direct patient care, indirect care such as filling meds, coordination with care team members, accessing and communicating information, documentation of patient records and other housekeeping tasks (Lundgren & Segesten, 2001; Tucker & Spear, 2006). Studies have shown that increased nursing time per patient results in better patient outcomes (Institute for Health care Improvement, 2004; Tucker & Spear, 2006).

However, the fact remains that nurses spend less than half their time delivering direct patient care (Institute for Health care Improvement, 2004). Nurses spend a lot of their time searching for other staff, materials, missing meds and supplies and also are frequently interrupted during their work to address these problems (Tucker & Spear, 2006). In one study, a hospital nurse was interrupted 43 times during a 10-hour period, including 10 instances when necessary materials, equipment and personnel were unavailable (Potter et al., 2004).

At the root of the inefficiencies in health care is a physical and organizational infrastructure that is completely out of sync with the optimal practice of health care. It is becoming increasingly clear that poorly designed physical environments along with other factors such as lack of social support and an unsupportive work culture, reduces the effectiveness of staff in providing care and potentially leads to medical errors.

Nurses spend a lot of time walking

According to an unpublished time and motion study by Hendrich and colleagues (cited in the 2004 Institute of Medicine Report, Keeping patients safe: Transforming the work environment of nurses, pp. 251), most of nurses' time is spent walking between patient rooms, the nursing unit core and the nurses' station. Most older existing hospital units have centralized nursing stations with different configurations such as radial, racetrack, single or double corridor where the nursing station is located centrally and patient rooms are located around the perimeter. This kind of arrangement necessitates frequent trips between patient rooms and the nurses' station to look for supplies, charting, filling meds, and so on. According to one study, almost 28.9 percent of nursing staff time was spent walking (Burgio, Engel, Hawkins, McCorick, & Scheve, 1990). This came second only to patient-care activities, which accounted for 56.9 percent of observed behavior.

A few studies have examined the impact of unit layout on the amount of time spent walking (Shepley, 2002; Shepley & Davies, 2003; Sturdavant, 1960; Trites, Galbraith, Sturdavant, & Leckwart, 1970) and two studies showed that time saved walking was translated into more time spent on patient-care activities and interaction with family members. Shepley and colleagues (2003) found that nursing staff in a radial unit walked significantly less than staff in a rectangular unit (4.7 steps per minute versus 7.9 steps per minute). Two other studies also found that time spent walking was lower in radial units as compared to rectangular units (Sturdavant, 1960; Trites, Galbraith, Sturdavant, & Leckwart, 1970). It must be noted that in the units examined in these studies, the nursing station was centralized with rooms arrayed around it.

These studies seem to suggest that bringing staff and supplies physically and visually closer to the patients helps in reducing the time spent walking. Centralized location of supplies, however, could double staff walking and substantially reduce care time irrespective of whether nurses stations were decentralized (Hendrich, 2003). There is also anecdotal evidence that staff members who move from a centralized nursing unit to a decentralized unit often feel isolated and miss the camaraderie and support of the centralized unit. The social interactions that occur within the care team are critical for information sharing and effective communication. While the decentralized unit potentially has many benefits, it is important to consider how the design might impact staff interactions.

98,000 needless deaths a year

According to the IOM report, "To err is human: Building a safer health care system", more than 98,000 people die each year in U.S. hospitals due to medical errors (Kohn, Corrigan, & Donaldson, 1999). According to Reiling and colleagues (2004) while some errors (active failures) occur at the point of service (for example, a nurse administering the wrong drug), most occur due to flaws in the health care system or facility design—such as due to high noise levels or inadequate communication systems.

Inadequate lighting and a disorganized chaotic environment are likely to compound the burden of stress for nurses and lead to errors. A few studies have shown that lighting levels and workplace design can impact errors in dispensing medication in pharmacies. One study examined the effect of different illumination levels on pharmacists' prescription-dispensing error rate (Buchanan, Barker, Gibson, Jiang, & Pearson, 1991). They found that error rates were reduced when work-surface light levels were relatively high (Buchanan et al., 1991). In this study, three different illumination levels were evaluated (450 lux; 1,100 lux; 1,500 lux). Medication-dispensing error rates were significantly lower (2.6%) at an illumination level of 1,500 lux (highest level), compared to an error rate of 3.8% at 450 lux.

This is consistent with findings from other settings that show that task performance improves with increased light levels (Boyce, Hunter, & Howlett, 2003). Two investigations of medication dispensing errors by hospital pharmacists found that error rates increased sharply for prescriptions when an interruption or distraction occurred, such as a telephone call (Flynn et al., 1999; Kistner, Keith, Sergeant, & Hokanson, 1994). Thus, lighting levels, frequent interruptions or distractions during work, and inadequate private space for performing work can be expected to worsen medication errors.

PHYSICAL ENVIRONMENT IMPACTS STAFF & PATIENT SATISFACTION

There is evidence that a supportive physical work environment, along with other factors such as high autonomy, low work pressure and supervisor support, positively impacts job satisfaction and burnout among nurses (Constable & Russell, 1986; Mroczek, Mikitarian, Vieira, & Rotarius, 2005; Tumulty, Jernigan, & Kohut, 1994; Tyson, Lambert, & Beattie, 2002). Further, studies show that environments (i.e. physical environment, culture and work processes) that include patients and families as active participants in the care process (as opposed to passive recipients of care) result in higher levels of satisfaction among patients and families (Sallstrom, Sandman, & Norberg, 1987; Uhlig, Brown, Nason, Camelio, & Kendall, 2002).

Studies show that physical design changes in long-term care settings such as interior design modifications, natural elements, furniture repositioning to support social interaction, design supports for resident independence (such as large clocks, handrails, additional mirrors) and orientation (large, clear signposts and reality orientation boards), and artwork were related to improved morale and satisfaction among staff (Christenfeld, Wagner, Pastva, & Acrish, 1989; Cohen-Mansfield & Werner, 1999; Jones, 1988; Loeb, Wilcox, Thornley, Gun-Munro, & Richardson, 1995; Parker et al., 2004). Tumulty and colleagues (1994) suggest that if staff were allowed to

make small design modifications to their existing environments, their satisfaction with their jobs might increase.

Other studies, primarily conducted in long-term-care settings, suggest that smaller units contribute to reduced stress and increased staff satisfaction. A cross-sectional survey of 1,194 employees and 1,079 relatives of residents in 107 residential-home units and health-center bed wards found that large unit size was related to increased time pressure among employees and reduced quality-of-life for residents (Pekkarinen, Sinervo, Perala, & Elovainio, 2004). Other studies found that small unit sizes were positively associated with increased supervision and interaction between staff and residents in a special-care unit for residents with dementia (McCracken & Fitzwater, 1989). However, no consistent numbers are offered on what makes a unit large or small (Day, Carreon, & Stump, 2000) and it is also not clear how these findings translate to acute care settings. Further, even in small units, it is important to consider how the design impacts staff ability to monitor residents. Morgan and Stewart (Morgan & Stewart, 1998) found that in a newly designed, low-density special-care unit with private rooms, enclosed charting spaces, and secluded outdoor areas and activity areas, staff spent increased time monitoring and locating residents.

An important point that is emphasized in many of these studies is that design changes alone are not likely to impact staff behavior, satisfaction and stress. They must be accompanied by a supportive culture and progressive work practices to result in overall beneficial outcomes for patients and staff.

NOW IS THE TIME

We believe there is an urgent need to address the inherent problems in the health care workplace that lead to staff injuries, medical errors, and waste. The physical environment plays an important role in improving the health and safety for staff, increasing effectiveness in providing care, reducing errors and increasing job satisfaction. By utilizing available evidence to plan and design new facilities, VA hospitals can create work environments that help reduce staff turnover and increase retention, two key factors related to providing quality care.

However, it has become increasingly clear to us that efforts to improve the physical environment alone are not likely to help any health care organization achieve its goals without a complementary shift in work culture and work practices. While the studies we cited in this testimony demonstrate that well designed physical workplaces can support staff in their work and increase health and safety for both staff and patients, there is a definite need for more research examining the effectiveness of new design innovations such as acuity adaptability, standardized patient rooms, and decentralized nursing stations within the larger context of any health care organization's culture, technology changes, and work practices.

Respectfully submitted,

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